WELCOME TO OUR OFFICE

I am honored that you chose my practice for your medical needs. To get started, the following information is necessary for our records.

Note: If the patient is your child or for whom you are a guardian, please print the PATIENT information in the PATIENT INFORMATION SECTION and your, parent or guardian, information in the RESPONSIBLE PARTY INFORMATION SECTION.

Patient Information:

Last Name		First Name	
Street		Date of Birth	
City		Gender at Birth	Male Female
State & Zip		Current Gender Identity	Male Female Non-Binary Transgender Intersex
Home Phone		Marital Status	Sing. Mar. Sep. Div. Widow
Cell Phone		Email	
Work Phone		Employer Name	
Emergency Contact	Name and Phone #		
Referred By	Name and Phone #		

Responsible Party Information:

Relation to patient	Self (skip to next section) Spouse Parent Guardian		Other (Please explain):
Last Name		First Name	
Street		Home Phone	
City, State & Zip		Cell Phone	
Name of Employer			
Work Phone		Workplace city	

Pharmacy Information:

Name		Phone #	

Dr. Thorpe's Commitment to You

I will use the best skills and knowledge I possess to try to improve your condition. While at my office you will be provided with a safe and comfortable environment and offered the best treatment regardless of age, race, religion or sexual orientation. Recommendations will be explained in detail and your questions answered to the fullest extent possible. Any medications prescribed will come with an explanation of side effects, risks and the potential benefits.

CONSENT FOR TREATMENT

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by Dr. M. Thorpe and MLT Medical LLC. These services may include psychiatric evaluation, psychotherapy, medication evaluation and management, laboratory tests and diagnostic procedures.

Dr. M. Thorpe and the MLT Medical LLC do not participate in Health Insurance Programs. You will be provided with an invoice for each visit. Medical professional procedure code and diagnostic code will be provided to submit for potential reimbursement; however, it is not this office's responsibility to follow up on such claims and there is no guarantee of reimbursement.

By signing this consent, you agree to the fee for service rate discussed with your provider. Dr. M. Thorpe's current rates are as follows:

$450 for an initial psychiatric evaluation (60 minutes)
$350 for 60-minute follow-up sessions
$275 for 45-minute follow-up appointments
$200 for 30-minute follow-up appointments
$125 for 20-minute follow-up appointments
$75 for 15-minute follow-up appointments
$50 for no-show or late cancellations

Note that fee schedule is the same for in-person or phone appointments.

Dr. M. Thorpe and MLT Medical LLC reserve the right to terminate the Doctor-Patient relationship if such circumstances arise as detailed below.

- inability or refusal to follow up appropriately for medication management as recommended by your doctor.
- continued missed appointments that were not cancelled 24 hours in advance.
- continued late presentation not allowing the appropriate time for thorough follow up and recommendations.
- evidence that there is any medication diversion or inappropriate administration, not following specific medication guidelines as prescribed by your doctor. This includes NOT informing the doctor of medications prescribed by other physicians, the use of dangerous or illicit substances contraindicated in your medication regimen (Alcohol, Illicit or OTC drugs).
- inability or refusal to pay for services in a timely manner.

- inability or refusal to coordinate Primary Medical Doctor or specialist referral and follow up as recommended by your doctor.
- inability or refusal to obtain laboratory studies as recommended by your doctor.
- any misconduct in the office or otherwise deemed inappropriate behavior or dangerous behavior toward the doctor or staff.
- any misconduct or abuse of telephone communication privilege with the doctor or staff.
- not arranging for follow-up visits to obtain renewals of prescribed medication.

The undersigned understands that he/she has the right to:

1. be informed of and participate in the selection of treatment modalities.
2. receive a copy of this consent.
3. withdraw this consent at any time.

____ _______________
Signature of Patient Date Signed

____ _______________
Signature of Parent, Legal Guardian or Conservator Date Signed

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Dr. M. Thorpe, or MLT Medical LLC staff, are willing to communicate via email or text message if this is more convenient for you. Please be advised that this may NOT be a confidential medium to communicate personal sensitive medical or psychiatric concerns. It is recommended that in office or telephone consultation is preferred in accordance with HIPPA.

However, if you would like Dr. M. Thorpe or staff to communicate via Email or Text Message, please include email and or phone number below. Please indicate by checking how you would like your appointments to be confirmed:

Text only _______ Email only ________ Both ______

Cell Phone # ________________________________

Email: _______________________________________

I am aware that Email or electronic text messaging may not be a confidential medium to communicate sensitive personal medical/psychiatric concerns. I DO CONSENT for Dr. M. Thorpe and MLT Medical staff to use this form of correspondence when necessary.

I **CONSENT**: _________
Initials of Patient or Parent / Legal Guardian

I would like to **OPT OUT** of this form of communication. __________
Initials of Patient or Parent / Legal Guardian

Please complete all information and bring it to the first visit. It may seem long, but it is most important to have this information to give you the best care possible. You may need to ask family members about the family history. Thank you for taking the time to complete.

Patient Name: ___________________________________ Date: ___________________

Primary Care Physician: ____

Physician's telephone #: ___________________________________

Do you give permission for updates to be provided to your primary care physician?
YES / NO

Current Therapist/Counselor
____

Therapist's telephone #: ____________________________________

Do you give permission to speak to your therapist/counselor? **YES / NO**

What are the problems/issues for which you are seeking help?

1. ____
2. ____
3. ____

What are your treatment goals?

____
____

Current Symptoms Checklist: (Check any symptoms that are present)

	Elated or Depressed mood		**Racing thoughts**		**Excessive worry**
	Unable to enjoy activities		**Impulsivity**		**Anxiety attacks**
	Sleep pattern changes		**Increased risky behavior**		**Panic attacks**
	Loss of interest		**Hearing voices**		**Hallucinations**
	Inattentiveness		**Repetitive behaviors**		**Suspiciousness**
	Change in appetite		**Change in energy**		**Excessive guilt**
	Increased irritability		**Fatigue**		**Crying spells**
	Increased or decreased libido		**Other:**		
	Suicidal thoughts		**Suicidal plans**		**Suicidal attempts**
	Access to guns	**If yes, explain:**			

Medical History:

Current weight: ___________lbs.   Height: ____ft. ____ inches

Allergies (explain):
____

Allergies to medications (list):
____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications, vitamins or supplements you take:

Medication Name	How often used	Dosage

Current medical problems:
____
____

Past medical problems, non-psychiatric hospitalizations, or surgeries:

List, if any:
____

____

Have you ever had an EKG? **YES** ____   **NO** ____   If yes, when _________________

Was the EKG: Normal ____   Abnormal ____ Unknown ____

Date and place of last physical examination:
____

Patient's Past Psychiatric History:

Outpatient treatment: **YES** _____ **NO** _____

If yes, please describe when, by whom and the nature of the treatment.

Reason	Date range	By Whom

Psychiatric Hospitalization: **YES** ____ **NO** ____

If yes, describe for what reason, when and where.

Reason	Dates	Where Hospitalized

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

	YES	Which Family Member
Bipolar Disorder		
Depression		
Anxiety		
Anger		
Suicide		
Schizophrenia		
Post-traumatic Stress		
Alcohol Abuse		
Other Substance Abuse		
Violence		

Personal and Family Medical History:

Disease	YOU	FAMILY	Which Family Member
Thyroid Disease			
Anemia			
Liver Disease			
Chronic Fatigue			
Kidney Disease			
Diabetes			
Asthma/Respiratory			
Stomach/Intestinal			
Cancer			
Fibromyalgia			
Heart Disease			
Epilepsy or Seizures			
Chronic Pain			
High Blood Pressure			
PTSD			
Other:			

Women Only:

Date of last menstrual period ___________________ N/A: ________ (skip to next section)

Are you currently pregnant or do you think you might be pregnant? **YES** ___ **NO** ____

Are you planning to get pregnant in the near future? **YES** ____ **NO** ____

Birth control method (if applicable) __________________________________

How many times have you been pregnant: ________ How many live births? _______

To the best of my knowledge the answers and declarations above are accurate and true:

Patient Initials ______ **Date** ___________________

Guardian Initials ______ **Date** ____________________

For office use only

Reviewed by: ____ Date _____________

Revised 1/2023

PATIENT-PHYSICIAN AUTHORIZATION AND AGREEMENT

STATEMENT OF FINANCIAL RESPONSIBILITY

Authorizations and agreements with Dr. Michelle Thorpe, M.D.

Patient name: ____

I acknowledge that Dr. Thorpe is an out-of-network provider and that I am solely financially responsible for all services received in connection with the medical care and treatment rendered by Dr. Michelle Thorpe, M.D. and that:

- fees for services must be paid at the time services are rendered
- the patient or the responsible party is responsible for filing for any out of network insurance reimbursement.

I also understand that if:

- the account is not paid when due, reasonable collection and court costs will be paid by the undersigned
- if checks are returned, all fees will be paid by the undersigned
- fees for appointments not kept or canceled without a 24 hour of the appointment are the responsibility of the undersigned. The fee is $50.00

______________________________ ____________________
Patient or parent's signature Date

______________________________ ____________________
Responsible party's signature Date

Revised 1/2023