Treatment Consent

1. I, _____, consent to psychiatric evaluation and treatment by Michael B. Jackson, M. D. I understand that he does not, and cannot, guarantee any specific results. I understand that his ability to help me/patient depends on the completeness and accuracy of the information provided to him.

2. I consent to the exchange of information, such as diagnoses, medications prescribed, medical records, and diagnostic test results, between Dr. Jackson, hospitals, and other treating professionals when necessary to facilitate treatment. Otherwise, I understand that psychiatric records are confidential and privileged and will not be released to anyone without proper written authorization, unless legally required.

3. I consent specifically to the exchange of information, both for Michael B. Jackson, MD to provide and to receive information including diagnoses, medications prescribed, medical records, and diagnostic test results from the following individuals and providers:

Y N Spouse/Partner/Significant Other: _____Phone:_____

Y N Therapist: _____Phone:_____

Y N School counselor: _____Phone:_____

Y N Primary Care Physician: _____Phone:_____

Y N Other Medical Specialists: _____Phone:_____

Y N Other Medical Specialists: _____Phone:_____

Y N Other (please specify):_____Phone:_____

Y N Other (please specify):_____Phone:_____

4. I consent to the release to any third party payer or its agents any information necessary for the processing of a claim for services rendered. Should hospitalization be required, I consent to the release of any information needed for utilization review. Should prior authorization of outpatient treatment or prescription drugs be required, I consent to the release of any information needed.

5. The undersigned agrees, whether he or she signs as guardian, agent or as patient, that in consideration of the services to be rendered to the patient, he or she hereby individually obligates himself or herself to pay the account of the physician. Should the account be referred to an attorney or outside agency for collection, the undersigned shall pay reasonable attorney's fees and collection expense.

6. I agree to the terms of Dr. Jackson's Office and Payment Policies. I understand that I am financially responsible for all charges, and that payments are due at the end of each session. In particular, I understand that I personally must pay the full fee for the time reserved for any appointment which I miss without 24 hours notice.

7. This consent is subject to revocation at any time, by written request, except to the extent that action has been taken in reliance thereon.

Patient Name: _____ Signature: _____

Date: _____

Office and Payment Policies

Medications:

- To ensure quality of care, regular follow up with routine office visits is necessary for prescriptions to be provided.
- If two or more scheduled office visits have been missed, or the time since last visit exceeds 90 days, the patient must be seen in the office before any further prescriptions are written.

Insurance:

- Dr. Jackson's Office does not participate in any insurance plan other than Consolidated Health Plans.
- Dr. Jackson will provide a comprehensive receipt that can be submitted to an insurance company to facilitate out-of network re-imbursement upon request.

Payment:

- All patients are financially responsible for all charges, and payments/co-pay's are due at the end of each office visit
- Dr. Jackson's Office accepts Cash, personal checks, Visa/MasterCard.
- Requests for written reports may incur an additional charge
- There is a $25 charge for returned checks.

Cancellations:

- Because your appointment time has been reserved for you alone, you will be charged for cancellations/no shows with less than 24 hours notice. Charges for missed appointments must be paid prior to any further appointments can be scheduled.
- Charges for missed appointments are not covered by insurance and are automatically charged to the credit card on file unless prior arrangements are made.
- For patients with Consolidated Health Plans insurance, please note that missed visit charges include the amount normally covered by the insurance company in addition to the copay amount.

I have read and agree to the policies listed above: _____ Date: _____

E-mail/Text Message Policies

Dr. Jackson utilizes e-mail for scheduling/rescheduling appointments and non-patient care related communications.

Please be aware that the transfer of information via email is not a secure and confidential form of communication.

Dr. Jackson does not communicate via encrypted email and thus strict confidentiality cannot be guaranteed.

Dr. Jackson cannot account for what the various e-mail hosting entities may do with the information contained in an email, and strongly discourages all prospective and current patients from including any health or treatment related information in an email communications with Dr. Jackson.

Dr. Jackson's office does not send or receive Text Messages of any kind.

Signature of acknowledgement of above: _____ Date: _____

Due to the increased incidents of non-payments, all patients must have a credit card on file.

Please provide Visa or MasterCard (credit or debit) information below. This will only be used in the event of returned checks or other forms of non-payment, unless otherwise requested by the patient. Thank you.

Credit Card # _____

Exp. Date _____Three Digit Security Code_____

Print Name _____

Signature _____

MICHAEL B. JACKSON, M.D., LLC

General and Forensic Psychiatrist and Diplomate of the American Board of Psychiatry & Neurology

New Patient Information Form

Name:_____ Today's date:_____

Sex: [ ] M [ ] F

Date of birth:_____/_____/_____ Birthplace:_____ Social security #_____-_____-_____

Home address:_____Phone: _____

_____

Email address:_____

Primary care physician:_____ Phone:_____

Therapist:_____Phone:_____

Pharmacy:_____Phone:_____

Emergency
Contact:_____Phone:_____

Spouse/Partner Name:_____Phone:_____

Marital status: S M D W Sep

Children (names and ages if any): _____

_____

Home address:_____

_____

Educational Level Obtained:_____

Occupation:_____

Employer name:_____ Job title:_____

Employment address:_____ Phone: _____

_____

Who referred you to this office? _____

For what problem(s) do you seek help?

_____

_____

_____

_____

_____

Medication History

Allergies to medications:

Please list any medications/doses you are now taking. Take care to include all prescribed medication and any over-the counter medication/supplement (this includes vitamins, diet pills/drinks and herbal preparations).

_____

_____

_____

_____

_____

_____

_____

_____

Please list all psychiatric medications that you have taken in the past. Please include the dosage, length of medication trial, and effects (both positive and negative).

_____

_____

_____

_____

_____

_____

Please circle each of the following that you have taken, (even once):

Stimulants/ ADHD Medications

Adderall/**Adderall XR**
Focalin/dexmethylphenidate
Intuniv/guanfacine
Dexedrine/dextroamphetamine sulfate
Strattera/atomoxetine
Cylert/pemoline
Vyvanse/lisdexamfetamine
Ritalin/**Concerta**/**Metadate**/**Methylin**/methylphenidate
Provigil/modafinil
Nuvigil/armodafinil

Antidepressants/Anti-Anxiety Agents

Prozac/**Sarafem**/fluoxetine
Luvox/fluvoxamine
Effexor/venlafaxine
Remeron/mirtazapine
Sinequan/**Adapin**/doxepin
Vivactil/protriptyline
Anafranil/clomipramine
Desyrel/trazodone
Parnate/tranylcypromine
Pristiq/Desvenlafaxine
BuSpar/buspirone
Zoloft/sertraline
Celexa/citalopram
Cymbalta/duloxetine
Elavil/**Endep**/amitriptyline
Tofranil/imipramine
Triavil/**Etrafon** Limbitrol
Asendin/amoxapine
Serzone/nefazodone
Marplan/isocarboxazid
Aplenzin/ bupropion BrCl
Viibryd/Vilazodone
Paxil/**Pexeva**/paroxetine
Lexapro/escitalopram
Wellbutrin/**Zyban**/bupropion HCl
Pamelor/**Aventyl**/nortriptyline
Norpramin/desipramine
Surmontil/trimipramine
Ludiomil/maprotiline
Nardil/phenelzine
Eldepryl/deprenyl/selegiline
Emsam/selegiline

Mood Stabilizers & Anticonvulsants

Lithium/Eskalith/Lithobid
Lamictal/lamotrigine
Trileptal/oxcarbazepine
Lyrica/pregabalin
Depakote/**Depakene**/valproic acid
Tegretol/**Epitol**/**Equetro**/carbamazepine
Neurontin/gabapentin
Topamax/topiramate

Anti-anxiety medications/ Tranquilizers/ Sleeping Medications

Valium/diazepam
Paxipam/halazepam
Ativan/lorazepam
Dalmane/flurazepam
Halcion/triazolam
Sonata/zaleplon
Vistaril/**Atarax**/Hydroxyzine
Silenor/**Sinequan** /doxepin
Librium/chlordiazepoxide
Centrax/prazepam
Xanax/alprazolam
Restoril/temazepam
ProSom/estazolam
Lunesta/eszopiclone
Tenex/guanfacine
Tranxene/clorazepate
Serax/oxazepam
Klonopin/clonazepam
Doral/quazepam
Ambien/zolpidem
Rozerem/ramelteon
Catapres/Clonidine

Antipsychotics/Neuroleptics/ Mood Stabilizers

Risperdal/risperidone
Seroquel/quetiapine
Artane/trihexyphenidyl
Mellaril/thioridazine
Trilafon/perphenazine
Compazine/prochlorperazine
Orap/pimozide
Moban/molindone
Invega/ paliperidone
Clozaril/clozapine
Geodon/ziprasidone
Cogentin/benztropine
Serentil/mesoridazine
Stelazine/trifluoperazine
Torecan/**Norzine**/thiethylperazine
Navane/thiothixene
Loxitane/loxapine
Saphris/asenapine
Zyprexa/olanzapine
Abilify/aripiprazole
Thorazine/chlorpromazine
Latuda/lurasidone
Prolixin/fluphenazine
Haldol/haloperidol
Taractan/chlorprothixene
Symbyax/ olanzapine+fluoxetine
Fanapt/Iloperidone

Others

Aricept/donepezil
Namenda/memantine
Exelon/rivastigmine
Symmetrel/amantadine
Reminyl/galantamine