



Comprehensive Psychiatry Group, Inc.

INSURANCE INFORMATION

☐

No Change in Insurance

Account # _____

Patient Name: _____ Soc. Sec. #: _____ DOB: _____

Address: _____
Street Address City State Zip Code

Phone: (____) _____ ☐ Cell ☐ Home ☐ Work E-mail: _____

Emergency Contact: _____ Phone: _____

PRIMARY INSURANCE:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child

Insured Name: _____ Soc. Sec. #: _____ DOB: _____

Address: ☐ same _____
Street Address City State Zip Code

Phone: (____) _____ ☐ Cell ☐ Home ☐ Work E-mail: _____

Insurance Company/Address: _____

Insurance ID# _____ MMIS# _____

SECONDARY INSURANCE:

Relationship to Patient: ☐ Self ☐ Spouse ☐ Child

Insured Name: _____ Soc. Sec. #: _____ DOB: _____

Address: ☐ same _____
Street Address City State Zip Code

Phone: (____) _____ ☐ Cell ☐ Home ☐ Work E-mail: _____

Insurance Company/Address: _____

Insurance ID# _____ MMIS# _____

I HEREBY AUTHORIZE **CPG** TO RELEASE TO MY INSURANCE COMPANY, ALL MEDICAL INFORMATION NECESSARY IN ORDER TO PROCESS MY MEDICAL CLAIMS. I REQUEST THAT PAYMENT OF AUTHORIZED BENEFITS BE MADE ON MY BEHALF & ASSIGN THE BENEFITS PAYABLE FOR SERVICES RENDERED TO ME AND / OR MY DEPENDENTS TO **COMPREHENSIVE PSYCHIATRY GROUP, INC.** TO SUBMIT A CLAIM ON MY BEHALF.

Insured's Signature (sign or type full name)

Date



Comprehensive Psychiatry Group, Inc.

PATIENT MEDICAL HISTORY & PHYSICAL SCREENING

Patient Name _____ Gender _____ Date of Birth _____

Current Health Status (check one) ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Allergies/Adverse Reactions _____

Primary Care Physician _____ Last Physical Exam _____

Height _____ Weight _____

Vaccinations: ☐ Smallpox ☐ DPT ☐ MMM ☐ MMM Booster ☐ Hepatitis B ☐ Tetanus (last dose)

NUTRITIONAL ASSESSMENT

Appetite ☐ Normal ☐ Poor Weight Change ☐ No ☐ Yes _____ lbs

Any special diet? ☐ No ☐ Yes _____

Growth problems/eating disorder ☐ No ☐ Yes _____

SURGERIES / HOSPITALIZATIONS

REASON	YEAR	AGE	REMARKS
1.			
2.			

FAMILY MEDICAL HISTORY

PROBLEM	YES	NO	WHOM	PROBLEM	YES	NO	WHOM
Alcohol / Drugs	<input type="checkbox"/>	<input type="checkbox"/>		Seizures	<input type="checkbox"/>	<input type="checkbox"/>	
Cancer	<input type="checkbox"/>	<input type="checkbox"/>		Hypertension	<input type="checkbox"/>	<input type="checkbox"/>	
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>		Heart Problems	<input type="checkbox"/>	<input type="checkbox"/>	
Depression/Suicide	<input type="checkbox"/>	<input type="checkbox"/>		Stroke	<input type="checkbox"/>	<input type="checkbox"/>	
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>		Thyroid	<input type="checkbox"/>	<input type="checkbox"/>	
Psychiatric Care	<input type="checkbox"/>	<input type="checkbox"/>		Obesity	<input type="checkbox"/>	<input type="checkbox"/>	
Allergies	<input type="checkbox"/>	<input type="checkbox"/>		Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	



Comprehensive Psychiatry Group, Inc.

System Review /Medical Conditions

	Now	Past		Now	Past		Now	Past
Food Cravings	<input type="checkbox"/>	<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	<input type="checkbox"/>	Itching / Rash	<input type="checkbox"/>	<input type="checkbox"/>
Sleep Difficulty	<input type="checkbox"/>	<input type="checkbox"/>	* Chest Pain	<input type="checkbox"/>	<input type="checkbox"/>	Jaundice	<input type="checkbox"/>	<input type="checkbox"/>
Headaches	<input type="checkbox"/>	<input type="checkbox"/>	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	Excessive Sweating	<input type="checkbox"/>	<input type="checkbox"/>
Migraine / Tension	<input type="checkbox"/>	<input type="checkbox"/>	Nausea / Vomiting	<input type="checkbox"/>	<input type="checkbox"/>	* Chronic Pain	<input type="checkbox"/>	<input type="checkbox"/>
* Seizures	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal Pain	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes / Insulin	<input type="checkbox"/>	<input type="checkbox"/>
Dizziness	<input type="checkbox"/>	<input type="checkbox"/>	Heartburn	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>
* Blackouts	<input type="checkbox"/>	<input type="checkbox"/>	Diarrhea	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>
Anxiety	<input type="checkbox"/>	<input type="checkbox"/>	Constipation	<input type="checkbox"/>	<input type="checkbox"/>	Drug Abuse/Addiction	<input type="checkbox"/>	<input type="checkbox"/>
Depression	<input type="checkbox"/>	<input type="checkbox"/>	* Irregular Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Neurological Disease	<input type="checkbox"/>	<input type="checkbox"/>
Eye Problems	<input type="checkbox"/>	<input type="checkbox"/>	Painful Menstruation	<input type="checkbox"/>	<input type="checkbox"/>	Irritable Bowel / Colitis	<input type="checkbox"/>	<input type="checkbox"/>
Hearing Problems	<input type="checkbox"/>	<input type="checkbox"/>	* Vaginal Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Fatigue / Exhaustion	<input type="checkbox"/>	<input type="checkbox"/>
Ear Infections	<input type="checkbox"/>	<input type="checkbox"/>	* Breast Lumps	<input type="checkbox"/>	<input type="checkbox"/>	Grinding Teeth	<input type="checkbox"/>	<input type="checkbox"/>
Sinus Infections	<input type="checkbox"/>	<input type="checkbox"/>	Burning Urination	<input type="checkbox"/>	<input type="checkbox"/>	Stiff / Painful Neck	<input type="checkbox"/>	<input type="checkbox"/>
* Frequent Nose Bleeds	<input type="checkbox"/>	<input type="checkbox"/>	* Penis Discharge	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid Problems	<input type="checkbox"/>	<input type="checkbox"/>
Speech Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Bladder Infections	<input type="checkbox"/>	<input type="checkbox"/>	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>
Swallowing Difficulties	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>
* Shortness of Breath	<input type="checkbox"/>	<input type="checkbox"/>	Joint Pain / Swelling	<input type="checkbox"/>	<input type="checkbox"/>	(Type): _____		
Persistent Cough	<input type="checkbox"/>	<input type="checkbox"/>	Tumors	<input type="checkbox"/>	<input type="checkbox"/>	Bed-wetting	<input type="checkbox"/>	<input type="checkbox"/>
Smoker # Packs Day ____	<input type="checkbox"/>	<input type="checkbox"/>	* Paralysis	<input type="checkbox"/>	<input type="checkbox"/>	Soiling	<input type="checkbox"/>	<input type="checkbox"/>
High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	* Loss of Sensation	<input type="checkbox"/>	<input type="checkbox"/>	Ticks / Twitches	<input type="checkbox"/>	<input type="checkbox"/>
			Hair Pulling / Twisting	<input type="checkbox"/>	<input type="checkbox"/>			

- = Triggers an immediate need for Physical Screening with PCP / Specialist

REPRODUCTIVE HEALTH

☐ N/A

Age at Puberty ____ ☐ N/A Pregnancies ____ Menopause ____

Completed by: (Patient / Parent Name) _____ Date _____

Patient

Please complete the next page if patient is 18 years or younger



Comprehensive Psychiatry Group, Inc.

CHILD / YOUTH PHYSICAL HEALTH ASSESSMENT

Please specify concerns about your child's functioning in any of the following areas

Specify Current or Past Concerns

☐ **motor** development ☐ NO ☐ YES _____

☐ **sensorimotor** functioning ☐ NO ☐ YES _____

☐ **speech** functioning ☐ NO ☐ YES _____

☐ **hearing** functioning ☐ NO ☐ YES _____

☐ **language** functioning ☐ NO ☐ YES _____

☐ **visual** functioning ☐ NO ☐ YES _____

☐ **immunization** status ☐ NO ☐ YES _____

☐ **oral health & hygiene** ☐ NO ☐ YES _____

☐ Parent is recommended to follow up with a specialist for additional in-depth screening / assessment for

☐ motor development ☐ sensorimotor functioning

☐ speech functioning ☐ hearing functioning

☐ language functioning ☐ visual functioning

☐ oral health ☐ immunization status

☐ N/A to all of the above – no external referrals warranted

Completed by: (Patient / Parent Name) _____ Date _____

TO BE COMPLETED BY THE REVIEWER

Reviewed By _____ Date _____

Additional Information Needed ☐ NO ☐ YES

☐ PATIENT IS RECOMMENDED TO FOLLOW UP WITH PEDIATRICIAN / PRIMARY CARE PHYSICIAN FOR EVALUATION & TREATMENT OF _____

(Physical / Medical Condition or Symptom(s))

☐ N/A



Comprehensive Psychiatry Group, Inc.

PATIENT MEDICATION LIST

Patient Name _____ Date This Form Completed _____

LIST ALL CURRENT PRESCRIPTION MEDICATIONS

MEDICATION NAME	DOSE & DURATION	REASON PRESCRIBED	RESPONSE TO MEDICATION	PRESCRIBER	START DATE
1.					
2.					
3.					
4.					
5.					

LIST ALL CURRENT OVER THE COUNTER MEDICATION, VITAMINS, SUPPLEMENTS, NEUTRICEUTICALS, HERBALS & OTHERS

MEDICATION NAME	DOSE & DURATION	REASON PRESCRIBED	RESPONSE TO MEDICATION	START DATE
1.				
2.				
3.				
4.				

PAST PSYCHIATRIC MEDICATIONS ONLY

MEDICATION NAME	DOSE & DURATION	REASON PRESCRIBED	RESPONSE TO MEDICATION	PRESCRIBER	START DATE
1.					
2.					
3.					
4.					

Please attach a second page if additional space if needed



Comprehensive Psychiatry Group, Inc.

955 Windham Court

Boardman, OH 44512

Phone (330) 726-9570 Fax (330) 726-9031

Consent to Release and Request Information

NAME OF PATIENT: _____ DOB: _____

I understand that it may be necessary to communicate to other parties about my treatment at CPG and that my treating provider can ONLY do so if I complete and sign this release form. I hereby give my consent to release information to the following parties / obtain information from the following parties for the purpose of evaluation and treatment. I understand that if I wish to communicate with my behavioral healthcare provider via email/text there may be some level of risk that the information in the email/text could be read by a third party. CPG and its providers cannot guarantee the security of information sent via email/text. If I still wish to send / receive PHI in this way, it is my right to do so as long as I am aware that CPG and its providers are not responsible for the unauthorized access of PHI while in transmission to me.

☐ Emergency Contact _____ / _____ / _____
name relationship number

☐ Primary Care Physician / Pediatrician _____
(Name & Address) _____

☐ With Whom Can We Speak about Appts / Rescheduling / Medications etc.? _____
(Name & Relationship) _____

☐ School / Other: _____
(Name & Address) _____

			TYPE OF CONTACT
<input type="checkbox"/> Psychiatric Evaluation	<input type="checkbox"/> Treatment Summary	<input type="checkbox"/> School Communication	<input type="checkbox"/> Written
<input type="checkbox"/> Psychological Testing	<input type="checkbox"/> Medications	<input type="checkbox"/> Treatment Plan	<input type="checkbox"/> Verbal / Phone
<input type="checkbox"/> Psychological History	<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Aftercare Planning	<input type="checkbox"/> Electronic

Patient (or Parent / Guardian)

Date

Relationship to Patient

Witness

This consent is valid until: _____
(termination of Tx unless otherwise specified)

I understand that I can terminate / revoke this consent at any time. To do so, I must simply check the box below and enter the date. By doing so, all further communication with the above indicated parties will immediately cease.

☐ I hereby revoke this consent / release on this date _____
Name & Relationship to Patient

Federal regulations (42 CFR Part 2) prohibit any further disclosure of these materials without the specific written consent of the patient and or parent / guardian involved. If you feel that you have received this communication in error, please contact the sender immediately.



Comprehensive Psychiatry Group, Inc.

955 Windham Court Boardman, OH 44512 Phone (330) 726-9570 / Fax (330) 726-9031

Pradeep Mathur, MD
& Clinical Associates

Social Media Policy

This document outlines Comprehensive Psychiatry Group's policies as it relates to our use of social media and how we conduct ourselves as mental health professionals. Please review it to better understand what to expect about how we use electronic media and any internet based platforms. If you have any questions about the information herein, please discuss them with your CPG Clinician.

Website Access - CPG's website (www.cpgboardman.com) was designed, implemented and is regularly updated and maintained in order to provide potential / existing patients about the variety of behavioral health services that are available at our office. On this website, potential patients can access information about the clinical staff, get directions to our office, complete a satisfaction survey, and complete, download, and submit all New Patient Paperwork Forms to CPG to ease the new patient registration process and expedite the scheduling of a new patient appointment.

Electronic Communication - Emails, cell phones, computers and faxes are not private and all patients should know that no form of electronic patient communication can be guaranteed to be 100% private. CPG utilizes remote server access (i.e. no patient data is stored directly on the clinician's computer), and all electronic data must pass through a firewall in effort to protect patient confidentiality. CPG contracts with Security Metrics who routinely inspect our electronic processes and completes routine external vulnerability scans to ensure that we are as protected as possible from outside threats that could compromise patient confidentiality. CPG utilizes an interactive email / text system for appointment reminders. Most patients find this very helpful, but each patient is given the choice to opt out of this service (just let your provider know that you do NOT wish to utilize this service). CPG staff may selectively use electronic means of communication (email / text / telehealth) in order to communicate with patients but ONLY if the patient / guardian have been educated to the inherent risks involved in this type of communication and grants approval despite these risks. Despite all the precautions that CPG takes, conversations can be overheard; emails / texts / faxes can be sent to the wrong recipient and phone calls can be listened to by others. Any patient that wishes to communicate with CPG clinical staff via one or more of these forms of electronic communication does so with the understanding that CPG cannot guarantee the confidentiality of these forms of communication and CPG will assume that the patient has made an informed decision to communicate in this manner and will view it as the patients agreement to assume the risk that such communication may be intercepted.

Social Media Searching - The staff of CPG do NOT access social media sites (Facebook, Twitter, Snapchat etc.) in order to verify the identity of a given patient or to "checkup" on them. The staff of CPG do not "Friend" / "Follow" / "Like" patients or their posts on the patient's own social media sites,

(nor do we solicit friend requests from any of our patients on our own social media sites) as we believe that doing so can compromise the patient's right to confidentiality and privacy.

Requests to follow a patient on any social media platform (including more supposedly professional platforms such as LinkedIn) will be ignored in order to safeguard your confidentiality. If the patient has any questions about this, they are encouraged to speak to their clinician about them.

Telehealth Services – CPG utilizes the platform of Doxy.me for its telehealth services. (Doxy.me is HIPAA, GDPR, PHIPA / PIPEDA, & HITECH compliant and they meet worldwide security requirements). Should a patient decide that they wish to engage in Telehealth service, after having been educated to the pros and cons of such services, the patient understands that CPG cannot 100% guarantee the confidentiality of their appointment despite the above referenced security protocols.

Location-Based Services – If any patient uses location-based services on their mobile phone / tablet etc., they need to be aware of the privacy issues related to using these services. CPG does not place its practice as a check-in location on any sites. However, if the patient has GPS tracking enabled on their device, it is possible that others may surmise that they are receiving behavioral health counseling or medication management services due to regular check-ins at the practice.

Business Review Sites are Not an Effective Place to Voice Your Complaint – Patients may find the practice of Comprehensive Psychiatry Group listed on sites such as Google, Bing, Yelp, Healthgrades etc. Some of these sites include a forum in which users can rate their providers or the services they received at the practice. Many of these sites comb search engines for business listings and automatically add listings regardless of whether the business had added itself to the site. If a patient should find a listing for Comprehensive Psychiatry Group on any such site, please know that this is NOT our request for a testimonial, rating, or endorsement from you. Patients of course have the right to express themselves and their opinions on any sight they wish. But due to confidentiality laws, all patients must know that we will NOT respond to any comments made on such sites, regardless of whether the comment is positive or negative. If a patient chooses to leave a review, we want them to be aware that they may be revealing personal information in a public forum. For that reason we encourage patients to create a pseudonym that is not linked to their regular email address for their own privacy and protection.

Our patient's satisfaction is important to us and if any patient has a complaint and wishes CPG to address it, there exists a Patient Concern and Complaint Form that can be completed and submitted to CPG so that the concern / complaint can be reviewed and addressed as needed. We also always encourage patients to provide their clinician with direct feedback, good or bad, so that we can be aware of our opportunities for improvement and take the necessary corrective action when possible.

If a patient feels that their clinician has done something harmful or unethical and does not feel comfortable addressing it with the clinician directly, they can contact one of the appropriate licensing boards listed below:

**State of Ohio Counselor, Social Worker,
Marriage and Family Therapist Board**
77 S High St 24th Floor, Room 2468
Columbus, OH 43215

State of Ohio Medical Board
30 E. Broad Street, 3rd Floor
Columbus, OH 43215

State of Ohio Nursing Board
17 S High St #660
Columbus, OH 43215

State of Ohio Psychology Board
77 S High St # 1830
Columbus, OH 43215

Conclusion – Thank you for taking the time to review Comprehensive Psychiatry Group’s Social Media Policy. If you have any questions or concerns about this policy, please bring them to the attention of your clinician.

Acknowledgement of Receipt / Review of Social Media Policy

By signing below I am indicating that I have reviewed this document, and that I understand the Social Media policy of Comprehensive Psychiatry Group. I have been offered a printed copy of the Social Media Policy and all questions regarding this policy have been answered to my satisfaction.

Patient / Guardian Printed Name

Parent / Guardian Name
(if patient is a minor child)

Date

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ DATE: _____

Over the *last 2 weeks*, how often have you been bothered by any of the following problems?
(use “✓” to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way	0	1	2	3

add columns: + +

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card.) TOTAL:

10. If you checked off *any* problems, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all

Somewhat difficult

Very difficult

Extremely difficult

PHQ-9 is adapted from PRIME MD TODAY, developed by Drs Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues, with an educational grant from Pfizer Inc. For research information, contact Dr Spitzer at rls8@columbia.edu. Use of the PHQ-9 may only be made in accordance with the Terms of Use available at <http://www.pfizer.com>. Copyright ©1999 Pfizer Inc. All rights reserved. PRIME MD TODAY is a trademark of Pfizer Inc.

PHQ-9: Modified for Teens

Name: _____ Clinician: _____ Date: _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an “X” in the box beneath the answer that best describes how you have been feeling.

	(0) Not At All	(1) Several Days	(2) More Than Half the Days	(3) Nearly Every Day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?
☐ Yes ☐ No

If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home or get along with other people?
☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult

Has there been a time in the past month when you have had serious thoughts about ending your life? <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you EVER , in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? <input type="checkbox"/> Yes <input type="checkbox"/> No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: Severity score: _____

Modified with permission by the GLAD-PC team from the PHQ-9 (Spitzer, Williams, & Kroenke, 1999), Revised PHQ-A (Johnson, 2002), and the CDS (DISC Development Group, 2000)