PLEASE NOTE: This form is not submitted online.

You must either:

1. Fill it out as presented online, print it, and bring it to your appointment, OR
2. Print it out, hand-write your information, and bring it to your appointment.

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)**

_______**OPTION 1. YES. I WANT TO RECEIVE THESE ITEMS OR SERVICES**

I understand I will be responsible for payment of these services.

_______**OPTION 2. NO. I DO NOT WANT TO RECEIVE THESE ITEMS OR SERVICES.**

____ _____________________________________

Signature of patient or legal guardian Date

NOTE: Your health information will be kept confidential. Any information that we collect on this form will be kept confidential in our office.

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:

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**

_____married ____
_____engaged ____
_____separated ____
_____divorced ____
_____breakup of important relationship ____
_____child left home ____
_____death of spouse, or other loved one ____
_____bad health (behavior) of family member ____
_____personal injury, illness ____
_____changes at school, work ____
_____retired, lost job ____
_____changed residences ____
_____legal difficulties, multiple traffic tickets ____
_____owe money ____
_____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.

_____ *none* ____
_____ marijuana ____
_____ amphetamine/speed ____
_____ heroin/opiates ____
_____ PCP ____
_____ LSD/hallucinogens ____
_____ cocaine/crack ____
_____ barbiturates/sedatives/ downers ____
_____ purchased prescriptions/ controlled substances via the internet ____
______other ____

Past History:

Check if during childhood you...	COMMENTS
____ 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	________________

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

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.

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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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
	Prozac / fluoxetine		
	Paxil / paroxetine		
	Zoloft / sertraline		
	Celexa / citalopram		
	Lexapro / escitalopram		
	Luvox / fluvoxamine		
	Wellbutrin / bupropion		
	Aplenzin / bupropion hydrobromide		
	Serzone / nefazodone		
	Effexor XR / venlafaxine		
	Remeron / mirtazapine		
	Desyrel / trazodone		
	Elavil / amitriptyline		
	Anafranil / clomipramine		
	Viibryd / vilazodone		
	Tofranil / imipramine		
	Cymbalta / duloxetine		
	Norpramin / desipramine		
	Pamelor / nortriptyline		
	Nardil / phenelzine		
	Parnate /tranylcypromine		
	Oleptro / trazodone ER		
	Marplan / isocarboxazid		
	Pristiq / desvenlafaxine		
	Emsam / selegiline patch		
	Nuedexta / DM-quinidine		
	Deplin / L-methyl folate		
	Risperdal / risperidone		
	Zyprexa / olanzapine		
	Seroquel / quetiapine		
	Symbyax / Olan-fluoxetine		
	Geodon / ziprasidone		
	Abilify / aripiprazole		
	Clozaril / clozapine		
	Fanapt / iloperidone		
	Saphris / asenapine		
	Invega / paliperidone		
	Mellaril / thioridazine		
	Prolixin / fluphenazine		
	Trilafon / perphenazine		
	Latuda / lurasidone		
	Haldol / haloperidol		

Taken?	Medication	Helpful?	Side effects, if any
	Eskalith / Lithobid / lithium		
	Depakote ER / divalproex		
	Depakene / valproic acid		
	Tegretol / Carbatrol / carbamazepine		
	Trileptal / oxcarbazepine		
	Lamictal / lamotrigine		
	Topamax / topiramate		
	Gabitril / tiagabine		
	Neurontin / gabapentin		
	Buspar / buspirone		
	Inderal / propranolol		
	Catapres / clonidine		
	Atarax / Vistaril / hydroxyzine		
	Ambien / zolpidem		
	Sonata / zaleplon		
	Lunesta / eszopiclone		
	Somnote/chloral hydrate		
	Restoril / temazepam		
	Halcion / triazolam		
	Silenor / doxepin		
	Dalmane / flurazepam		
	Rozerem / ramelteon		
	Xanax / alprazolam		
	Klonopin / clonazepam		
	Valium / diazepam		
	Tranxene / clorazepate		
	Librium / chlordiazepoxide		
	Ativan / lorazepam		
	Serax / oxazepam		
	Ritalin / Concerta / methylphenidate		
	Adderall / D-amph/amph		
	Vyvanse / lisdexamfetamine		
	Dexedrine / dextroamphetamine		
	Strattera / atomoxetine		
	Provigil / modafinil		
	Nuvigil / armodafinil		
	Intuniv / guanfacine		
	Revia / naltrexone		
	Campral / acomprosate		