

WELCOME

Thank you for scheduling an initial appointment with our clinic. The purpose of this letter is to explain what you can expect from us during your first session. Please review this letter carefully.

The session usually lasts 45-60 minutes. The focus will be on determining the specific nature of your problem, and outlining an initial treatment plan. This is primarily an information-gathering meeting and will not involve much “talk therapy.” At the conclusion of this session, you will be given specific recommendations in order to begin your treatment.

We will be reserving this time specifically for you. If you are going to be late, please call our office. Also, please **call our office 48 hours prior to your appointment and confirm your attendance. If we do not hear from you, we will assume you have cancelled your appointment.** If it would make you feel more comfortable being accompanied by a friend or relative, please feel free to invite them.

Prior to your appointment, please review and complete the enclosed SELF-ASSESSMENT FORM. This will save time and allow for more discussion during the session. After completing the form, please bring the original with you to the session.

Insurance plans have become more numerous and complex. It is in your best interest to contact your insurance company prior to the initial session. We would recommend asking the following questions:

- 1) Are mental health services covered?
- 2) Is there a mental health deductible in addition to a medical deductible?
- 3) Is there a co-payment or other percentage that the patient is liable for?
- 4) Are our providers signed up with your plan?

As a service to you, our office will file your insurance claim. Co-payments and unmet deductibles will be due at the time of service. If you are unaware of your mental health benefits and we are unable to obtain the information from your insurance company, you will be asked to pay the entire fee at the time of service. Our office will reimburse you for the amount we collect from your insurance company.

A 24-hour notice is required for all cancellations or you may be billed for the session. If your insurance company requires treatment plans to be completed, this will be done in the follow-up visit with you. It is your responsibility to keep track of your authorized visits and bring the treatment plan to my office to be completed.

We hope this letter is helpful to you. If you have further questions, please feel free to contact our office. We look forward to our meeting. **Remember to confirm your attendance 48 hours prior to your appointment.**

Sincerely,

~Dr. Ripperger and Associates, PLLC

POLICY AND PROCEDURES

Please keep this for future reference.

OFFICE HOURS:

Office hours are Monday-Thursday from 9:00am to 5:00pm, excluding holidays. We close for lunch from 12:00pm-1:00pm. If you have an urgent problem requiring attention after-hours, you may contact the psychiatrist on call. This number changes on a monthly basis, so call our office at (405)579-4111 and the phone number for the on-call psychiatrist will always be updated on our voicemail. Prescription refills are NOT considered an emergency.

APPOINTMENTS:

A 24-hour notice is required for all cancellations. Appointments that are missed without cancellation will be charged at the full fee. Remember: insurance companies will not cover fees for missed appointments. Any outstanding balances on your account must be paid or payment arrangements must be made before more services are given.

TELEPHONE CALLS:

Our telephone is answered during regular office hours. You may leave a message on our voice mail after hours and your call will be returned the next business day. Calls received on weekends will be returned on Monday. After hour telephone consultations with your physician will be reserved for emergency situations only.

PRESCRIPTIONS AND REFILLS:

Allow at least 3 days to process prescription renewals and/or pick-up requests. Sometimes requests are filled sooner than this. You are responsible for knowing when your medication will run out and accounting for the time it takes for our providers to authorize your request. Have your pharmacy fax a refill request to (405) 579-4223. Prescriptions require a scheduled follow-up appointment before we will refill. Count your pills and make sure you have enough to last until your next visit. No refills will be authorized if there is a history of missed appointments. No controlled prescriptions will be replaced if lost, stolen, misplaced, or overused. No prescriptions will be refilled on Fridays, Saturdays, Sundays or Holidays. Prescription phone-in/pick-up: Monday-Thursday, 9:00am-5:00pm. Prescriptions will not be filled for unauthorized walk-in patients. Signed "Controlled-Substance Policy" is required for narcotic/controlled medications. New symptoms require an appointment. Providers will not diagnose via phone. Medications are for the prescribed individual's use only. It is illegal to share or sell your medicine. You must pick-up your prescription in person, unless pre-authorized by our staff. Please note: we will not refill SUBOXONE® early under any circumstance. Our practice takes the controlled substance policy very seriously. When the physician-patient relationship is strained due to perceived drug-seeking behavior, providers may continue service but cease in prescribing any controlled substances. In other cases, a patient may be terminated from this office and given direction to locate another medical office for continued care. Patient termination is at the discretion of the provider. Common reasons for termination include, but are not limited to, chronic noncompliance with recommended therapy, drug-seeking behavior, and abusive behavior towards staff, physicians, visitors or other patients.

INSURANCE AND PAYMENT:

As a service to you, our office will file your insurance claim. Co-payments and unmet deductibles will be due at the time of service. We accept MasterCard, Visa, personal check and cash. A service charge will be added to your account for any returned checks. If your insurance company does not pay your claim within 90-days, we require you to follow-up with them and pay the balance due. Any outstanding balance that is not paid-off in 120 days will be turned over to a collection agency.

TIPS FOR FUTURE VISITS

Please keep this for future reference.

Once you are an established patient:

1. Arrive 30 minutes early for your initial evaluation. Arrive 10 minutes early for all appointments thereafter to avoid last-minute rushes.
2. **To avoid being charged, give a 24 hour notice for cancellation.** Otherwise, your provider might charge you the full price of the visit. You will be responsible for the balance, and it must be paid off before services will be rendered again. Missed appointment charges are not covered by your insurance.
3. The physician on call is available 24 hours per day for emergencies. Do not use this service if it is not an emergency. Prescription refills will not be considered an urgent matter.
4. Count your pills before your visit. Get a written prescription to ensure you have enough medicine to last until your next visit.
5. Know your charge and write checks beforehand to make the best use of your session time.
6. Do not change appointment times unless absolutely unavoidable.
7. For routine matters, call during office hours only.
8. Know your insurance benefits. Call your insurance company before receiving services. Find out your exact copayment and/or deductible amount. Remember that if our provider is out-of-network, you will be responsible for the full charge.
9. Unless prior arrangements are made, payment is required at the time of service.

PATIENT INFORMATION

Please provide the information requested in the spaces provided. This and all other information relating to your association with Joseph M. Ripperger, M.D. & Associates is regarded as strictly confidential and will not be share with anyone without your signed consent.

Date: _____ Referred by: _____

Patient Name: _____

Street Address: _____ City: _____ State: _____ Zip: _____

Sex: _____ Birth date: _____ Marital Status: _____ Social Security #: _____

Employer: _____ Employer Phone: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Primary Insured or Responsible Party

If insurance does not pay your bill, who is financially responsible for the balance?

Name: _____ Street Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Social Security Number: _____ Date of Birth _____

INFORMATION

#1 Insurance Company: _____ Policy #: _____

Policy Holders Name: _____ DOB: _____

Social Security #: _____ Mail insurance claim forms to: _____

#2 Insurance Company: _____ Policy #: _____

Policy Holders Name: _____ DOB: _____

Social Security #: _____ Mail insurance claim forms to: _____

Name and address of policy holder's employer: _____

_____ Policy holder's work phone: _____

AUTHORIZATIONS AND AGREEMENTS:

Payment Policy and Cancellation Agreement: I understand that the office files my primary insurance as a courtesy, but the bill is MY responsibility. I am aware that notice of cancellation must be given 24 hours in advance so that I will not be charged.

Patient's Signature: _____

Release of Information and Assignment of Benefits Agreement: I authorize Joseph M. Ripperger, MD & Associates to release any information acquired in the course of my treatment to my insurance company and assign the insurance payment due to me Joseph M. Ripperger, MD & Associates.

Patient's Signature: _____

PATIENT RECORD OF DISCLOSURE

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications on PHI be made by alternative means, such as sending correspondence to the your office instead of your home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (Check all that apply):

_____ Home Telephone _____

_____ O.K. to leave message with detail information

_____ Leave message with call-back number only

_____ Other _____

_____ O.K. to leave message with detail information

_____ Leave message with call-back number only

_____ Work Telephone _____

_____ O.K. to leave message with detail information

_____ Leave message with call-back number only

Patient Signature

Date

Print Name

Birthdate

Parent or Guardian

(If patient is under 18 years old)

Date

Print Name

Relationship to Patient

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to the uses or disclosures made pursuant to an authorization requested by the individual.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES: A complete description of how my medical information will be used and disclosed by Joseph M. Ripperger & Associates is in the "Notice of Privacy Practices." A copy of the "Notice of Privacy Practices" is posted in the clinical site and is available if you would like a copy.

I have accepted a copy of "Notice of Privacy Practices" Yes _____ No _____

Reason for the refusal, if No _____

ADVANCE BENEFICIARY NOTICE

PATIENT NAME: _____

NOTE: You need to make a choice about receiving these healthcare items or services. Medicare/Private Insurance will not pay for the item(s) or service(s) that are described below. They do not pay for all of your health care costs. They only pay for covered items and services when Medicare/Private Insurance rules are met. The fact that Medicare/Private Insurance will not pay for a particular item or service does not mean that you should not receive it. There may be a good reason your doctor recommended it. Right now, in your case:

MEDICARE/PRIVATE INSURANCE DOES NOT PAY FOR THESE SERVICES:

- **Prior Authorization Request**
- **Letters/Forms Completed**
- **Patient Assistance for Medication**
- **Phone Sessions**

The purpose of this form is to help you make an informed choice about whether or not you want to receive these items or services, known, that you will have to pay for them yourself. Before you make a decision about your options, you should read this entire notice carefully.

- Ask us to explain, if you don't understand why Medicare/Private Insurance won't pay.
- Ask us how much these items or services will cost you. **(Estimated Cost: \$20.00)**

<p>_____ OPTION 1. YES. I WANT TO RECEIVE THESE ITEMS OR SERVICES</p> <p>I understand I will be responsible for payment of these services.</p> <p>_____ OPTION 2. NO. I DO NOT WANT TO RECEIVE THESE ITEMS OR SERVICES.</p>

Signature of patient or legal guardian

Date

<p>NOTE: Your health information will be kept confidential. Any information that we collect on this form will be kept confidential in our office.</p>
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INFORMED CONSENT, CONFIDENTIALITY, DESCRIPTION OF SERVICES

Description of Services:

It is my understanding that Joseph M. Ripperger, M.D. is a licensed Psychiatrist, qualified in Oklahoma to practice medicine and provide psychotherapy. Counseling and psychotherapy involve discussing in detail my concerns, giving background information, and talking about areas that may cause me emotional pain, all for the purpose of trying to develop new and more effective methods of coping with problem areas in my or my child’s life. I understand that I am free to withdraw from therapeutic contact at any time if I so desire and will only be responsible to pay for the completed sessions.

Confidentiality:

All services provided and all information obtained is kept confidential and cannot be released without your written permission. You need to know, however, that there are special situations under which confidential information could be revealed such as:

1. A “duty to warn” ethic allows a psychiatrist to break confidentiality when danger exists to the patient or others.
2. Under special circumstances, the court may subpoena patient records and may order a psychiatrist to give testimony during a court hearing.
3. Third party payers, such as insurance companies, have a right to review patient’s records prior to payment.
4. Delinquent accounts may be turned over to a Collections Agency.
5. Based on clinical judgment, consultation with another professional with respect to your treatment may be sought.
6. Actual or suspected abuse to children or the elderly must be reported to authorities.

Your signature indicates that you have read and understood the above information concerning confidentiality and that you have read and understood the description of possible services, and consent is given to provide services to you and/or your child (or children), _____, who is (are) not of legal age.

PATIENT NAME

SIGNATURE

DATE

RELATIONSHIP, IF PT IS MINOR

WITNESS

DATE

SELF-ASSESSMENT FORM

Please Print

Date: _____ Name: _____

Street: _____

City: _____ State: _____ Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Age: _____ Date of Birth: _____ Place of Birth: _____

With whom do you live (relationship, if any)? _____

Religion: _____

Education: (Highest level completed) _____ Degree, if any: _____

Occupation: _____

Marital History:

If you have been married, how many times? _____ If you have been divorced, how many times? _____

Current Marital Status:

Never married: _____ Married: _____ Living cooperatively: _____ Separated: _____ Divorced: _____ Widowed: _____

Emergency Contact: Name of person to call in an emergency: _____

Relationship: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Address: _____

Name of person filling out form, if not patient: _____

Medical Care:

Who is your primary care physician? _____ Phone: _____

Are you are currently doing therapy with anyone else? If so, who? _____

Please state the principal reason you are requesting a consultation or treatment:

JOSEPH M. RIPPERGER, M.D. & ASSOCIATES
WEBSITE NEW PATIENT PACKET

Please describe your illness from the time of your first symptom to the present. Provide as many dates, names, and addresses of psychiatrists, psychologists, and/or social workers you have seen. Also, please provide the kinds of treatment you have received:

Please briefly describe any expectations you or your family members may have regarding treatment:

Suicide:

Have you ever thought about suicide? Yes _____ No _____

If "yes", when was the last time? _____

Have you ever attempted suicide? Yes _____ No _____

If "yes", when and how? _____

Do you have thoughts about suicide now? Yes _____ No _____

Recent stressful life events:

(Check any of the following that have occurred in the last 1-year)

Comments

<input type="checkbox"/> married	_____
<input type="checkbox"/> engaged	_____
<input type="checkbox"/> separated	_____
<input type="checkbox"/> divorced	_____
<input type="checkbox"/> breakup of important relationship	_____
<input type="checkbox"/> child left home	_____
<input type="checkbox"/> death of spouse, or other loved one	_____
<input type="checkbox"/> bad health (behavior) of family member	_____
<input type="checkbox"/> personal injury, illness	_____
<input type="checkbox"/> changes at school, work	_____
<input type="checkbox"/> retired, lost job	_____
<input type="checkbox"/> changed residences	_____
<input type="checkbox"/> legal difficulties, multiple traffic tickets	_____
<input type="checkbox"/> owe money	_____
<input type="checkbox"/> traumatic experience(s)	_____

Alcohol use:

Do you drink Alcohol? Yes _____ No _____

If yes, how many drinks do you consume in an average day? _____ Week? _____

In the past 12 months, have you had 3 or more alcoholic drinks within a 3-hour period on 3 or more occasions? Yes _____ No _____

Was there ever a time when you felt you were, or someone told you, you were drinking too much? Yes _____ No _____

If "yes" under what circumstance? _____

Drug Use:

Check any drugs you have taken. List the circumstances and pattern of use, or any consequences to the use. Also state the amount you used at its heaviest, and the last time you used.

<input type="checkbox"/> none	_____
<input type="checkbox"/> marijuana	_____
<input type="checkbox"/> amphetamine/speed	_____
<input type="checkbox"/> heroin/opiates	_____
<input type="checkbox"/> PCP	_____
<input type="checkbox"/> LSD/hallucinogens	_____
<input type="checkbox"/> cocaine/crack	_____
<input type="checkbox"/> barbiturates/sedatives/ downers	_____
<input type="checkbox"/> purchased prescriptions/ controlled substances via the internet	_____
<input type="checkbox"/> other	_____

Past History:

Check if during childhood you-

- were afraid to go to school
- had difficulty with reading, writing, or math
- were truant
- failed or repeated a grade
- wet bed after age 5
- had tics
- had stutter/stammer
- nightmares, disturbed sleep, fear of the dark.
- ran away from home
- were cruel to animals
- frequently lied to families or others.
- set fires.
- moved frequently
- were exposed to incest
- worried excessively about your appearance

Comments

Family History:

Please list all psychiatric illnesses (include **depression, bipolar disorder, anxiety, substance abuse, suicide attempts**, etc.).
Indicate their relationship to you (mother, father, child, grandparent, aunt, uncle, sibling, etc), age, and age at death if deceased.

Relationship	Age	Age at death if deceased	Psychiatric illnesses

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WEBSITE NEW PATIENT PACKET

Health History:

Weight

What is your current weight in pounds? _____

Has your weight increased or decreased by more than 10 pounds in the last year: Yes _____ No _____

If yes, please explain circumstances:

Sleep Do you:

Have difficulty falling asleep? Yes _____ No _____

Have difficulty staying asleep? Yes _____ No _____

Experience excessive daytime sleepiness? Yes _____ No _____

Snore or wake up short of breath or with a headache? Yes _____ No _____

Jerk or have restless legs in your sleep? Yes _____ No _____

Smoking

Do you smoke? Yes _____ No _____ If yes, do you want to quit? Yes _____ No _____

Caffeine

Do you drink caffeinated coffee, tea, or colas? Yes _____ No _____ If yes, how much? _____

Do you believe you are sensitive to caffeine? Yes _____ No _____

Sexual Functioning

Active? Yes _____ No _____

Satisfied with libido or your level of desire? Yes _____ No _____

Satisfied with functioning? Yes _____ No _____

Allergies

List all allergies. Be sure to include medication allergies.

Medical Problems

List all past and present medical problems as well as any surgeries or accidents. Please list the age of onset or occurrence.

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WEBSITE NEW PATIENT PACKET

Check if you have had:

____ Head injury ____ CAT scan or MRI of the brain ____ Seizure ____ EEG ____ Neurological exam

Current Medications:

(Include prescriptive, herbal and over-the-counter medications)

Name	Dosage and frequency	Physician	How long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
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_____	_____	_____	_____
_____	_____	_____	_____

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Past Psychiatric Medications:

This is a list of commonly prescribed psychotropics. Please indicate all that you have tried in the past. Both trade and generic names are provided. If you have taken any, please indicate those that were particularly helpful or unhelpful, and any negative side effects you experienced.

Taken?	Medication	Helpful?	Side effects, if any	Taken?	Medication	Helpful?	Side effects, if any
	Prozac / fluoxetine				Eskalith / Lithobid / lithium		
	Paxil / paroxetine				Depakote ER / divalproex		
	Zoloft / sertraline				Depakene / valproic acid		
	Celexa / citalopram				Tegretol / Carbatrol / carbamazepine		
	Lexapro / escitalopram				Trileptal / oxcarbazepine		
	Luvox / fluvoxamine				Lamictal / lamotrigine		
	Wellbutrin / bupropion				Topamax / topiramate		
	Aplenzin / bupropion hydrobromide				Gabitril / tiagabine		
	Serzone / nefazodone				Neurontin / gabapentin		
	Effexor XR / venlafaxine				Buspar / buspirone		
	Remeron / mirtazapine				Inderal / propranolol		
	Desyrel / trazodone				Catapres / clonidine		
	Elavil / amitriptyline				Atarax / Vistaril / hydroxyzine		
	Anafranil / clomipramine				Ambien / zolpidem		
	Viibryd / vilazodone				Sonata / zaleplon		
	Tofranil / imipramine				Lunesta / eszopiclone		
	Cymbalta / duloxetine				Somnote/chloral hydrate		
	Norpramin / desipramine				Restoril / temazepam		
	Pamelor / nortriptyline				Halcion / triazolam		
	Nardil / phenelzine				Silenor / doxepin		
	Parnate /tranylcypromine				Dalmane / flurazepam		
	Oleptro / trazodone ER				Rozerem / ramelteon		
	Marplan / isocarboxazid				Xanax / alprazolam		
	Pristiq / desvenlafaxine				Klonopin / clonazepam		
	Emsam / selegiline patch				Valium / diazepam		
	Nuedexta / DM-quinidine				Tranxene / clorazepate		
	Deplin / L-methyl folate				Librium / chlordiazepoxide		
	Risperdal / risperidone				Ativan / lorazepam		
	Zyprexa / olanzapine				Serax / oxazepam		
	Seroquel / quetiapine				Ritalin / Concerta / methylphenidate		
	Symbyax / Olan-fluoxetine				Adderall / D-amph/amph		
	Geodon / ziprasidone				Vyvanse / lisdexamfetamine		
	Abilify / aripiprazole				Dexedrine / dextroamphetamine		
	Clozaril / clozapine				Strattera / atomoxetine		
	Fanapt / iloperidone				Provigil / modafinil		
	Saphris / asenapine				Nuvigil / armodafinil		
	Invega / paliperidone				Intuniv / guanfacine		
	Mellaril / thioridazine				Revia / naltrexone		
	Prolixin / fluphenazine				Campral / acomprosate		
	Trilafon / perphenazine						
	Latuda / lurasidone						
	Haldol / haloperidol						