INITIAL PATIENT INFORMATION - Please Provide Your Information Below

Is this an emergency? □ No □ Yes □ Unsure

Last Name	First Name	MI

Date of Birth	Age	Gender Identity □ Male □ Female □ Transitioning

Current Address: **City** **State** **Zip**

Ok to mail to this address? □ No □ Yes

Primary Phone: □ Cell □ Residence □ Work	Secondary Phone: □ Cell □ Residence □ Work
( )	( )
Ok to Call? □ No □ Yes	Ok to Call? □ No □ Yes
Ok to leave message? □ No □ Yes	Ok to leave message? □ No □ Yes

Email Address:
I consent to RIMG emailing me even though email may not be secure? □ No □ Yes

Emergency Contact:
Name: _________________________ Relationship: _________________________ Phone: ( )

Race/Ethnicity
- □ African-American/Black
- □ American Indian/Alaska Native
- □ Asian Indian
- □ Chinese/Chinese-American
- □ Cuban
- □ Filipino/Filipino-American
- □ Guamanian or Chamorro
- □ Japanese/Japanese-American
- □ Korean/Korean-American
- □ Mexican/Mexican-American/Chicano
- □ Native Hawaiian
- □ Other Asian: ______________________________
- □ Other Pacific Islander: ______________________
- □ Other Spanish/Latino: ______________________
- □ Polynesian/Micronesia
- □ Puerto Rican
- □ Samoan
- □ Vietnamese/Vietnamese American
- □ White
- □ Decline to Answer
- □ Other (specify): ___________________________

Sexual Orientation
□ Heterosexual □ Bisexual □ Gay/Lesbian □ Questioning □ Decline to Answer □ Other:_________

Relationship Status
□ Single □ Married □ Domestic Partnership □ Separated □ Divorced □ Widowed

Emergency Contact
Name:_______________________ Relationship to Patient: ____________________ Phone: ( )

Level of Education
- □ Elementary Grades 1-8
- □ Some High School (no diploma)
- □ High School Diploma/GED
- □ Some College (no degree)
- □ Associate's Degree
- □ Bachelor's Degree
- □ Master's Degree
- □ Professional Graduate Degree (MD, JD, etc.)
- □ Doctoral Degree (PhD, EdD, etc.)

Check All that Apply
- □ Single Parent
- □ Unemployed
- □ Former Foster Youth
- □ Veteran
- □ Do you have a disability? □ No □ Yes
  If yes, diagnosis: _________________________

Referred By
□ Self □ RIMG Health Provider: ___________________________ □ Other: _______________________
Does RIMG have permission to thank this person for the referral? □ No □ Yes
If yes, referral name and phone number: ____

Please Check All that Apply and Rank Your Top 3 Concerns (ex. Depression – 1, Chronic Pain – 2, etc.)

□ Addictions	□ Drug Use	□ Legal Problems	□ Racing Thoughts
□ Aggression	□ Eating Concerns	□ Loneliness	□ Self-Esteem
□ Alcohol Use	□ Failure	□ Manic Behavior	□ Self-Neglect
□ Anger Management	□ Family Problems	□ Medical Procedures	□ Sexual Abuse
□ Anxiety, Fears	□ Fatigue, Low Energy	□ Medication Issues	□ Sexual Issues
□ Assault	□ Financial Difficulties	□ Menstrual Problems	□ Sleep Problems
□ Career Concerns	□ Grief, Loss, or Death	□ Menopause	□ Smoking/Tobacco
□ Childhood Abuse	□ Guilt	□ Mood Swings	□ Spiritual or Religious Issues
□ Chronic Pain	□ Headaches	□ Multicultural Issues	□ Stress or Tension
□ Compulsive Behavior	□ Health Concerns	□ Obsessions	□ Suicidal Thoughts
□ Confusion	□ Hospitalizations	□ Panic Attacks	□ Trouble Deciding
□ Cutting, Self-Injury	□ Impulsive Behavior	□ Paranoia	□ Unemployment
□ Decision Making	□ Internet Use	□ Pessimism	□ Weight and Diet Issues
□ Depression	□ Interpersonal Issues	□ Phobias	□ Withdrawal
□ Divorce/Separation	□ Lack of Motivation	□ Physical Abuse	□ Work Problems

How long have the concerns you selected above been bothering you?

What additional information would you like your counselor to know?

Please Circle Your Current Level of Distress

Physical Health							**Emotional Well-Being**						
Low	1	2	3	4	5	Severe	Low	1	2	3	4	5	Severe
Social Relationships							**Daily Routine**						
Low	1	2	3	4	5	Severe	Low	1	2	3	4	5	Severe

Have you ever thought about harming yourself?	□ No	□ Yes	If yes, when: ___________________
In the past, have you seriously considered suicide?	□ No	□ Yes	If yes, when: ___________________
In the past, have you injured yourself with suicidal intent?	□ No	□ Yes	If yes, when: ___________________
Are you currently injuring yourself with suicidal intent?	□ No	□ Yes	If yes, when: ___________________
Have you ever made a suicide attempt?	□ No	□ Yes	If yes, when: ___________________
Did you receive help for a suicide attempt?	□ No	□ Yes	If yes, where: _________________
Have you seriously considered harming someone?	□ No	□ Yes	If yes, when: ___________________
Have you intentionally physically harmed another person?	□ No	□ Yes	If yes, when: ___________________

Health History

In the past, have you been in counseling?	□ No	□ Yes	If yes, where: ________________________
Are you obtaining mental health services elsewhere?	□ No	□ Yes	Provider Name: ______________________ Provider Phone: _____________________
Are you currently taking psychiatric medication?	□ No	□ Yes	If yes, what: _________________________
In the past, have you taken psychiatric medication?	□ No	□ Yes	If yes, when: ________________________
Have you been hospitalized for a psychiatric concern?	□ No	□ Yes	If yes, when: ________________________
Are you currently taking non-psychiatric medication?	□ No	□ Yes	If yes, what: _________________________
Have you had any surgeries or major medical procedures?	□ No	□ Yes	If yes, what: _________________________
Are you currently experiencing any health concerns?	□ No	□ Yes	If yes, what: _________________________

Do you drink alcohol?

□ No □ Daily □ 3-5 Times Per Week □ Once a Week □ Only on Weekends □ On Special Occasions

Do you think your alcohol consumption is a problem? □ No □ Yes

Do you binge drink alcohol (5 or more drinks)? □ No □ Yes

In a typical two week period, how often to you have 5 or more alcoholic drinks in one sitting?

□ 0 □ 1-3 Times □ 3-5 Times □ 5-7 Times □ More than 7 Times

In the past month, have you used any drug not prescribed by a doctor? □ No □ Yes If yes, circle below:
Acid, Adderall, Cocaine, Codeine, Diet Pills, Ecstasy, Heroin, LSD, Marijuana, Meth, Mushrooms, PCP, Ritalin, Special K, Xanax, Valium, Other: ____

How often do you use recreational drugs? □ Never □ Rarely □ Monthly □ Weekly □ Daily or Almost Daily

STATEMENT OF FINANCIAL RESPONSIBILITY

1. **I understand that Rockville Internal Medicine (RIMG) will bill my health plan for the care I receive. I agree that payments from my health plan will go directly to Rockville Internal Medicine Physicians.**
2. **If you are a member of a RIMG participating health insurance plan, a claim for the services you receive will be submitted on your behalf.**
3. **I know that under Maryland law, RIMG can send me a bill in any of these cases: 1) When I choose to have care my health plan covers but I did not get a needed referral or approval from my health plan, 2) When I opt not to use my health plan, 3) When my health provider does not participate with my health plan for the care I want or need, and 4) When I receive care that is not covered under my health plan.**
4. **I know that I must pay for any co-payment or other part of the bill that my health plan says I must pay. I know may need to pay this prior to being treated.**
5. **Payment for services received at RIMG is due at the date of service.**
6. **Payment is accepted in the form of cash, credit card, or debit card.**
7. **You will be charged a $75 fee if you cancel a behavioral health appointment less than 48 hours in advance or do not attend your appointment.**

Patient Initials _________

SERVICES INFORMATION

1. **Rockville Internal Medicine Group (RIMG) offers time-limited psychological services that can be helpful for many presenting issues in a medical setting.**
2. **Your initial counseling session at RIMG will include an assessment of your concerns, the development of a treatment plan, and to determine whether RIMG's services are the best option for meeting your needs. Brief counseling may not be appropriate for longer-term counseling needs. In this case, your counselor will help connect you will community providers.**
3. **It is your responsibility to follow-up with and schedule appointments with the referrals you receive.**
4. **Psychological services may have both benefits and risks. For example, risks may be experiencing unpleasant feelings when discussing hurtful experiences or trying to implement healthier lifestyle habits. Some of the benefits may include learning new skills or reducing distress.**
5. **Participation in psychological services is voluntary, and you can end treatment at any time.**
6. **RIMG mental health providers adhere to the highest ethical standards. This professional relationship should not have planned social or sexual contact outside of the therapeutic relationship.**
7. **Initial counseling appointments are made as soon as possible. However, it is common to experience a wait for an appointment during busy times. Please keep your scheduled appointment and arrive on time to avoid a delay in services.**
8. **If you think your situation is an emergency, please inform RIMG staff when requesting an appointment.**
9. **If it is determined that Rockville Internal Medicine's psychological services are not best able to help you, your counselor will discuss this with you based on Maryland state mandates and provide you with appropriate referrals. Situations may include, but are not limited to: 1) Patients' clinical concerns are outside the scope of psychological services provided at RIMG, 2) There is an existing relationship with you or someone else that may impede your counselor's objectivity, and 3) You engage in behaviors that threaten the safety of those associated with RIMG.**
10. **To protect your privacy, email is not used as a regular form of communication.**
11. **If you are experiencing a medical or urgent health related emergency, please call 911 or go the emergency room. Please also call RIMG at 301-762-5020 to contact your counselor.**

Patient Initials _________

PRIVACY AND CONFIDENTIALITY NOTIFICATION

The purpose of the information requested on this form is to assist the counselor. This information is confidential and its maintenance is in accordance with federal and Maryland state laws. You will not be penalized for an incomplete form as your participation is voluntary. To facilitate your care, your RIMG counselor and other RIMG health providers may consult and share your medical and mental health information as needed. RIMG keeps confidential electronic records of the medical and mental health services you receive. RIMG medical, administrative, insurance, and billing staff has access to your records, and these privileges will only be used to provide quality care in accordance with legal and accepted professional practices. Your confidential health information will not be disclosed outside of RIMG except with your written authorization and in accordance with legal requirements. Please note – Some of the ways your patient information may be disclosed without your consent by RIMG professional staff is if: 1) Imminent risk of you harming yourself or others is present, 2) You are unable to care for yourself as outlined by Maryland state law, 3) The abuse of an adult, child, elder, or disabled person has been or is suspected of being abused or neglected, or 4) If there is a valid court order. We may also discuss your care with providers outside RIMG in certain instances, such as for hospitalization. Please review Rockville Internal Medicine Group's Notice of Privacy Practices for more information on how your health information can be used and disclosed.

Patient Initials _________

Acknowledgement

Please sign and date below to confirm you have read and understand all of the statements in this document:

X ____

Signature	**Printed Name**	**Date**