JULIE BRANN, D.MIN, MSN, NP-RXN

REGISTRATION FORM

(Please Print)

Today's date:				PCP:		
PATIENT INFORMATION						
Patient's last name: First: Middle:			❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / Div / Sep / Wid	
Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F	
Street address:		Social Security no.:		Home phone no.: ( )		
P.O. box:	City:		State:	ZIP Code:		
E-Mail Address:						
Occupation:	Employer:			Employer phone no.: ( )		
Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other						
Other family members seen here:						

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Person responsible for bill:	Birth date: / /	Address (if different):	Home phone no.: ( )
Is this person a patient here? ❑ Yes ❑ No			
Occupation:	Employer:	Employer address:	Employer phone no.: ( )
Is this patient covered by insurance? ❑ Yes ❑ No			

Please indicate primary insurance ❑ Aetna ❑ Blue Cross Blue Shield (BCBS) ❑ United Healthcare ❑ Tricare ❑ Cigna ❑ Medicare ❑ Medicaid ❑ Humana Military ❑ Welfare *(Please provide coupon)* ❑ Other						
Subscriber's name:	Member ID# or Tricare Benefits#:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $	
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other						
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:		
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other						
PREFERRED Pharmacy: Name:						
Address:						
Phone #:						

What mental health symptoms bring you to the office today?

Have you ever received a mental health diagnosis in the past? If yes, what previous treatment have been helpful?

Are there any mental health issues on your mother's or father's side of the family? Or your siblings? Or your children?

List any allergies here:

List any current medications here, or any over the counter supplements, herbals supplements, or vitamins:

Check any of the following antidepressants you have taken in the past:

- ☐ Prozac/Sarafem/fluoxetine
- ☐ Zoloft/sertraline
- ☐ Paxil/Pexeva/paroxetine
- ☐ Luvox/fluvoxamine
- ☐ Celexa/citalopram
- ☐ Lexapro/escitalopram
- ☐ Effexor/venlafaxine
- ☐ Wellbutrin/Zyban/bupropion
- ☐ Remeron/mirtazapine
- ☐ Cymbalta/duloxetine
- ☐ Other

Check any of the following mood stabilizers you have taken in the past:

- ☐ Lithium/Eskalith/Lithobid
- ☐ Depakote/Depakene/valproic acid
- ☐ Lamictal/lamotrigine
- ☐ Tegretol/Epitol/Equetro/carbamazepine
- ☐ Trileptal/oxcarbazepine
- ☐ Neurontin/gabapentin
- ☐ Lyrica/pregabalin
- ☐ Topamax/topiramate
- ☐ Other

Check any of the following anxiety/sleep agents you have taken in the past:

- ☐ Valium/diazepam
- ☐ Librium/chlordiazepoxide
- ☐ Ativan/lorazepam
- ☐ Xanax/alprazolam
- ☐ Klonopin/clonazepam
- ☐ BuSpar/buspirone
- ☐ Restoril/temazepam
- ☐ Halcion/triazolam
- ☐ Ambien/zolpidem
- ☐ Sonata/zaleplon
- ☐ Lunesta/eszopiclone
- ☐ Rozerem/ramelteon
- ☐ Other

Check any of the following antipsychotics/tranquilizers/anti-parkinsonians you have taken in the past:

- ☐ Invega/paliperidone
- ☐ Risperdal/risperidone
- ☐ Clozaril/clozapine
- ☐ Zyprexa/olanzapine
- ☐ Seroquel/quetiapine
- ☐ Geodon/ziprasidone
- ☐ Abilify/aripiprazole
- ☐ Latuda/lurasidone
- ☐ Thorazine/chlorpromazine
- ☐ Mellaril/thioridazine
- ☐ Trilafon/perphenazine
- ☐ Haldol/haloperidol
- ☐ Artane/trihexyphenidyl
- ☐ Cogentin/benztropine
- ☐ Symmetrel/amantadine
- ☐ Other

Check any of the following other psychoactive substances you have taken in the past:

- ☐ Adderall/Adderall XR
- ☐ Vyvanse
- ☐ Ritalin/Concerta/Metadate/Methylin
- ☐ Daytrana/methylphenidate
- ☐ Focalin/dexmethylphenidate
- ☐ Strattera/atomoxetine
- ☐ Provigil/modafinil
- ☐ Aricept/donepezil
- ☐ Exelon/rivastigmine
- ☐ Razadyne/Reminyl/galantamine
- ☐ Namenda/memantine

- ☐ Suboxone/Subutex/buprenorphine
- ☐ Antabuse/disulfiram
- ☐ Campral/acamprosate
- ☐ Revia/Vivitrol/naltrexone

Smoking Status

- ☐ Never smoker
- ☐ Former smoker
- ☐ Light tobacco smoker
- ☐ Current some day smoker
- ☐ Current every day smoker
- ☐ Heavy tobacco smoker

How much caffeine do you use? Coffee? Tea? Caffeinated sodas? Energy Drinks?

Recreational Drug use? Check any of these substances you have used in the past:

- ☐ Antabuse/disulfiram
- ☐ Alcohol
- ☐ Marijuana/grass/pot/weed/hash
- ☐ Ecstasy/MDMA
- ☐ LSD
- ☐ Mescaline
- ☐ Peyote
- ☐ Psilocybin/mushrooms
- ☐ DMT
- ☐ STP
- ☐ PCP
- ☐ Glue/other volatile inhalants
- ☐ Heroin/other opiates
- ☐ Quaaludes
- ☐ Barbiturates
- ☐ Other

Current or past medical condition. Check any that apply:

- ☐ Do you have any chronic conditions? Thyroid problems? Diabetes? Fibromyalgia? Other autoimmune disorder? Glaucoma? Any history of anemia? History of cancer? TB?
- ☐ Have you ever had a head injury? Headaches? Any problems with vision or hearing?
- ☐ Any heart problems or a history of heart disease? High blood pressure?
- ☐ Respiratory difficulties? Any history of asthma, COPD, lung disease, or respiratory problems?

- ☐ Stomach issues? GERD? Ulcers? Diarrhea or constipation? Diverticulitis?
- ☐ Any urinary problems? Kidney problems? Frequent bladder infections?
- ☐ Do you have chronic pain? Cervical, thoracic, or lumbosacral pain? History of spinal disease or procedures?
- ☐ History of seizures or loss of consciousness? Paralysis? Dizziness, lightheadedness, or vertigo symptoms?
- ☐ Any problems with your skin? Eczema? Psoriasis?

FOR WOMEN: When was your last menstrual period? Are you regular?

List any surgeries you have had in the past, and include the dates

Have you had the flu, shingles, tetanus, and/or pneumonia vaccines? If yes, list date of the most recent:

In order for any patient under 18 to be seen we must have the consent from BOTH parents if it is notated that they have joint medical decision making concerning said patient.

Is patient under 18? Yes ____ No___

If so are parents , Married_____ Divorced_____

If Divorced, do parents share joint medical decision making ? Yes_____ No_____

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Julie Brann, D.Min, MSN, NP-RxN or insurance company to release any information required to process my claims. *Patient/Guardian signature* *Date*			
SYMPTOMS			

JULIE BRANN, D.MIN, MSN, NP-RXN

Authorization to Use and Disclose Health Information

Identifying Information

_____ _____

Client Name **Date of Birth**

_____ _____

Address (include city/state/zip) **Phone Number**

RELEASE FROM AND TO:

I authorize information about the above referenced participant to be exchanged between Brain and Body Integration, P.C and the following System of Care User Group agencies, individuals, or programs as listed below (Include fax number to ensure that information is transmitted to the correct party). Please notate below if you would only like Brain and Body Integration to receive collateral information from an individual/business (as opposed to exchanging information between parties)

*

*

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I understand that information disclosed may be written, verbal or electronic form and may include date(s) of contact, locations and reasons for contact, symptoms presented, treatment progress, outcome information, prescriptions, written referrals, educational records, medical records, tests performed, and/or diagnosis. I understand that disclosure may include: psychological/psychiatric; medical; shelter and case management; and/or alcoholism, drug and/or alcohol abuse information. Information to be released may include information regarding the following.

I understand that the purpose of this information disclosure is to allow the participating entities (identified above) to access and use the information to establish and maintain continuity of care, better assess the effectiveness of the program, and/or to improve their services based on service utilization studies.

I understand that I may refuse to sign this authorization, and no one is conditioning treatment, payment, enrollment or eligibility for benefits on signing this authorization.

I understand that there is potential for information disclosed, as a result of this authorization, to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy Regulations. When applicable, an assessment of the minimum necessary amount of information required has been applied to this authorization.

I understand that I may revoke this authorization, at any time, by giving written notice to the authorized System of Care User Group agencies or programs, except to the extent that action has already been taken to comply with it. Without such revocation this authorization will expire on, or if left blank, one year from my signature date.

I understand that I am entitled to a copy of this authorization.

_____ _____

Signature Date

CONSENT TO TREATMENT

Thank you for choosing the practice of Julie Brann, NP-RXN**.** We believe it is important for you to understand your rights and responsibilities as patients and supportive family members. Your signature on this form provides consent for treatment, payment, and acknowledges receipt of other general information. If you have questions, please contact us at 719-373-2075.

Consent for Treatment

I consent to and authorize the attending physician, physician's assistant, nurse practitioner, referring providers and others of the healthcare team, including providers in training, and students in other disciplines-to perform healthcare examinations, treatment, diagnostic testing, transfers and transportation as deemed medically necessary in their professional judgment.

Privacy, Confidentiality and Safety: Personal information shared with us during our sessions is confidential and not shared with anyone without a signed release of information, except under specific legal and safety concerns as defined by laws. If there is an indication of child abuse, risk of danger to self, or risk of danger to others, we are legally bound to report the concerns to the appropriate authorities. As noted above, communication with your other care providers including your family doctor, therapist, or other clinicians is strongly recommended for the best possible treatment outcome. Please provide their contact information and your consent to communicate with them. Only essential and pertinent medical will be shared with your providers in accordance with privacy laws. Your signed consent is necessary for us to be able to communicate with them.

Assignment of Benefits and Release of Information

- I agree to be responsible for my co-payments, deductibles or other charges of Julie Brann, NP-RXN and of providers rendering services not covered or paid by insurance or other third party payers-except as prohibited by any agreement between my insurance company and Julie Brann, NP-RXN or by state or federal law.
- I authorize Julie Brann, NP-RXN to file any claims for payment of any portion of the patient bills and assign all rights and benefits payable for provider services to the provider or organization furnishing the services.
- I further agree, subject to state or federal law, to pay all costs, attorney fees, expenses, delinquent charges and interest in the event Julie Brann, NP-RXN has to take action to collect same because of my failure to pay in full all incurred charges within 60 days after the receipt of the bill.
- The term of this consent will be until final payments are made for any and all services.
- If and when there are changes to my insurance plans, I will notify Julie Brann, NP-RXN staff immediately.

Cancellation and Late Policy

__I agree that:

- If I do not show up, or cancel my appointment with less than 24 hours notice that I will be billed $75.00.
- If I do not show up for an appt or cancel late 2 or more times that I will be rescheduled and considered a late cancel.
- If I arrive more than 10 minutes late for an appointment that it will be rescheduled and considered a late cancel.

Billing Policy

__I agree that:

- If I have an outstanding balance, I will be required to pay this balance in full before scheduling any future appointments and will help Julie Brann, NP-RXN to resolve any issues with my insurance company.
- I will be charged $50 per 10 minutes of time that is used to address issues that occur outside of session such as letter or report writing and telephone calls of clinical importance (non-scheduling related).

General Information

__I understand:

- Julie Brann, NP-RXN may prescribe medication and require that the patient takes the medication as recommended.
- The first appointment is approximately one hour. All subsequent "follow-up" visits are intended to provide a brief checkup on the patient's status and to adjust or refill prescriptions. I will review the number of pills the patient has left before coming to the office.
- Julie Brann, NP-RXN will give me a list of recommended therapists if they feel it is appropriate, which they expect the patient to see on a regular basis.
- Julie Brann, NP-RXN will check the PDMP (Prescription Drug Monitoring Program) on a regular basis if you are prescribed a controlled substance.

Notice of Privacy Practices

__I acknowledge that I have been offered and/or received the receipt of Julie Brann, NP-RXN "Notice of Privacy Practices" brochure

_____	_____
Print Patient's Name	Guardian's Printed Name/Relationship (if applicable)
_____	_____
Patient Address	Patient or Guardian Signature
_____	_____
City/State/Zip	Date