Gregory P Brown, MD, Professional Corporation

Diplomate of the American Board of Psychiatry and Neurology in Psychiatry and Forensic Psychiatry

Associate Professor of Psychiatry, University of Nevada Las Vegas School of Medicine

Demographic Data

Name:
Street address:
City, State, Zip:

Phone number:

Date of birth:
Age:
Social Security #:

Primary care physician:
Primary care physician's phone number:

Billing information

Please indicate name, address, phone number and relation to patient/evaluee if a third party is responsible for payment:

Patient contract: each line must be initialed prior to evaluation

[init] I understand I am responsible for payment in full for all charges at the time of service.

[init] I understand that I will be sent to collections if charges are not paid in a timely manner, and that I understand that such action does not constitute breach of either privilege or confidentiality.

[init] If I am here for treatment purposes, I understand that information provided is confidential. It will be documented in my chart. I also understand that certain information is neither privileged nor confidential, including, but not limited to, threats of harm to self, threats of harm to others, suspicion of child or elder abuse, failure to pay bills to provider, etc.

[init] I understand that any appointment must be cancelled at least 48 hours in advance or a full charge will apply.

[init] I understand that if I miss more than two consecutive appointments or more than four appointments total in six months that my chart will be closed and due notice will be considered automatically given.

[init] I understand that no medication refill request will be honored with less than three working day's notice, and that no medication refill request will be honored unless there has been an office visit within the past 60 days.

[init] I may, at my discretion text Dr. Brown at 702-232-3256, but due to the vagaries of text technology, I understand Dr. Brown is not responsible for the receipt of any text message. Dr. Brown will respond to anything other than appointment requests via email rather than text.

[init] I understand that I may contact Dr. Brown by email at gbrown@gregorypbrownmd.com and that responses from Dr. Brown may be via an encrypted server to which I will set up my own password. Email should never be used for urgent communication as response may take in excess of 24 hours.

[init] I understand that I may call Dr. Brown at 702-232-3256, and that general messages will usually have a response time within one business work day, excepting vacations and conferences. If I have a need for additional information, I may contact the UNLV Department of Psychiatry at 702-671-6475. I fully understand that if I have any form of crisis and cannot reach Dr. Brown that it is entirely my responsibility to seek care at the nearest Emergency Room and/or call 911, and I fully indemnify Dr. Brown for any issues related to the need for a higher level of care or crisis, as I accept responsibility for myself to identify and follow through with reaching crisis care on my own. Dr. Brown does not provide any form of inpatient services.

I consent, assent and request evaluation and or treatment by Dr. Brown. I understand that treatment does not guarantee symptom resolution and that some individuals may show no improvement or even worsen.

signature date

Dr. Brown does not accept any form of insurance, including Medicare and Medicaid. Payment must be in the form of cash, money order, or credit card. A $50 fee will be charged for any check with insufficient funds. I understand this billing policy and I choose to waive all of my insurance benefits with regard to payment for services. I understand that I may pay for services with an MSA or MHA credit card if I wish.

signature date

***If I have Medicare or Medicaid, I choose to waive my benefits for all services with Dr. Brown.**

signature date

Patient/Evaluee History Form

Name:
Age:
Marital status:
Educational level:

What is the purpose of your evaluation?

Why now?

What symptoms or problems have you been experiencing and for how long?

What clinicians have you seen for this problem? What treatments worked and didn't work in the past?

Please list any medications you are allergic to:

Please list any medications you are taking currently for any condition:

Please list any medications you tried in the past for the difficulty which brings you here today, the results of the medications and the side effects noted.

Please list any herbal supplements you take on a regular basis:

Please list all previous psychiatric hospitalizations with dates and reason for admission:

Mother's age and health status:

Father's age and health status:

Siblings ages and health status:

Number of times married:

Children's ages and health status :

Who is currently living in the home with you?:

Describe any medical problems you have been treated for:

Describe any recent stressors:

Describe your formal religious affiliation:

Describe any personal spiritual practices:

Describe your alcohol use/tobacco use/substance use:

Describe any past or current legal history:

Have you ever attempted suicide? If so, describe the number of times and circumstances:

Have you ever attempted to physically harm another person? If so, describe the number of times and circumstances:

If female: age of menarche: are periods regular: age of menopause:
are you pregnant currently:

Current symptoms:

Describe your mood
Describe your sleep
Describe your appetite
Describe your physical condition
Describe your sexual drive
Describe any symptom or difficulty you have at the present time

Release of Information Form:

I hereby authorize record release to and from:

And to and from:

This release includes a request for all previous treatment records, all psychological testing, all psychological/psychiatric reports, all medication records; it also allows for verbal two way communication between the providers for the purpose of continuity of care. If this is for contact between a psychiatrist and a therapist the consent will last for the duration of treatment; otherwise will expire one year after signature.

I am aware that my records are confidential under state and federal law and by this release, I am allowing said records to be shared or obtained. Once another entity has possession of the records the law may not protect against further disclosure. I acknowledge any and all rights granted under HIPAA, although this office is HIPAA exempt at the time of this document signature.

I voluntarily and freely give consent for release of information between the above listed providers/ persons/organizations/entities. I forever release the above clinicians from all liability related to this release.

signature print name date

date of birth Soc. Sec. #