ROCHESTER CENTER FOR BEHAVIORAL MEDICINE

PATIENT/ INSURANCE INFORMATION FORM

Please check your doctor's or therapist's name:

- □ Joel L. Young, M.D.
- □ Karen Donoughe, M.S., M.A., L.L.P.C., N.C.C.
- □ C. Lynn Florek, M.A., L.L.P., L.P.C.
- □ Debra Gorney-Jankowski, M.S.N., R.N., C.S.
- □ Tanya Kuprianiak, M.A., L.L.P.
- □ Marie McMahon, L.M.S.W., A.C.G.
- □ Nikhil Vora, M.D.
- □ Melissa Oleshansky, PhD
- □ Erika Parsons, M.A., L.L.P.C., N.C.C.
- □ Judy C. Redmond, M.A., L.P.C., N.C.C.
- □ Carol L. Rembor, M.S., A.P.R.N., B.C.
- □ Jaime M. Saal, M.A., L.P.C., N.C.C.
- □ Jessie Spitsbergen, M.A., L.L.P.C., N.C.C.
- □ Yvonne Stumpf, M.S.W., R.N., C.S.
- □ Kathy Tessmar, L.L.M.S.W.
- □ Mindy Layne Young, J.D., M.S.W., C.S.W.

Patient Info:

Patient Name:____________________ Social Security Number: ____________

Street Address: ________________ City: __________ State: ____ Zip: ____

Primary Phone Number:____________ please circle: Cell/ Work/ Home OK to leave detailed message? Y N

Secondary Phone:____________ please circle: Cell/ Work/ Home OK to leave detailed message? Y N

E-Mail Address: ____________________

What is the best way to contact you btw 8am and 6pm?__ please circle: Primary Phone # / Secondary Phone # / E-Mail

Birth Date: ________ Age: ____ Sex: ____ Marital Status: __________

Employer (if applicable): ____________________

Please circle one: Hourly Salary Retired

Responsible Party (Insurance Policyholder) Info—PRIMARY INSURANCE POLICY:

Name: ____________________

Relationship to Patient: ____________ Social Security Number: ____________

Birth Date: __________ E-Mail Address: ________________

Street Address: ________________ City: __________ State: ____ Zip: ____

Primary Phone Number:____________ please circle: Cell/ Work/ Home OK to leave detailed message? Y N

Secondary Phone Number:____________ please circle: Cell/ Work/ Home OK to leave detailed message? Y N

E-Mail Address: ________________ Birth Date: __________

Age: ____ Sex: ____ Marital Status: __________

Employer (if applicable): ____________________

Please circle one: Hourly Salary Retired

Type of Insurance: ____________________

Policy Number: ________________ Group Number: ____________

Effective Date: ____________________

Responsible Party (Insurance Policyholder) Info—SECONDARY INSURANCE POLICY (if applicable):

Name: ____________________

Relationship to Patient: ____________ Social Security Number: ____________

Birth Date: __________ E-Mail Address: ________________

Street Address: ________________ City: __________ State: ____ Zip: ____

Primary Phone Number:____________ please circle: Cell/ Work/ Home OK to leave detailed message? Y N

Secondary Phone Number:____________ please circle: Cell/ Work/ Home OK to leave detailed message? Y N

E-Mail Address: ________________ Birth Date: __________

Age: ____ Sex: ____ Marital Status: __________

Employer (if applicable): ____________________

Please circle one: Hourly Salary Retired

Type of Insurance: ____________________

Policy Number: ________________ Group Number: ____________

Effective Date: ____________________

Please make sure front and back of form are complete!

Emergency Information:
<u>In Case of Emergency, Please Notify:</u>
Name: ____
Relationship: ______________________ E-Mail: ______________________
Primary Phone Number:______________ please circle: Cell/ Work/ Home OK to leave detailed message? Y N
Secondary Phone Number:______________ please circle: Cell/ Work/ Home OK to leave detailed message? Y N

Referral Information:
May we release information to your referral source? Y N Name of Referring Party: ______________
Facility: ______________________City and State: ______________________

Release of Information:
I hereby authorize the Rochester Center for Behavioral Medicine to release information regarding my/my child's case to my insurance company and to any other referring colleague at the Rochester Center for Behavioral Medicine.

Signature: ______________________ **Relationship:** ______________ **Date:** __________

Payment Responsibilities: I understand that I am fully responsible for all charges incurred, regardless of any insurance policy(ies). I agree to pay in full any and all debts that I may incur in the course of treatment for either myself or as a guarantor. I further understand that all fees are payable at the time of service.

Signature: ______________________**Relationship:** ______________ **Date:** __________

Please make sure front and back of form are complete!

Medication List

Current Psychiatric Medications:

NAME OF MEDICINE	STRENGTH (i.e. 50 mg)	FREQUENCY (i.e., once a day)	DURATION (i.e., 6 months)	HOW HELPFUL (0-5)? 0=Unhelpful, 5=Very helpful

Past Psychiatric Medications:

NAME OF MEDICINE	STRENGTH (i.e. 50 mg)	FREQUENCY (i.e., once a day)	DURATION (i.e., 6 months)	HOW HELPFUL (0-5)? 0=Unhelpful, 5=Very helpful

Current NON-PSYCHIATRIC Medications/Vitamins/Supplements:

NAME OF MEDICINE	STRENGTH (i.e. 50 mg)	FREQUENCY (i.e., once a day)	DURATION (i.e., 6 months)	HOW HELPFUL (0-5)? 0=Unhelpful, 5=Very helpful