PATIENT REGISTRATION

Patient Demographics

LAST NAME | FIRST NAME | MI | DATE OF BIRTH

STREET ADDRESS | CITY | STATE | ZIP

SSN | MOBILE PHONE | EMAIL ADDRESS

GENDER IDENTITY | MARITAL STATUS | OCCUPATION / EMPLOYER

Emergency Contact

NAME | RELATIONSHIP | PHONE

Insurance Information

PRIMARY INSURANCE | MEMBER ID | GROUP

SUBSCRIBER NAME (IF NOT PATIENT) | SUBSCRIBER DOB | RELATIONSHIP

Referral Source

HOW DID YOU HEAR ABOUT US?

I verify that the above information is accurate. I authorize the release of any medical information necessary to process claims and request payment of benefits to Unique Minds Behavioral Health Services, LLC.

PATIENT/GUARDIAN SIGNATURE | DATE

Unique Minds
BEHAVIORAL HEALTH SERVICES, LLC

CLINICAL HISTORY

Current Medications & Allergies

Medication	Dose/Freq	Provider

ALLERGIES (MEDICATION/FOOD/ENVIRONMENT)

Reason for Visit

Medical & Psychiatric History

Psychiatric History

- ☐ Depression
- ☐ Anxiety / Panic
- ☐ Bipolar Disorder
- ☐ ADHD
- ☐ PTSD / Trauma
- ☐ Schizophrenia/Psychosis
- ☐ History of Suicide Attempt

Medical History

- ☐ Diabetes
- ☐ Hypertension
- ☐ Thyroid Disease
- ☐ Seizures / Epilepsy
- ☐ Head Injury / TBI
- ☐ Heart Condition
- ☐ Asthma / COPD

Substance Use History

Strictly Confidential

Substance	Currently Use?	Frequency/Amount	Date Last Used
Alcohol	☐ Yes		
Cannabis	☐ Yes		
Other	☐ Yes		

Consents & Authorizations

Consent to Treatment

I voluntarily consent to psychiatric evaluation, medication management, and/or psychotherapy by the providers (NP, DNP, MD, LCSW) at Unique Minds Behavioral Health Services, LLC. I understand that the practice of psychiatry is not an exact science and that treatment involves risks and benefits. No guarantees have been made regarding the results of treatment.

☐ **I Consent to Treatment**

Telemental Health Consent

I agree to receive care via secure video/audio technology. I understand that: 1) I must be in a private, secure location. 2) I must be physically located in Washington DC or Maryland during the session. 3) In the event of a technology failure, I will contact the office immediately by phone. 4) Emergency situations (suicidal intent) may require the provider to contact local emergency services (911) to my location.

☐ **I Consent to Telemental Health**

Release of Information (PCP/Coordination)

Coordination of care improves safety. I authorize Unique Minds to contact my Primary Care Provider (PCP) or Therapist to coordinate my treatment.

PROVIDER NAME

PHONE/FAX

☐ YES, Authorize ☐ NO, Do Not Contact

Pharmacy Info

PHARMACY NAME

PHARMACY PHONE/LOCATION

Controlled Substance Agreement

Purpose: This agreement is designed to protect your access to controlled substances (e.g., stimulants for ADHD, benzodiazepines for Anxiety) and to protect our ability to prescribe them responsibly.

I understand and agree to the following:

1. I am responsible for my medication. **Lost or stolen prescriptions/medications will NOT be replaced early.**
2. I will not share, sell, or trade my medication. This is a felony and causes immediate discharge.
3. I will not seek controlled substances from other providers while under the care of Unique Minds.
4. I agree to use the medication exactly as prescribed. I will not change dosage without provider approval.
5. **Refills:** Refills must be requested during appointments. Refills requested between appointments may take up to 72 hours and may require an appointment.
6. **Monitoring:** I understand my provider checks the Prescription Drug Monitoring Program (PDMP) before every prescription.
7. **Urine Toxicology:** I agree to random urine drug screens. Refusal to provide a sample or testing positive for illicit substances (cocaine, heroin, non-prescribed opioids) may result in the discontinuation of controlled substances.
8. **Cannabis:** If I use medical/recreational cannabis, I must disclose this. Mixing sedatives with cannabis or alcohol is dangerous and may lead to stopping sedatives.

Violation Policy: Any violation of this agreement may result in the immediate termination of controlled substance prescribing and potential discharge from the practice.

☐ **I have read and agree to the Controlled Substance Agreement.**

PATIENT SIGNATURE

DATE

Financial & Administrative Policy

Cancellation & No-Show Fees

We require **24 business hours** notice for cancellations. Late cancellations or No-Shows will incur a fee that INSURANCE DOES NOT COVER.
Psychiatric Appt Fee: $50.00
Therapy Appt Fee: $25.00 - $50.00
This fee must be paid before your next appointment can be scheduled.

☐ **I Agree**

Insurance & Financial Responsibility

It is your responsibility to verify your benefits. You are responsible for all Co-pays, Deductibles, and Co-insurance amounts at the time of service. If your insurance denies a claim, the full balance becomes your responsibility.

Communication Policy

Our providers do not offer 24/7 crisis coverage. For emergencies, call 988 or 911. Administrative requests (forms, letters) may require up to 7-10 business days and may incur a fee ($25-$50).

Credit Card on File Authorization

I authorize Unique Minds to keep my card on file for copays, deductibles, and late cancellation fees.

CARDHOLDER NAME

TYPE (VISA/MC)

CARD NUMBER (LAST 4 DIGITS ONLY)

EXP

CVV

SIGNATURE

DATE

Patient Rights & Responsibilities

- **Right to Respect:** You have the right to be treated with dignity, respect, and non-discrimination.
- **Right to Privacy:** Your records are confidential, protected by HIPAA and 42 CFR Part 2.
- **Right to Information:** You have the right to know your diagnosis, treatment plan, and medication side effects.
- **Right to Consent:** You have the right to refuse treatment or medications.
- **Right to Grievance:** You have the right to file a complaint without fear of retaliation.

Patient Responsibilities

- Provide accurate information about your health and history.
- Participate in your treatment plan.
- Treat staff and other patients with respect. Aggression is grounds for discharge.
- Pay for services rendered.

Notice of Privacy Practices (HIPAA)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED.
We are committed to protecting your health information (PHI). We use it to provide care (Treatment), obtain payment (Payment), and run our practice (Healthcare Operations).

Disclosures Without Consent:
Required by Law, Public Health (disease reporting), Abuse/Neglect reporting, Oversight (audits), Law Enforcement citations, and Threats to Safety (Duty to Warn).

Your Rights:
Inspect/Copy records, Request Amendments, Request Restrictions on disclosures, and file complaints with HHS.gov.

Acknowledgement:
You are acknowledging you have received a copy or have been offered a copy of this Notice.

Final Authorization

Consent for Treatment of Minor (If Patient is < 18)

I attest I am the legal guardian with authority to consent to treatment.

GUARDIAN NAME

RELATIONSHIP

By signing below, I acknowledge I have received and agreed to:
1. Consent to Treatment & Telemental Health
2. Financial/Cancellation Policy
3. Controlled Substance Agreement
4. Notice of Privacy Practices (HIPAA) & Patient Rights

PATIENT PRINTED NAME

SIGNATURE OF PATIENT / GUARDIAN

DATE