Commit to Change

with Dr. Renee B Bonin & Associates
200 Beaullieu Dr. Bldg 9B-1
Lafayette, LA 70508
Phone: 337-504-3483
Fax: 337-504-3573

Please be advised:

Initial appointments must be kept in order to further services.

If you are unable to come to the scheduled appointment, please call the office at least 24 hours in advance.

Thank you!

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Patient Information

Please print

Today's Date: _____

Patient's Full Name: _____ Birthdate: _____
Home Address: _____
City: _____ State: _____ Zip: _____

Best Phone Number: _____ □ Home □ Cell □ Work
Voicemail active? □Yes □No *Is it okay if we leave a message? □Yes □No*

Alt Phone Number: _____ □ Home □ Cell □ Work □ Other: _____
E-mail: _____

Appointment Reminders will be sent by e-mail.
Appointment reminders are done as a courtesy only, patients are responsible for all appointments.
Appointments must be cancelled/rescheduled 24 hours in advance, to avoid a late cancellation/no show fee.

***SSN**:* _____ Referred by: _____

Patient's Marital Status: □Single □Married □Separated □Divorced □Widowed
Spouse's name (if applicable): _____ Birthdate: _____

Patient Gender: □Male □Female Veteran: □Yes □ No
Race(s)/Ethnicity: _____ Religion: _____
Native American: □Yes □No *If yes, tribe affiliation: _____

Primary Care Physician: _____
Phone: _____ Fax: _____

Pharmacy: _____
Phone: _____ *Fax:* _____

Emergency Contact Name: _____ Phone: _____

Reason for appointment: _____

Insurance Information

Primary Insurance: _____ Member ID#: _____
Policy Holder: _____ Birthdate: _____
SSN: _____ Company Phone #: _____

Secondary Insurance: _____ Member ID#: _____
Policy Holder: _____ Birthdate: _____
SSN: _____ Company Phone #: _____

Guarantor (if different from self)

Name: _____ Birthdate: _____

Address: _____

City: _____ State: ___ Zip: _____ Relation: _____

Phone Number: _____ SSN: _____

I _____(patient) authorize _____ (guarantor) to make payments on my account and receive my billing information. This includes statement of balance, receipts for payments made towards my account, and insurance payments made to my account.

Patient Signature: _____ Date: _____

Billing Information

All professional services rendered are the responsibility of the patient/guarantor. Necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, regardless of insurance coverage. If it is necessary to turn this service over to collection for non-payment after 60 days, then the patient must pay all fees to collection agency.

AUTHORIZATION TO PAY BENEFITS TO PROVIDER:
I hereby authorize payment directly to the undersigned Provider for my charges.

AUTHORIZATION TO RELEASE INFORMATION:
I hereby authorize the undersigned Provider to release any information acquired in the course of my treatment to my insurance company in writing or by fax.

Patient Signature: _____ Date: _____

Card on File
If you would like us to keep a card on file, to bill after each appointment, please let the check-out staff know, and they will give you a form to complete.

Present Concerns

Please briefly describe your present symptoms: _____

_____

_____

Are you currently having any thoughts of suicide or self-harm? __ Yes __No

If yes, please explain: _____

Please list the names of other practitioners/mental health professionals that you have seen for this problem: _____

_____

Has there been a disruption in treatment with any current providers? __ Yes __ No

**If yes, please explain why:* _____

_____

Have you ever been a patient of a provider that is practicing in our office? Yes No

**If yes, who? _____

Please list any Psychiatric Hospitalizations. (include where, when, and for what reason):

_____

_____

_____

How did you hear about our office? _____

Current Medications

Please continue on back, if necessary.

Name of Drug: Dose: Prescriber: Any issues?

1.) _____

2.) _____

3.) _____

4.) _____

5.) _____

6.) _____

7.) _____

Will you continue to get your medication prescribed by current provider?

□ Yes □ No

If not, are you looking for a different provider? Please explain:

_____

_____

Drug Allergies: □No □Yes to: _____

Who currently lives in your household?		
Name	Relation	Age

Personal History

- Were there any problems with your birth? ☐Yes ☐No
  - If yes, please explain: _____
- Where were you born and raised? _____
- What is your highest education?

  ☐High School ☐Some College ☐College Graduate ☐Adv Degree:_____
- Are you currently working? ☐Yes ☐No
  - If yes: Employer: _____ Occupation: _____
    Hours/Week: _____
  - If no: Are you ☐Retired ☐Disabled ☐on Sick leave?

    Past Occupation: _____
- Do you receive disability or SSI? ☐Yes ☐No
  - If yes, for what disability? _____
    How long have you had this disability? _____
- Have you ever had any legal problems? ☐Yes ☐No
  - If yes, please specify: _____
    _____

Review of Systems

Do you now or have you ever had:

__Diabetes	__Leukemia	__Pneumonia	__Cataracts	__Tuberculosis
__High Blood Pressure	__Psoriasis	__Pulmonary Embolism	__Colitis	
__High Cholesterol	__Angina	__Asthma	__Anemia	
__Hypothyroidism	__Hear Problems	__Emphysema	__Jaundice	
__Goiter	__Heart murmur	__Stroke	__Hepatitis	
__Kidney Disease	__Kidney Stones	__Epilepsy (seizures)	__HIV/AIDS	
__Cancer (type) _____		__Rheumatic fever	__Stomach/ Peptic Ulcer	

Please list any other medical conditions, that are not listed: _____

_____

Substance Use

- Have you ever been treated for Alcohol or drug use or abuse? □Yes □No
  - If yes, for which substances? _____
  - If yes, where were you treated and when? _____
    _____
- How many days per week do you drink any alcohol? _____
  - What is the least number of drinks you will drink in a day? _____
  - What is the most number of drinks you will drink in a day? _____
  - In the past 3 months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
- Have you ever felt you ought to cut down on your drinking or drug use? □Yes □No
- Have people annoyed you by criticizing your drinking or drug use? □Yes □No
- Have you ever felt bad or guilty about your drinking or drug use? □Yes □No
- Have you ever had a drink or used drugs first thing in the morning to steady your nerves to get rid of a hangover? □Yes □No
- Do you think you may have a problem with alcohol or drug use? □Yes □No
- Have you used any street drugs in the past 3 months? □Yes □No
  - If yes, please list: _____
- Have you abused prescription medication? □Yes □No
  - If yes, which ones and for how long: _____
    _____

Family Psychiatric History

Has anyone in your family been diagnosed with or treated for: (please state relation):

□Bipolar disorder	□Schizophrenia	□Depression	□Anxiety
_____	_____	_____	_____
_____	_____	_____	_____
□Post-traumatic stress	□Alcohol Abuse	□Anger	□Violence
_____	_____	_____	_____
_____	_____	_____	_____
□Suicide	□Substance abuse	□Other:_____	
_____	_____	_____	
_____	_____	_____	

Other information:

Please list any other information you would like your provider to have that was not addressed in this information: _____

_____

_____

_____

_____

_____

No Show/Late Cancellation Appointments

Appointments must be cancelled or rescheduled at least 24 hours in advance, or a **$50 fee** will be charged to the patient/guarantor. *Payments not made within 48 hours, any future appointments will be cancelled.* We will call twice after late cancelled/no show appointments.

Patient/guarantor must call the office within a week during our office hours (Mon-Thurs 8-5) and speak to either an office assistant or office manager. If no called is made back to our office, within the week, we will send the bill to collections.

Appointments are booked for an entire hour, unless for medication only, and we do not double book.

Please sign, acknowledging that you have read and will pay the fee, if necessary.

Patient/Guarantor Printed Name: _____

Patient/ Guarantor Signature: _____ Date: _____

HIPAA Signature Compliance

Your signature below acknowledges that you understand and agree to the office policies outlined in the three page document for Dr. Bonin and that you have been given a copy of the HIPAA policies (located in office binder). If you would like your own copy for your records, please ask receptionist.

Patient Printed Name: _____

Patient Signature: _____ Date: _____