MICHIGAN PROGRESSIVE HEALTH - REGISTRATION FORM

Name ____ DOB __________________

Preferred Pronouns:

[ ] He/Him/His [ ] She/Her/Hers [ ] They/Them/Theirs Other: _________________________

Address ____

City _________________________________ State ____________ ZipCode _____________

If patient is a minor: Guardian _________________________ Address [ ] Same as above

Guardian Cell Phone __________________________

Cell Phone _____________________ May we leave a message? [ ] Y [ ] N Text? [ ] Y [ ] N

Home Phone _____________________ May we leave a message? [ ] Y [ ] N

Email Address ____

Would you like to receive newsletters, monthly meeting reminders and clinic updates via e-mail?
[ ] Y [ ] N

Would you like to receive important clinic emails regarding pricing/policy changes via e-mail?
[ ] Y [ ] N

What is your preferred method for the clinic to communicate with you? ____________________

Emergency Contact: Name ________________________ Relationship__________________

Number _______________________

Primary Care Physician ______________________________ Phone # __________________

Psychiatrist ____ Phone # __________________

Therapist ____ Phone #__________________

Preferred Pharmacy _____________________________ Phone #______________________

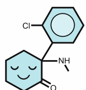
City ___________________________________ Zip Code ______________________

Insurance Provider Medicare? [ ] Y Medicaid? [ ] Y Self Pay? [ ] Y

Private Carrier ____

ID Number __________________________ Group Number __________________

How did you find out about us? ____



1010 N. Campbell Rd Suite 4 Royal Oak, MI 48067 248-291-7709

2300 Washtenaw Ave Suite 100 Ann Arbor, MI 48104 734-585-5587

DATE ______________________

MICHIGAN PROGRESSIVE HEALTH - OFFICE POLICIES

- We at MPH hold your privacy in the utmost importance.
- We will not share your protected health information without express written permission.
- If you would like us to discuss your case with your physician, therapist or family, please have the office staff provide you a HIPAA release.
- For your safety, infusions are monitored with security cameras but are not recorded.
- Payment is due at the time services are rendered. We take cash, credit card or check.
- MPH takes limited insurance. At your request, we will provide you with a superbill that you can submit back to your insurance company for reimbursement if you have out of network benefits.
- If you have Medicare, you may not submit superbills for reimbursement and must sign a contract acknowledging your understanding of this policy.
- We are available by phone 24/7 and respect that you will only call in case of an urgent/emergent need.
- We reserve the right to reschedule or cancel your appointment if you are more than 15 minutes late.
- Any appointment canceled with less than 24 hours notice will be charged 50% of the visit fee. Exceptions will be made for medical or family emergencies. Patients will be asked to keep a credit card on file and this will be charged for missed appointments without prior approval.
- You should continue to maintain a primary treatment relationship with your current psychiatrist or primary care physician, and follow-up with that person on an on-going basis after completion of your ketamine treatment. All medication changes should be done under their supervision.
- We will not refill prescriptions for your established chronic medications.
- MPH providers may use technology via SureScripts to import any available medication history.
- MPH can provide you a consult letter that discusses your treatment course here at no cost.
- MPH can provide you with a work note or fill out FMLA paperwork for your treatment days.
- We will not fill out short or long-term disability paperwork or write referrals to other physicians. This is the responsibility of either your PCP, psychiatrist or pain management physician.
- Ketamine treatment and Integrative Psychiatry are evolving sciences. We pledge to stay knowledgeable on current best practice in these fields.
- It is our goal to help every patient we encounter. Unfortunately, we can not guarantee that patients will respond to ketamine therapy. We do not offer refunds based on failure to achieve a response or based on the quality of experience during infusions.

I have read the above statements and agree with the policies.

Name: ______________________________ Signature: ________________________________

HIPAA AGREEMENT

THIS NOTICE DESCRIBES HOW MEDICAL/HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION - Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information. This is required by the Privacy

Regulations created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPAA). The following circumstances may require us to use your health information:

1. To coordinate your care with your physical therapists, pharmacist, suppliers of medical equipment, referring/primary treating physician or in the event of an emergency.

2. To file claims with your insurance carrier for the purpose of billing and payment.

3. To comply with Worker's Compensation regulations.

4. At the request of public health oversight agencies that are authorized to collect patient health information, via the electronic exchange of clinical data through a networked environment.

5. At the request of a law enforcement official.

6. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of others.

7. As legally required in the case of lawsuits or similar proceedings

Your rights regarding your health information:

1. Except as described in this notice, we will use and disclose your health information only with your written consent. You may revoke your consent to disclose at any time.

2. You can request a restriction in our use or disclosure of your health information. Additionally, you have the right to request that we restrict our disclosure of your health information to only certain individuals involved in your care. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records. You must submit your request in writing to Michigan Progressive Health.

4. You may ask us to amend your health information if you believe it is incomplete or incorrect, and as long as the information is kept by or for our practice. You must submit an amendment in writing to Michigan Progressive Health. You must provide us with a legitimate reason that supports your request for amendment.

5. You are entitled to receive a copy of this Notice of Privacy Practices. At any time, you may obtain a copy by asking the front desk.

6. If you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be submitted in writing to Michigan Progressive Health. You will not be penalized for filing a complaint.

I hereby acknowledge that I have been provided a Privacy Notice and understand my rights as a patient.

Signature:______________________________ Date: __________________________

CREDIT CARD PRE-AUTHORIZATION

For Use By Michigan Progressive Health

I authorize Michigan Progressive Health to keep my signature on file and to charge my Credit Card for payment of my session and/or treatment in the amount established by my provider for the following purposes:

Please initial each box below:

☐ For a no-show or missed session and/or treatment without a 24 hour cancellation notice.

☐ For phone/telehealth sessions.

☐ For past due sessions and/or treatments.

- I understand that my card will be charged only in the event that I fail to provide payment in full at the time of my session.
- I understand that in the event of a missed or canceled session without sufficient notice (24 hrs prior to appointment start time) my credit card will be charged for 50% of the session and/or treatment rate. This fee may be waived in an “emergency”, which is considered an event beyond your control or knowledge 24 hours ahead of time (such as car accident, hospitalization or sickness that keeps you from work) and this is at the discretion of your therapist.
- I also understand that if I want to use another payment method for my session(s) that I will make arrangements before the start of the session.
- I agree that this form is valid for the length of one year from the date signed.

Client’s Name: ____

Card Holder’s Name: ____

Card Holder’s Address: ____

City: ______________________ State:______________ Zip: ______________

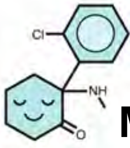
Phone: ______________________ Email: ____________________________

☐ Visa ☐ Master Card ☐ American Express ☐ Other

Acct. # ______________________________ CSC#______________
(3-digit # on back of card)

Cardholder Signature:______________________________ Exp. Date: _____/_____

Patient Signature:______________________________Todays Date:______________



Michigan Progressive Health

Megan Oxley, MD

Royal Oak: 1010 N. Campbell Rd., Suite 4 Royal Oak, MI 48067 **Ph:** 248.291.7709 **Fx:** 248.439.0515
Ann Arbor: 2300 Washtenaw Ave., Suite 100 Ann Arbor, MI 48104 **Ph:** 734.585.5587 **Fx:** 248.439.0515

Authorization to Release / Obtain Medical Records

Patient Name:____ Date of Birth:____________________

Preferred Phone:______________________________

I hereby authorize Michigan Progressive Health (MPH) Medical Providers and Therapists to:

☐ Release Personal Health Information (PHI) from my medical records to (This allows MPH to send your written chart to):

☐ Obtain PHI from my medical records from (This allows MPH to receive your written chart from):

☐ Share PHI relevant to my treatment with (This allows MPH to have written or verbal conversations about your care with):

Name:____________________________________Phone:____________________Fax:______________________

Address:____

Dates of Service:

☐ All medical records including diagnostic evaluation, progress notes, phone calls, labs, consults And neuroimaging reports. This does not include any records designated as psychotherapy notes. ____________________

☐ Medication records only ☐ Labs and imaging studies only ☐ The following specific info only: ____________________

Purpose of Disclosure:

☐ Coordination of Care ☐ School / College ☐ Family Member Access to Treatment
☐ Consult/Second opinion ☐ FMLA / Disability ☐ Insurance application (e.g., long-term care)
☐ Transfer of Care ☐ Other:____________________________

1. I understand that this authorization will expire one year after I have signed this form, or as specified here:__________________________
2. I understand that I may revoke this authorization at any time by notifying Michigan Progressive Health or the other clinician or organizational provider in writing, and my revocation will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by privacy regulations.
4. I understand that I am not required to sign this form in order to receive treatment.
5. I understand that there may be a fee for a copy of my medical record.
6. I understand that information to be released or obtained may include mental health information in accordance with CGS 52-146(d), substance abuse treatment information in accordance with 42 CFR 2.1-2.67, and/or HIV/AIDS-related information in accordance with CGS 19a-585(a), except as indicated below.

☐ No Substance Abuse treatment should be disclosed ☐ No HIV/AIDS information should be disclosed

______________________________ ____________
Signature of Patient Date

______________________________ ____________
Print Name

______________________________ ____________
Parent/Legal Guardian/Authorized Person Date

Please send to:

Megan Oxley, MD
Michigan Progressive Health
Fax: 248.439.0515
Email:
royaloak@michiganprogressivehealth.com
annarbor@michiganprogressivehealth.com

Patient Medication List

Please take the time to list your medications.

Name:____

Current Medication:

Name	Dose	Frequency	Start Date

Past Medication (to best of ability):

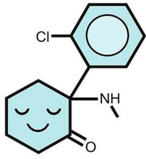
Name	Start Date	End Date

NKDA ___ Allergies: ____

NAME:____ DATE:____________

ACE Questionnaire

While you were growing up, during your first 18 years of life:	YES	NO
1. Did a parent or other adult in the household **often** swear at you, insult you, put you down, humiliate you, or act in a way that made you afraid that you might be physically hurt?		
2. Did a parent or other adult in the household **often** push, grab, slap, or throw something at you, or **ever** hit you so hard that you had marks or were injured?		
3. Did an adult or person at least 5 years older than you **ever** touch or fondle you, have you touch their body in a sexual way, or try to or actually have oral, anal, or vaginal sex with you?		
4. Did you **often** feel that no one in your family loved you, thought you were important or special, or your family didn't look out for each other, feel close to each other, or support each other?		
5. Did you **often** feel that you didn't have enough to eat, had to wear dirty clothes, and had no one to protect you, or your parents were too drunk or high to take care of you or take you to the doctor if you needed it?		
6. Were your parents **ever** separated or divorced?		
7. Was a parent or stepparent **often** pushed, grabbed, slapped, or had something thrown at them, or **sometimes or often** kicked, bitten, hit with a fist, or hit with something hard, or **ever** repeatedly hit over at least a few minutes or threatened with a gun or knife?		
8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?		
9. Was a household member depressed or mentally ill or did a household member attempt suicide?		
10. Did a household member go the prison?		



Substance Use Questionnaire

Michigan Progressive Health

A. Answer the following question. If your answer is *YES*, proceed to Part B. If your answer is *NO*, you are finished with this questionnaire:

Do you use any non-prescribed substance or overuse any prescribed substance to cope?

YES NO

B. In the last 6 months:

1. Have you felt like you have been using more of a substance or more often than is intended or prescribed.

   YES NO

2. Wanted to cut down or stop using but have not been able to?

   YES NO

3. Felt as if you were neglecting responsibilities and relationships because of your substance use?

   YES NO

4. Gave up on activities you used to care about because of your substance use?

   YES NO

5. Felt unable to complete tasks at home, work or school because of your substance use?

   YES NO

6. Used the substance in a risky setting that may put you or others in harm?

   YES NO

7. Had to use more of the substance to get the same effect?

   YES NO

8. Experienced withdrawal symptoms when the substance isn't used?

   ☐ YES ☐ NO