Miles Grant, MD
Brittany Roberts PA-C
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AMARILLO MEDICAL SPECIALISTS

REGISTRATION FORM

PATIENT INFO		
First Name:	Middle Initial:	Last Name:
Is this your legal name? **YES / NO**	If not, what is your legal name?	
Are you your own legal guardian? **YES / NO**	If not, who is your legal guardian?	
Gender:	Preferred Pronouns:	
Date of Birth:	Social Security #	
Race/Ethnicity:		
Mailing Address:		
Home Phone:	Cell Phone:	
Email:		

EMERGENCY CONTACT INFO
EMERGENCY CONTACT INFORMATION (PATIENTS 18 AND OVER)
Emergency Contact Name:
Address:
City/State/Zip:
Contact Home Phone:
Contact Cell Phone:

PREFFERED PHARMACY CONTACT INFO
Name of Pharmacy:
Location:
City/State/Zip:
Phone Number:
Fax Number:

PatientSignature:_____Date:_____

TREATMENT CONTRACT & OFFICE POLICIES

We respect your time and make every effort to stay on schedule. If we are running late, we may be dealing with an emergency. Please be patient and know that we are trying to provide the best care for you and our other patients

Patient Initials: _____

Dr. Grant/Brittany Roberts-PA requires that you see him/her **at least every 3 months** (either in person or via telehealth) so that he may monitor your mood, response to psychotropic medication(s), and any adverse side effects. You must present **in person at least once a year**.

Patient Initials: _____

All medications can cause side effects. Some psychotropic medications can increase your risk for metabolic syndrome. Others can increase your risk of thyroid dysfunction, kidney disease, liver damage, and blood disorders. **If one of these medications is indicated in your treatment, Dr. Grant/Brittany Roberts-PA will order baseline labs and then routine lab work during your course of treatment.** To monitor any adverse effects, it is crucial that you comply with recommended lab work. **If you are unable/unwilling to comply with recommended lab work, please let Dr. Grant/Brittany Roberts-PA know immediately** so that he/she may discuss alternative treatment options with you.

Patient Initials: _____

Dr. Grant/Brittany Roberts-PA specializes in mental health. He/she **does not** provide primary care, nor does he write or refill prescriptions for non-psychotropic medications. Therefore, he/she expects you to see your primary care physician (PCP) **at least yearly** for your annual physical/check-up.

Patient Initials: _____

If you are receiving psychotropic medications from another physician without our knowledge, you will be discharged from our clinic. This is known as "doctor shopping" and will not be tolerated.

Patient Initials: _____

You may have **one pharmacy** on file with our clinic. We will not call in medications to multiple pharmacies. If you switch pharmacies, you need to notify us and your previous pharmacy of this change.

Patient Initials: _____

All copays, co-insurance, and deductible amounts will be collected prior to your scheduled appointment. **We accept checks, cash, and credit cards.**

Patient Initials: _____

Please be courteous to all staff. Inappropriate or threatening behavior is **not tolerated** and will lead to discharge from our clinic.

Patient Initials: _____

Dr. Grant does not accept any social media requests or messages sent via social media. Please contact the office with any questions/concerns.

CONFIDENTIALTY POLICY

Your care and your medical records are confidential, except in these specific instances:

1. I am required by law to report suspected child/elder/disabled abuse.
2. If you threaten to harm someone, I am required by law to provide information to others in order to protect him/her.
3. If I believe you are in crisis and may harm yourself/someone else, I may call EMS and recommend hospitalization.

Patient Initials: _____

LATE POLICY

Please arrive at your scheduled appointment on time. We understand that delays can happen; however, we must try to keep our other patients on time. Therefore, if you arrive late to your appointment, you will be seen for the **remaining time** of your scheduled appointment only.

If you arrive more than 15 minutes late for your appointment, you will be asked to reschedule, if you do not call us the same day we will count it as a no show.

Patient Initials: _____

CANELLATION / NO SHOW POLICY

We understand there are times when you must miss an appointment due to family/work obligations or emergencies. If you need to cancel or reschedule an appointment, please call us at least 48 hours in advance.

If an appointment is not cancelled at least 24 hours in advance, you will be charged a $50 fee. This fee will not be covered by your insurance company and must be paid prior to rescheduling.

You will be discharged from the clinic if you:

1. **Are consistently late to your appointments**
2. **No show 2 appointments within a 12 month period.**
3. **Cancel 2 or more consecutive appointments.**
4. **Cancel multiple appointments within a 12 month period.**

Patient Initials: _____

TELEHEALTH POLICY

In certain circumstances, Dr. Grant/Brittany Roberts-PA may allow appointments to be made via telehealth. To deliver safe and effective care via telehealth, the following expectations must be met.

1. You must be seen **in person** at the clinic **at least annually**.
2. You must be in a **private location** with **adequate internet/phone service** during telehealth visits.
3. You must be stationary (**NO DRIVING**) during your telehealth appointments.
4. You must provide the physical **address** where you are located.
5. You must be **in Texas** during any telehealth appointments with Dr. Grant/Brittany Roberts-PA. If you will not be in Texas at the time of your appointment, please call us at least 24 hours in advance to reschedule your appointment.
6. You must be available during the **entirety** of the telehealth appointment.
7. If you have a **legal guardian**, your parent/guardian/caretaker must be present and available for the duration of the telehealth appointment.
8. You must be **sober** and refrain from using alcohol/illicit substances during the appointment.
9. You must be **dressed appropriately** for a doctor's appointment.
10. If you are having trouble connecting or do not see your doctor online, please call the clinic within the first **5 minutes** of your appointment.
11. The **late and cancellation / no show policies** apply to telehealth appointments.

Patient Initials: _____

AFTER HOURS POLICY

This clinic is **not** open after hours. Calls after hours will be answered by an answering service. If the patient is in crisis/there is an emergency, the patient will be directed to call 911 or go to the nearest emergency room

Patient Initials: ____

It is your responsibility to allow sufficient time to refill prescriptions during normal business hours. You will not be able to get refills after hours. If the medication is non-controlled, you may ask your pharmacy to provide a bridge over the weekend.

Patient Initials: ____

No medication changes will be made over the weekend. Calls will be returned within 24-48 hours of the next business day

Patient Initials: ____

CONTROLLED SUBSTANCES POLICY

The Texas Prescription Monitoring Program (PMP) collects and monitors controlled substances prescription data. If Dr. Grant/Brittany Roberts-PA learns that you are not taking your medication as prescribed, or that you are receiving controlled scripts from multiple providers/pharmacies, Dr. Grant/Brittany Roberts-PPA will stop prescribing these medications and you may be discharged from the clinic.

Dr. Grant/Brittany Roberts-PA may require you to complete a **urine drug test** before/during treatment with a controlled substance.

Dr. Grant/Brittany Roberts-PA **does not** provide **early refills** on controlled medications. If you are going out of town and need your medication refilled before you leave town, please let us know so that we can coordinate with your pharmacy.
If your medication is **lost or stolen**, you will need to file a police report before we send a replacement

Patient Initials: ____

LABORATORY & RADIOLOGY RESULTS POLICY

Laboratory and radiology results require a minimum of **seven (7) days** to be available in our office. This allows time for your physicians to review **ALL** results. Our office will call you once your results have been reviewed. If you have not heard from our office after **seven (7) days,** please feel free to contact us. If you have internet access, we encourage you to sign up for the web-based **patient portal called Healow**. Once your test results are reviewed, they will be available to view on the patient portal.

Patient Initials: ____

FORENSIC / CUSTODY EVUALUATION POLICY

Dr. Grant/Brittany Roberts-PA serves as a treating psychiatrist. His role is to help patients express their feelings and how to cope with and respond to the events occurring in their lives. When a treating psychiatrist is asked to weigh in on legal matters, the therapeutic relationships between psychiatrist and patient and between psychiatrist and the patient's loved ones are often compromised. Therefore, Dr. Grant/Brittany Roberts **does not** perform custody evaluations, provide recommendations/reports, or testify about a child's custody. Likewise, he/she **does not** perform parental fitness evaluations.

Patient Initials: ____

EMOTIONAL SUPPORT ANIMAL (ESA) / PSYCHIATRIC SERVICE DOG (PSD) POLICY

While we understand animals can serve as a source of comfort and support, animals can also be a liability. Dr. Grant/Brittany Roberts-PA does not evaluate an animal's behavior or assess an animal's impact on his/her owner. Therefore, he/she **does not** provide Emotional Support Animal (ESA) or Psychiatric Service Dog (PSD) letters

Patient Initials: ____

MEDICAL MARIJUANA POLICY

Dr. Grant/Brittany Roberts-PA is not registered with the Compassionate Use Registry of Texas (CURT), and he/she **does not** prescribe medical marijuana.

Patient Initials: ____

FMLA / DISABILITY PAPER WORK POLICY

Governmental and legal paperwork is outside the anticipated scope of Dr. Grant/Brittany Roberts-PA practices. Dr. Grant/Brittany Roberts-PA does not complete or sign paperwork. Rare exceptions may be made on a case-by-case basis.

Patient Initials: _____

I understand and agree to **all** of the above-mentioned policies.

Patient Signature:_____Date:_____

HEALTH INFORMATION EXCHANGE (HIE)

The Health Information Exchange (HIE) allows health care professionals and patients to access and securely share a patient's medical information electronically. It is a database where records are electronically stored. Doctors can sign into this database and see records from other doctors you have seen in the past. Only doctors you are currently seeing are allowed to access this database. Emergency rooms in Amarillo are also able to access this database.

This database is Health Insurance Portability and Accountability Act (HIPAA) approved

I understand and agree to the above-mentioned policies.

Patient Initials: _____

Patient Signature: _____Date:_____

ACKNOWLEDGEMENT OF PRIVACY PRACTICES (HIPAA)

Patient Name: _____Date of Birth:_____

All patient information is confidential and will not be shared without your consent. If you would like us to share your information with a family member/friend, please indicate that below.

1. Please list the family members and/or other persons, if any, whom we may inform about your medical condition (including diagnosis, treatment, payment, and other health care operations):

_____

Name & relationship to patient Phone Number

_____

Name & relationship to patient Phone Number

2. Please list the family members and/or other persons, if any, whom we may inform about your medical condition **ONLY IN AN EMERGENCY:**

_____

Name & relationship to patient Phone Number

_____

Name & relationship to patient Phone Number

3. Please list the telephone number(s) where you want to receive calls about your appointments, lab/imaging results, and any additional health care information:

_____

4. Can confidential messages be left on your answering machine? **YES / NO**

*****Please note that while we may ask you from time to time if there have been any changes to this information, it is your responsibility to update this information as needed.*****

By signing below, you acknowledge that you have received this Notice of Privacy Practices **prior** to any service being provided to you by the Practice, and you consent to the use and disclosure of your medical information as above.

Patient Signature: _____Date:_____

CHIEF COMPLAINT / REASON FOR APPOINTMENT

Please use back of this page if necessary

_____

_____

_____

_____

CURRENT MEDICATIONS

Please list ALL the medications you are currently taking, including over the counter medications, vitamins, and supplements.

Please use the back of this page if necessary

MEDICINE / VITAMIN	DOSE	FREQUENCY

PAST PSYCHIATRIC MEDICATIONS

Please list all psychiatric medications you've taken in the past. Make note of any side effects you recall

Please use the back of this page if necessary

MEDICINE / VITAMIN	DOSE	SIDE EFFECTS / NOTES

ALLERGIES

Please list any medications or products you have taken which may have caused a true allergic reaction or undesirable side effects (hives, itching, rash, difficulty breathing, muscle aches, cough, nausea. etc.)

Please use the back of this page if necessary

NAME OF MEDICATON	REACTION	NAME OF MEDICATION	REACTION

PAST MENTAL HEALTH TREATMENT

Please list your previous mental health providers.
Please use back of this page if necessary

PSYCHIATRIST / PHYSICIAN / PHYSICIAN ASSISTANT / NURSE PRACTITIONER / THERAPIST	DATES OF TREATMENT	MAY WE REQUEST YOUR MEDICAL RECORDS FROM THIS PROVIDER?
		YES / NO
		YES / NO
		YES / NO

SUICIDE ATTEMPTS

Please use the back of this page if necessary

Have you ever tried to kill yourself? If so, please briefly detail **when** and **how** below

_____

_____

_____

PAST PSYCHIATRIC HOSPITALIZATIONS

Please list all previous hospitalizations and residential treatment centers.
Please use the back of this page if necessary

REASON FOR HOSPITALIZATION	PLACE OF HOSPITALIZATION	DATES OF HOSPITALIZATION	MAY WE REQUEST YOUR MEDICAL RECORDS FROM THIS HOSPITAL
			YES / NO
			YES / NO
			YES / NO

PAST MEDICAL HISTORY

(non-psychiatric conditions)
Please use the back of this page if necessary

MEDICAL CONDITION	YEAR OF DIAGNOSIS	PHYSICIAN MONITORING/MANAGING THIS CONDITION

FAMILY HISTORY

FAMILY MEMBER	MENTAL HEALTH CONDITIONS (depression, anxiety, bipolar disorder, schizophrenia, personality disorder, ADHD, autism, substance abuse, etc.)

SOCIAL HISTORY

Martial Status:	Sexual orientation:
Do you have children? **YES / NO**	If yes, how many?
What is your current living situation?	
Who else lives in your home? (Name, Age, Relationship)	
Current employment status:	
Occupation:	Employer:
What is your highest level of education completed?	
Did you serve in the military? **YES / NO**	If yes, in what capacity?
Have you ever been arrested/been incarcerated? **YES / NO**	If yes, what for?

HABITS

Do you follow a special diet? **YES / NO**	If yes, what type:
Do you exercise regularly? **YES / NO**	If yes, what type and how often?
Do you currently use tobacco products? **YES / NO**	If yes, how many packs per day?
Do you drink alcohol? **YES / NO**	How many drinks per day or per week?
Do you regularly use sleeping pills, tranquilizers, or painkillers? **YES / NO**	If yes, which ones?
Do you currently use marijuana, methamphetamine, cocaine, LSD, MDMA, or other "recreational" drugs **YES / NO**	If yes, which ones?
Have you ever received substance abuse treatment? **YES / NO**	If yes, when and where?
Do you have any drug, nicotine, or alcohol habits that concern you? **YES / NO**	

GENERAL HISTORY	
Who is your primary care physician (PCP)?	
Do you see your PCP for regular well visits (at least yearly)? **YES / NO**	When did you last see your PCP?
What is your current weight?	Has it changed in the past 6 months? **YES / NO**
How much? + / -	Intentional? **YES / NO**
Are you pregnant or trying to get pregnant? **YES / NO**	Are you currently nursing? **YES / NO**
How would you rate your health at present? **POOR / FAIR / GOOD / EXCELLENT**	