Registration Information
Please Print

_____
(Date)

Patient Name: Last_____**First**_____**M.I.**_____

Address_____

City_____**State**_____**Zip**_____-_____

Home Phone( )_____**Work Phone( )**_____

Cell/Other Phone( )_____**Email Address**_____

Age_____ **Date of Birth**_____-_____-_____**Female/Male** _____**Social Security #**_____

Marital Status_____**Employer/School**_____

Referred by_____**Email**_____

Primary Care Physician/Address/Phone_____

In Case of Emergency call: Name_____**Phone#( )**_____

Person responsible for payment_____**DOB:**_____

-Relationship to patient_____**Social Security #**_____

-Employer of person responsible for payment_____

-Address of responsible party unless same as above_____

-City_____**State**_____**Zip**_____-_____

I am aware that I will be charged for any missed appointment not cancelled 48 hours in advance.
I am responsible for full & timely payment for services I request:_____
Signature of Responsible Party

Complete this part only if you plan to request reimbursement from insurance. Please discuss any parts of this that need clarification with your physician/therapist.

1. **Check whether your insurance coverage requires pre-certification (the phone number should be on your card.**
2. **Ask a secretary to make a copy of your insurance card(s).**
3. **Primary insurance:**_____**PolicyHolder:**_____**DOB:**_____
4. **Secondary insurance:**_____**PolicyHolder:**_____**DOB:**_____
5. **I authorize my physician/therapist to release information about my condition and treatment to my medical insurance carrier for reimbursement. I am responsible for full and timely payment for services I request. It is my responsibility to contact the insurance carrier promptly when payment is delayed or miscalculated.**

   Signature of responsible party_____**Date**_____
6. **I authorize the insurance company to reimburse my physician/therapist directly.**

   Signature of responsible party_____**Date**_____

For office use only: C_____**D**_____**E**_____**F**_____

Patient will submit for insurance themselves _____**Yes** _____ **No. Other arrangements agreed upon:**

_____

Therapist Name:_____

MEICHENG CHIANG, M.D., Ph.D.
3001 Highland Avenue
Cincinnati, OH 45219-2315
Telephone (513) 961-8846
Fax (513) 487-3770

Release of Information

I hereby give permission to _____ to release

information to _____ about the evaluation

and/or treatment of the medical, psychiatric, psychological or substance abuse conditions of

_____

whose date of birth is _____. This information is to be used only for the

purpose(s) of: gathering information for treatment planning _____yes _____no

other _____

Also I give permission for exchange of information between both parties _____yes _____no

I understand that by State and Federal law: (1) only the specified information can be released to the specified recipient; (2) I may revoke this authorization at any time in writing; revocation has no effect on prior action. This release will expire 180 days from the signature date unless specified otherwise. The release of any information concerning AIDS, HIV infection or AIDS-Related Complex are authorized unless specifically excluded.

_____
Signature

_____
Date

_____
Guardian (if indicated)

Prohibition of Redisclosure: Federal law (42CFR, part 2) prohibits redisclosure of any of the above information except with specific written consent by the person to whom it pertains.
A facsimile of this signed document may be accepted in lieu of the original.

Updated 11/24/98

Meicheng Chiang, M.D., Ph.D.
3001 Highland Avenue
Cincinnati, Ohio 45219
PHONE(513)961-8861 / FAX (513)487-3770

Informed Consent for medication therapy if it is indicated

I have had the opportunity to discuss the potential side-effects and the risk versus benefit of the prescribed medications with Dr. Chiang. These include the risk for T.D. (Tardive Dyskinesia) from the 2nd generation antipsychotics despite its risk being a lot lower than the 1st generation antipsychotics. These meds may be used to treat psychotic symptoms, unstable mood and as an augmenting agent for antidepressant.

_____
Please Print Name

_____ _____
Signature Date

HEALTH SCREENING QUESTIONNAIRE

Patient's name _____ age _____ gender _____ date_____
If patient is under 18 years old,

mother's name: _____ father's _____

address: _____

Phone # home: _____ cell: _____

PAST MEDICAL PROBLEMS AND/OR SURGERY:

PLEASE CHECK ANY ILLNESS OR CONDITIONS YOU ___ HAVE HAD IN THE PAST, OR YOUR FAMILY MEMBER ( ) HAS HAD

___( ) DIABETES	___( ) HI BLOOD PRESSURE	___( ) CHEST PAIN
___( ) CANCER	___( ) COPD/ASTHMA	___( ) SLEEP APNEA
___( ) REFLUX	___( ) GASTRIC ULCER	___( ) KIDNEY DISEASE
___( ) HI CHOLESTEROL	___( ) INCONTINENCE	___( ) PAIN URINATING
___( ) NUMBNESS/TINGLING	___( )SEXUAL PROBLEM	___( )VISION PROBLEM
___( ) HEPATITIS	___( ) PANCREATITIS	
___( ) SEIZURE	___( ) STD (OR HIV)	
___( ) MRDD/AUTISM	___( ) MENTAL ILLNESS	___( )OTHER

DETAILED DESCRIPTION OF ABOVE CHECKED PROBLEMS AND/OR PAST SURGERIES:

CURRENT MEDICATIONS (INCLUDING DOSAGE AND HOW OFTEN YOU TAKE THEM):

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

MEDICATION ALLERGY/REACTION:

IS THERE A CHANCE YOU MIGHT BE PREGNANT? YES / NO; describe as below