Reset Form

VirtualConsultMD

PATIENT INFORMATION & FINANCIAL POLICY

CO-PAYMENTS, DEDUCTIBLES, AND FEES:

- All co-payments, insurance deductibles, and fees for rendered services that are not covered by insurance are due at the time of service.
- All co-payments, insurance deductibles, and fees for rendered services that are not covered by insurance are due at the time of service.
- We accept cash, personal checks, and all major credit cards (ex. VISA, MasterCard, etc.). Payments can also be accepted by phone and mail.

INSURANCE:

- Your insurance policy is a contract between you and your insurance company; Virtual Consult MD is not a part of this contract agreement. **It is your responsibility to know and understand the provisions, limits and requirements of your individual benefit plan(s).**
- As a professional courtesy, our office will file your insurance claim for you; however, we cannot guarantee benefits or payments. If your insurance carrier denies payment for rendered services, **you remain 100% financially responsible for payment of rendered services by our office**, regardless of any insurance company determination, quote, or misquote, except where prohibited by law or prior contractual agreement.
- **We must have accurate billing information at each visit** in order to process claims through your insurance carrier. **Please bring your current insurance card to each visit** and notify our office staff of any changes to your insurance coverage prior to the start of service. **If you fail to provide accurate information required to process your claim, you will be held responsible for any subsequent charges**.

BILLING STATEMENTS:

- The balance on your statement is due and payable upon receipt, and is past due if not paid within thirty (30) days. **Payments can be made in person, by phone, or by mail.**
- If the balance is not paid in full or other arrangements are not made with our office, then a $10.00 processing fee will be applied to each additional statement.

PAST DUE ACCOUNTS:

- If your account balance is overdue by sixty (60) days or more, with no attempt to set up a payment plan; all future appointments will be cancelled and you will not be given the opportunity to make an appointment until the outstanding balance has been paid.
- If your account is past due beyond ninety (90) days, it will be sent to a collection agency. You will be responsible for all fees incurred from the collection agency and/or attorney fees.
- Financial non-compliance may result in termination from the practice.

RETURNED CHECKS:

- **There is a $30.00 charge for checks returned for insufficient funds** and may require future payments to be paid in cash, credit, or money order.

BILLING QUESTIONS & CONCERNS:

- Virtual Consult MD has contracted with a third party billing agency, for billing and collection services. Should you have any billing questions and concerns, please contact our office at (812) 848-2322.

MEDICAL RECORDS, FORMS & LETTERS:

- **There is a $20.00 fee for medical records up to ten (10) pages in length**. Additional pages will be charged 50¢ per page thereafter. The fee must be paid prior to release of the medical records.
- **There is a minimum fee of $20.00 for the completion of forms or letters**. Additional charges may be applied on the nature and complexity of the form or letter. The minimum fee must be paid in order for the provider or their designees to begin the form or letter.
- We require **7-10 Business days** to process a request for medical records or to complete forms or letters. There is a $10.00 fee for "rush" requests, which must be paid at the time of said request.

PRESCRIPTIONS & PRESCRIPTION REFILLS:

- **Medication refills require a 72-hour notice**. We do not consider medication refills as an "emergency." Therefore, if you run out of medication over the weekend/holiday or forget to call for a medication refill, it will have to wait until the office reopens.
- We will not refill prescriptions for any patient who has not had adequate follow-up visits or who has not been seen at our office in the last three (3) months.
- You are responsible for all medications prescribed to you. **If your prescription is lost, misplaced, stolen, or run out early, please understand it may not be replaced**.

CANCELATION & NO SHOW POLICY:

- We strive to provide excellent medical care to you, your family and all of our patients. "No-shows" and "late cancellations" inconvenience those individuals who need access to medical care in a timely manner. In an effort to reduce such occurrences, **we request you give our office a 24 to 48-hour notice in the event you need to cancel and/or reschedule your appointment**.
- If you miss an appointment and have not contacted our office, this will be considered as a ***"No Show."*** If an appointment is canceled within 24-hours of your scheduled appointment, this will be considered as a ***"Late Cancelation."*** **You will be charged $60.00.** This fee will not be covered by your insurance company and must be paid prior to rescheduling your appointment. **Medicaid patients cannot be charged this fee, but can be dismissed from the office, after missing an appointment.**
- If you are more than ten (10) minutes late for an appointment, our office cannot guarantee that you will be seen and we have the right to reschedule your appointment.
- As a professional courtesy, our office makes reminder calls and/or texts for all appointment types, but it may not always be guaranteed. **It is ultimately the patient's responsibility to remember their scheduled appointments.**

DISMISSAL FROM THE PRACTICE:

- If you are "dismissed" or "terminated" from the practice, it means you can no longer schedule appointments; received medication refills, or consider Virtual Consult MD to be your healthcare provider. You will be required to find another practice for your medical services/needs.

  Common Reasons for Dismissal include, but not limited to:
  - *Failure to keep appointments, frequent cancelations and/or no-shows.*
  - *Non-compliance or failure to follow office instructions and/or policies.*
  - *Abusive behavior to office staff and/or other individuals within the office.*
  - *Failure to pay your medical bills.*

- If you are "dismissed" or "terminated" from the practice, we will send a formal written notification letter via certified mail to your last known address. We will send a copy of your medical records to your new healthcare provider as per your request; in accordance to our office medical record release policy.

ACKNOWLEDGEMENT & CONSENT

I have read and understand the "Patient Information and Financial Policy" for Virtual Consult MD and I agree to be bound by its terms. I agree to assign insurance payments to be made directly to Virtual Consult MD, for services rendered. I also understand and agree that such terms and conditions may be amended or subject to change.

Please sign or click the checkbox below if sending form electronically.

_____ _____

Print Patient Name ***Date***

_____ _____

Signature ***Date***

☐ ***By checking this box, I agree to the terms stated under acknowledgement and consent.***

PATIENT INTAKE FORM

Date: _____

I. Patient Information:

Patient Name: _____ DOB: _____ Sex: ☐ M ☐ F

Social Security Number: _____ Race: _____ Ethnicity: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone Number: _____ Mobile Number: _____

Email Address: _____

II. Emergency Contact Information:

Name: _____ Relationship: _____

Phone Number: _____ Mobile Number: _____

III. Insurance Information:

Primary Insurance Co Name: _____ Psychiatric Coverage: ☐ YES ☐ NO

Member ID #: _____ Group Number: _____ Co Payment: _____

Address: _____ City: _____ State: _____ Zip Code: _____

Subscriber Information:

First Name: _____ Last Name: _____

Phone Number: _____ DOB: _____

IV. Pharmacy Information:

Name: _____ Phone No: _____ Fax No: _____

Address: _____ City: _____ State: _____ Zip Code: _____

IV. Laboratory Information:

Name: _____ Phone No: _____ Fax No: _____

Address: _____ City: _____ State: _____ Zip Code: _____

V. PCP Contact Information:

Provider Name: _____ Phone No: _____ Fax No: _____

Address: _____ City: _____ State: _____ Zip Code: _____

VI. Mental Health Provider Information:

Do You Currently Have a Psychiatrist? ☐ YES ☐ NO If Yes, Provider Name: _____

Do You Currently Have a Therapist? ☐ YES ☐ NO If Yes, Provider Name: _____

VII. Referral Source:

Source Name: _____ Contact #: _____

PATIENT MEDICAL HISTORY

I. Current Medication List:

Medication	Dosage	# Times/Day	Medication	Dosage	# Times/Day
1			6		
2			7		
3			8		
4			9		
5			10		

II. Allergies:

Medication	Reaction	Medication	Reaction
1		4	
2		5	
3		6	

III. Medical History: (Check All that Apply)

- ☐ Alcoholism
- ☐ Anemia / Blood Disease
- ☐ Arthritis / Joint Pain
- ☐ Asthma / Allergies
- ☐ Autoimmune (ex. Lupus)
- ☐ Bone Disease
- ☐ Cancer / Tumor
- ☐ Colitis / Diverticulitis
- ☐ COPD / Lung Disease
- ☐ Dementia / Delirium
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Eye Dis (ex. Glaucoma)
- ☐ Fatigue / Fibromyalgia
- ☐ GERD / Reflux Disease
- ☐ Headache
- ☐ Heart Disease
- ☐ Hepatitis / Liver Disease
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Kidney / Bladder Disease
- ☐ Menstrual Problems
- ☐ Migraine
- ☐ Myopathy / Muscular Dis
- ☐ Neurological Disorder
- ☐ Neuropathy
- ☐ Obesity
- ☐ Sexual Transmitted Dis
- ☐ Skin Trouble
- ☐ Sleep Apnea / Problems
- ☐ Stroke / TIA
- ☐ Thyroid Disease
- ☐ Traumatic Brain Injury
- ☐ Vasculitis / Vascular Dis
- ☐ Other: _____

_____

IV. Family Psych History:

Mother: ☐ ALIVE ☐ DECEASED Psychiatric Problems: _____

Maternal Side: *(Grandparents, Aunts, & Uncles)* Psychiatric Problems: _____

Father: ☐ ALIVE ☐ DECEASED Psychiatric Problems: _____

Paternal Side: *(Grandparents, Aunts, & Uncles)* Psychiatric Problems: _____

Sibling: ☐ ALIVE ☐ DECEASED Psychiatric Problems: _____

Children: ☐ ALIVE ☐ DECEASED Psychiatric Problems: _____

V. Psychiatry History (Check All that Apply)

- ☐ Anxiety Disorder
- ☐ Attention Deficit Disorder
- ☐ Bipolar Disorder
- ☐ Depression
- ☐ Dementia / Delirium
- ☐ Eating Disorder
- ☐ Mood Disorder
- ☐ OCD
- ☐ Panic Disorder
- ☐ Personality Disorder
- ☐ PTSD / Trauma
- ☐ Schizophrenia
- ☐ Sexual Dysfunction
- ☐ Sleep Disorder
- ☐ Substance Abuse Disorder
- ☐ Other: _____

V. Psychiatry History Cont.... (Check YES or NO. If YES, Please Explain)

Do You Have Any Prior Inpatient Admission? ☐ YES ☐ NO

i. When: _____ Where: _____ Why: _____

ii. When: _____ Where: _____ Why: _____

Do You Have Any Past Suicide Attempt or Self-Injuries? ☐ YES ☐ NO

i. When: _____ Describe Action: _____

Have You Ever Been Emotionally, Physically, or Sexually Abused? ☐ YES ☐ NO

Have You Ever Had Electroconvulsive Therapy? ☐ YES ☐ NO

Are You Currently Attending a PHP (Partial Hospitalization) or Rehab Program? ☐ YES ☐ NO

VI. Social History:

Marital Status: ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOWED

Do You Have Children? ☐ YES ☐ NO How Many? _____

Do You Live Alone? ☐ YES ☐ NO Who Lives with You? _____

Highest Level of Education: _____ Degree Earned: _____

Current Job Title/Role: _____ Company/Employer: _____

Do You Have Any Religious Beliefs? ☐ YES ☐ NO If Yes, please explain: _____

Do You Have Any Legal Problems? ☐ YES ☐ NO If Yes, please explain: _____

Are You Sexually Active? ☐ YES ☐ NO

VII. Substance Use History:

Do You Smoke Tobacco? ☐ YES ☐ NO If Yes, How Often? _____

If Yes, How Much? _____

Do You Drink Alcohol? ☐ YES ☐ NO If Yes, How Often? _____

If Yes, How Much? _____

In The Past 30 Days, Have You Been Prescribed Any of the Following Medications? *(Check All That Apply)*

- ☐ OPIATES *(Morphine, Oxycodone, Percocet, etc.)*
- ☐ SEDATIVES / "BENZO" *(Ativan, Klonopin, Valium, Xanax, etc.)*
- ☐ STIMULANTS *(Adderall, Ritalin, Vyvase, etc.)*
- ☐ NONE

In The Past 30 Days, Have You Used Any of the Following Substances? (*Check ALL That Apply*)

☐ COCAINE ☐ HEROIN ☐ MARIJUANA ☐ PCP / LSD ☐ NONE

INITIAL PSYCHIATRIC EVALUATION FORM

I. Current Symptoms: (Check All that Apply)

- ☐ Anger
- ☐ Binging
- ☐ Cannot Relax
- ☐ Changes in Weight
- ☐ Compulsions
- ☐ Concerned about Weight
- ☐ Decreased Energy
- ☐ Depression
- ☐ Difficulty Concentrating
- ☐ Difficulty Falling Asleep
- ☐ Difficulty Paying Attention
- ☐ Difficulty Staying Asleep
- ☐ Do Not Need Sleep
- ☐ Early Awakening
- ☐ Fearful
- ☐ Feeling Better off Dead
- ☐ Feeling on Top of the World
- ☐ Feeling Someone is After You
- ☐ Feeling Violent
- ☐ Feelings of Guilt
- ☐ Frustration
- ☐ Hearing Voices
- ☐ Helplessness
- ☐ Hopelessness
- ☐ Impulsivity
- ☐ Increased Energy
- ☐ Irritability
- ☐ Legal Problems
- ☐ Loss of Interest
- ☐ Mood Swings
- ☐ Obsessions
- ☐ Panic Attacks
- ☐ Promiscuity
- ☐ Purging
- ☐ Restlessness
- ☐ Seeing Things that Aren't There
- ☐ Sleeping All Day
- ☐ Social Anxiety
- ☐ Social Isolation
- ☐ Spending a lot of Money
- ☐ Using Drugs
- ☐ Worrying a Lot
- ☐ NONE OF THE ABOVE

II. Psychotropic Medication History: (Check All that Apply)

Have You Ever Taken Any of the Following Medications? (Check All that Apply)

- ☐ Abilify
- ☐ Ambien
- ☐ Adderall
- ☐ Anafranil
- ☐ Antabuse
- ☐ Ascendin
- ☐ Atarax
- ☐ Ativan
- ☐ Buspar
- ☐ Campral
- ☐ Celexa
- ☐ Chloral hydrate
- ☐ Clonidine
- ☐ Clozaril
- ☐ Cogentin
- ☐ Concerta
- ☐ Cymbalta
- ☐ Dalmane
- ☐ Depakote
- ☐ Dexedrine
- ☐ Haldol
- ☐ Doral
- ☐ Effexor
- ☐ Elavil
- ☐ Fanapt
- ☐ Geodon
- ☐ Halcion
- ☐ Klonopin
- ☐ Invega
- ☐ Lamictal
- ☐ Latuda
- ☐ Lexapro
- ☐ Librium
- ☐ Lithium
- ☐ Lunesta
- ☐ Luvox
- ☐ Marplan
- ☐ Mellaril
- ☐ Methadone
- ☐ Miltown
- ☐ Nardil
- ☐ Norpramine
- ☐ Orap
- ☐ Pamelor
- ☐ Parnate
- ☐ Paxil
- ☐ Prosom
- ☐ Pristiq
- ☐ Prolixin
- ☐ Remeron
- ☐ Restoril
- ☐ Risperdal
- ☐ Ritilan
- ☐ Saphris
- ☐ Serax
- ☐ Seroquel
- ☐ Serzone
- ☐ Soma
- ☐ Sonata
- ☐ Stelazine
- ☐ Strattera
- ☐ Suboxone
- ☐ Symmetrel
- ☐ Tegretol
- ☐ Thorazine
- ☐ Tofranil
- ☐ Topomax
- ☐ Traxene
- ☐ Trazodone
- ☐ Trileptal
- ☐ Valium
- ☐ Vibryd
- ☐ Vistraril
- ☐ Vivitrol
- ☐ Wellbutrin
- ☐ Xanax
- ☐ Zoloft
- ☐ Zyprexa
- ☐ Other: _____
- ☐ NONE OF THE ABOVE

VirtualConsultMD

BEHAVIORAL HEALTH QUESTIONNAIRE

Here at Virtual Consult MD, we strive to provide you with the best quality care possible.
Please answer the following questions, as your answers will help us to better assess your care.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
	For each question Choose ONE answer from the column			
Little interest or pleasure in doing things?	0	1	2	3
Feeling down, depressed, or hopeless?	0	1	2	3
Trouble falling or staying asleep, or sleeping too much?	0	1	2	3
Feeling tired or having little energy?	0	1	2	3
Poor appetite or overeating?	0	1	2	3
Feeling bad about yourself or that you are a failure or have let yourself or your family down?	0	1	2	3
Trouble concentrating on things, such as reading the newspaper or watching TV?	0	1	2	3
Moving or speaking so slowly that other people have noticed it? OR Being so fidgety or restless that you have been moving around a lot more than usual?	0	1	2	3
Thoughts that you would be better off dead, or of hurting yourself in some way?	0	1	2	3

TOTAL SCORE	

GENERALIZED ANXIETY DISORDER QUESTIONNAIRE (GAD-7)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	Not at All	Several Days	More than Half the Days	Nearly Every Day
	For each question Choose ONE answer from the column			
Feeling nervous, anxious or on edge?	0	1	2	3
Not being able to stop or control worrying?	0	1	2	3
Worrying too much about different things?	0	1	2	3
Trouble relaxing?	0	1	2	3
Being so restless that it is hard to sit still	0	1	2	3
Becoming easily annoyed or irritable?	0	1	2	3
Feeling afraid as if something awful might happen?	0	1	2	3

TOTAL SCORE	

VirtualConsultMD

ACKNOWLEDGEMENT & CONSENT

By signing below or clicking checkbox, I acknowledge that the information provided above is accurate and true. I consent to the use and disclosure of my health information to treat me and arrange for my medical care. I acknowledge that I have been informed of the privacy practice of this practice, and I have been informed that I must check my co-pay, deductible, and any limits to my benefits with my insurance company. I have also been informed of my responsibility for all collection costs, attorney and court costs, and any additional processing fees, if my account becomes delinquent.

_____ _____

Patient Name *Date*

_____ _____

Signature *Date*

☐ ***By checking this box, I agree to the terms stated under acknowledgement and consent.***

SUBMIT TO

Tell City Office **Evansville Office** **Washington Office**

Important: To submit by email, PDF document needs to saved locally to your computer, and opened with Adobe Reader. After completing the document, click on the location you would like the PDF to be sent. This will use your email client to create an email, and attach the PDF. For any questions, please call us at 812-848-2322.

Effective April 14,2003 the U.S. government regulators established a privacy rule; Health Information Portability and Accountability Act (HIPAA) & Governing Protected Patient Health Information (PHI). We are required by law to protect the privacy of health information that may reveal your identity, and provide you with this notice that describes the health information privacy practices of this practice. A copy of this notice is posted in our office.