

PATIENT INFORMATION AND REGISTRATION

Patient Name: _____ Nickname: _____
 Last First MI

Social Security # _____ - _____ - _____ Date of Birth _____ / _____ / _____ Age _____

Gender: _____ Marital Status: S / M / D Email: _____

Home #: (_____) _____ - _____ Cell #: (_____) _____ - _____ Preferred #: (_____) _____ - _____

Address: _____ City/State: _____ Zip Code: _____

Primary Care Physician: _____ Phone #: _____

Emergency Contact Person: _____ Phone #: _____

Relationship: _____

Local Pharmacy: _____ Location: _____

Party Responsible for Payment (If other than Patient)

Name: _____ D. O. B.: _____

Address: _____ Phone #: _____

_____ Drivers License #: _____

Insurance Information

Primary Insurance Comp. _____ Phone # : _____

Policy Holder's Name: _____ D. O. B.: _____

Policy I. D. # _____ Group # _____

I certify the information provided is correct and irrevocably authorize services be provided to the above named patient.

_____ Date _____
Signature of Patient/Parent or Guardian

Name: _____

Have you ever seen a psychiatrist, psychologist or counselor before? yes / no
If yes, when and who?

Have you ever been hospitalized for your mental health? yes / no If yes, when was this?

Which medications (prescription and over the counter) do you take at this time?
Please list, with dosages:

Have you previously had any allergic or other untoward reaction to psychiatric medications? yes / no
If yes, please explain:

How much of the following have you used in the past week?

Nicotine _____

Caffeine _____

Alcohol _____

Marijuana _____

Synthetics _____

Other drugs _____

Have you ever?

Do you work ? yes / no If yes, what kind of work do you do? _____

Do you go to school? yes / no

If yes, what level and where? _____

If no, what was the highest level of education you reached? _____

Do you have children? yes / no If yes, please give the age of your children:

Do you live *alone*? yes / no

If no, who lives with you? _____

Do you have *fire-arms* at home? yes / no

Name: _____

Please circle medications you have been on in the past

Antidepressants such as: Fluoxetine/Prozac/Sarafem

Paroxetine/Paxil

Sertraline/Zoloft

Citalopram/Celexa

Escitalopram/Lexapro

Venlafaxine/Effexor

Desvenlafaxine/Pristiq

Duloxetine/Cymbalta

Bupropion/Wellbutrin/Zyban/Forfivo

Vilazodone/Viibryd

Vortioxetine/Trintellix/Brintellix

Levominalcipran/Fetzima

Imipramine/Tofranil

Nortryptiline/Pamelor

Emsam Patch or any antidepressant that required a strict diet (MAOI)

Anti-anxiety agents such as: Lorazepam/Ativan

Alprazolam/Xanax

Clonazepam/Klonopin

Temazepam/Restoril

Diazepam/Valium

Bupirone/BuSpar

Mood stabilizers such as: Lithium/ Eskalith

Valproic acid//Depakote

Carbamazepine/Tegeretol

Gabapentin/Neurontin

Topiramate/Topamax

Olanzapine/Zyprexa

Quetiapine/Seroquel

Risperidone/Risperdal

Aripiprazole/Abilify

Lurasidone/Latuda

Asenapine/Saphris

Ziprasidone/Geodon

Brexipiprazole/Sapris

Cariprazine/Vraylar

Clozapine/Clozaril

Sleep medications such as Zolpidem/Ambien

Zaleplon/Sonata

Eszopiclone/Lunesta

Ramelteon/Rozerem

Suvorexant/Belsomra

Hydroxyzine/Vistaryl

ADHD medications such as: Clonidine/Catapress/Kapvay

Guanfacine/Tenex/Intuniv

Modafinil/Provigil

Armodafinil/Nuvigil

Methylphenidate/Ritalin/Concerta/Quilivant/Quilichew/Methylin/Metadate

Aptensio XR/Contempla

Daytrana Patch

Desmethylphenidate/Focalin

Mixed amphetamine salts/Adderall/Vyvanse/Mydayis/Adzenys XR ODT

Zenzedi/Procentra

Dyanavel/Evekeo

Atomoxetine/Strattera

Cyproheptadine/Periactin

Anti-craving medications such as: Naltrexone/ReVia

Acamprosate/Campral

Disulfiram/Antabuse

Name: _____ Date: _____

Have any of your blood relatives ever had any of the following? Please circle, and explain who

		Relationship
alcoholism	yes / no	_____
depression	yes / no	_____
epilepsy or seizures	yes / no	_____
genetic disease	yes / no	_____
heart disease/sudden heart death	yes / no	_____
hyperactivity/attention problems, ADHD	yes / no	_____
learning disabilities	yes / no	_____
manic-depressive illness/bipolar disorder	yes / no	_____
dementia/Alzheimers	yes / no	_____
nervousness or anxiety	yes / no	_____
schizophrenia	yes / no	_____
substance abuse	yes / no	_____
OCD	yes / no	_____

Do you have any medical problems? yes / no
If yes, please explain:

Do you suffer from *pain*? yes / no
If yes, please explain:

Have you ever had a concussion, head injury, loss of consciousness or a seizure? yes / no
If yes, please explain:

Do you have heart disease or glaucoma? yes / no
If yes, please explain:

Practice Policies and Fees:

Please read carefully and feel free to bring up any questions you may have.

Scope of practice:

The aim of Caroline C. Batenburg, M.D. is to provide excellent psychiatric services to the community of New Braunfels and surrounding areas. In principle, she provides psychiatric care in person. In certain circumstances, she will allow televisits, as long as it does not interfere with the quality of care.

Treatment of Minors:

Treatment of patients under the age of 18 will be provided only with the consent of the parent or legal guardian. In cases of divorce, a copy of the custody agreement must be provided. By signing the consent form on page 3 of this document, the parent acknowledges that he or she is the guardian (as established by the state or the divorce decree) of any minor presented for treatment.

*** If the patient is a minor, he/she will not be seen without his/her legal guardian present.**

Financial Agreement:

All balances are due and payable in full at the time of treatment, unless other arrangements are made prior to appointment. We are required to notify you that certain services that may be deemed necessary by Dr. Batenburg may not be covered by your Private Insurance, Medicare or Medicaid.

Missed, late or cancelled appointments:

Your appointment time is a reservation for psychiatric services. Therefore, you will be billed for missed appointments or appointments canceled with less than 24 business hour notice. (Monday appointments will need to be canceled by noon on the preceding Friday.) Patients arriving 10 minutes late maybe asked to reschedule.

As a courtesy we send appointment reminders but ultimately you are responsible for keeping your appointments.

Refill Requests:

ALL MEDICATION REFILLS NEED TO BE REQUESTED 48 to 72 HOURS IN ADVANCE.

Please contact your pharmacy directly to request a refill. They will have all the information needed to properly contact us for your prescription. This is the most efficient way for you to obtain your medication refill. Please note that due to the high volume of requests, prescriptions take 48 – 72 hours to process. **Refills that need to be filled the same day or prior to the 48 to 72-hour notification may be assessed a fee up to \$50 per prescription. Also, if a non-emergency refill is granted on a weekend, you will be charged a \$50.00 fee.**

Please check with your pharmacy *before* calling our office to check on the status of your refill. Also, if Dr. Batenburg has sent a prescription during a visit, this may be taken by the pharmacy as a new prescription with a different prescription number. Please check with the pharmacy first to confirm this.

It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations may result in a denial of refills.

Prior Authorization for medications may take up to seven days and a charge of \$50 will be assessed for this service.

CONTROLLED SUBSTANCES:

Controlled substance prescriptions are monitored via the Texas Prescription Monitoring Program. Stimulant medication (Adderall, Concerta, Vyvanse, Ritalin, Dexedrine, Focalin, Metadate, ect) refills **WILL NOT** be processed on weekend or after business hours. Keeping track of quantities and when prescriptions will be needed is critical to avoid going without medication.

Controlled substance prescriptions that are stolen require an appointment and a police report to be replaced or refilled.

Forms and Letters:

Patients frequently request letters/forms for school, work, special accommodations, and other matters during routine appointments. Please keep in mind that appointments are scheduled for the purpose of assessing progress in treatment and response to medication. If time permits, you may be able to make these requests but it will take time to process the request. Your fee will be determined by the length of time and level of complexity required to complete the letter/form.

Dr. Batenburg will not complete disability paperwork nor will she write letters for emotional support animals.

Phone calls/Emergency Phone calls:

In cases of emergency phone calls, or calls due to side effects of medications, there will be no fees. For non-emergency calls, there is no charge for phone calls of 5 minutes or less in duration, phone calls from 6-15 minutes will be billed as a medication check and phone calls from 16-30 minutes will be billed as a medication check/psychotherapy visit. Please see our published fee schedule for additional information

Termination of Care Policy:

1. Patient are free to terminate their care with Caroline C. Batenburg, M.D. at any time or for any reason by notifying our office directly.
2. Patient's being disrespectful, threatening, or verbally abusive towards the Doctor, Staff, or other patients and their families in the waiting room will not be tolerated. These behaviors will also result in termination of care and clinical services.
3. Caroline C. Batenburg, M.D. may exercise her right to terminate care after:
 - Three No call/No shows
 - Three cancellations that are not cancelled within 24 hours of appointment time.
 - Three rescheduled appointments
4. If you are still in need of mental health services, you may go to the nearest emergency room. You may also contact one of the following psychiatric hospitals that provides services for child and adolescents: Laurel Ridge (210) 491-9400, Methodist Hospital (210) 575-0500, and Nix Hospital (210) 341-2633, Clarity Mental Health (210) 616-3000. If you are without health insurance, you may contact The Center for Health Care Services (210) 261-1000, Comal County MH Center (830) 620-6221.

I understand the Practice Policies and Fees (updated January 2023).

I have read the policies and fees notice and understand that if I request any services that are not covered by any insurance plan, that I will be billed accordingly.

Please print patient’s name

Date of Birth

Signature of Patient or Guardian

Date

Caroline C. Batenburg, M.D.

Date