JOHN TIERNEY, MD, PLLC

Diplomate of the American Board of Psychiatry and Neurology
Board Certified in Adult and Geriatric Psychiatry
American College of Psychiatry since 1998
Fellow American Psychiatric Association

Patient Information

Patient Name: _____ Date of Birth:_____ Sex: ☐ Male ☐ Female
Address:_____ City:_____ State:_____ Zip: _____
Cell Phone: _____ Home Phone:_____ Email:_____
Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced
In case of an EMERGENCY please contact:
Name: _____ Phone: _____ Relationship:_____
Name of Referring Physician:_____ Phone: _____
May we send a letter with treatment reccomendations referring physician or therapist? ☐ Yes ☐ No

Preferred Pharmacy

Name: _____ Phone: _____
Address:_____ City:_____ State:_____ Zip: _____

Employment & Education

Patient Employer:_____ Occupation:_____
Spouse's Name:_____ Occupation:_____
Graduated High School:☐ Yes ☐ No ☐ GED College: ☐ PhD ☐ Masters ☐ Bachelors ☐ Some ☐ None

Insurance Information

Although Dr. Tierney is not a provider for any insurance plans, and will not submit for any kind of reimbursement, we ask that you provide us with your current insurance, so we may complete any prior authorizations that may be required for medication purposes.

Do you have Medicare? ☐ Yes ☐ No Do you have Medicaid? ☐ Yes ☐ No

Primary Insurance
Name of Insurance: _____ Plan/Policy: _____
Policyholder: _____ Policyholder DOB: _____
Member ID: _____ Group Number: _____
RX BIN: _____ RX PCN: _____ RX Group: _____
Pin Number: _____ Insurance Phone: _____

Secondary Insurance (If Applicable)
Name of Insurance: _____ Plan/Policy: _____
Policyholder: _____ Policyholder DOB: _____
Member ID: _____ Group Number: _____
RX BIN: _____ RX PCN: _____ RX Group: _____
Pin Number: _____ Insurance Phone: _____

I _____ authorize the office of John Tierney, MD, MA to file prior authorization and release my medical information to my insurance company for medication purposes.

_____ _____
Signature Date

JOHN TIERNEY, MD, PLLC

Medical History

Primary Care Physician: _____ Phone: _____

Other Physicians

Physician Name:	Specialty:	Phone:

When was your last physical exam? _____ Examining Physician: _____
Height:_____ Weight:_____ Blood Pressure:_____

Do you have any known medication or other allergies? ☐ Yes ☐ No If yes, please specify below:

_____

_____

Do you have a history of any of the following illnesses?

Family History				Personal History				
	Yes		No		Yes		No	Glaucoma
	Yes		No		Yes		No	Ear, Nose, Throat Problems
	Yes		No		Yes		No	Thyroid Problems
	Yes		No		Yes		No	GI Problems (Hepatitis, Colitis)
	Yes		No		Yes		No	Heart Problems (MI, CAD)
	Yes		No		Yes		No	Hypercholesterolemia
	Yes		No		Yes		No	Hypertension
	Yes		No		Yes		No	Epilepsy, Head Trauma
	Yes		No		Yes		No	Frequent/Severe HA
	Yes		No		Yes		No	Lung Disease (TB, COPD)
	Yes		No		Yes		No	Kidney Disease
	Yes		No		Yes		No	Cancer
	Yes		No		Yes		No	Prostate Problems
	Yes		No		Yes		No	Sexually Transmitted Disease
	Yes		No		Yes		No	Anemia or Bleeding Disorders

Please list any previous surgeries and/or hospitalizations:

_____

_____

_____

_____

_____

Medical History Continued

Do you smoke?	☐	No	☐	Yes, _____ packs per day
Do you vape or use e-cigarettes?	☐	No	☐	Yes
Do you use recreational drugs?	☐	No	☐	Yes
Do you have a history of prescription abuse?	☐	No	☐	Yes
Do you drink alcohol?	☐	No	☐	Yes, _____ glasses/bottles per day
Do you consume caffeinated drinks?	☐	No	☐	Yes, _____ caffeinated drinks daily

**** Female Patients ONLY ****

Are you currently using any form of birth control? ☐ **No** ☐ **Yes**

If so what kind?

☐ Abstinence	☐ IUD/Implant	☐ Oral Contraceptives
☐ Diaphragm	☐ Condom	☐ Foam
☐ Sponge	☐ Vasectomy	☐ Hysterectomy

Psychiatric History

Have you been significantly depressed over the last two weeks? ☐ No ☐ Yes

Please check any symptoms that apply:

Pervasive sadness	☐	No	☐	Yes
Sleep disturbance	☐	No	☐	Yes
Decreased interest	☐	No	☐	Yes
Guilt	☐	No	☐	Yes
Low energy	☐	No	☐	Yes
Decreased concentration	☐	No	☐	Yes
Increased/Decreased appetite	☐		☐	
Helplessness	☐		☐	
Hopelessness	☐		☐	
Suicidal thoughts/plans	☐		☐	

Have you ever been treated for depression ☐ No ☐ Yes

Are you currently being treated for depression? ☐ No ☐ Yes

If so, who is the treating physician? _____ Date of Last Visit? _____

Have you ever been hospitalized for any psychiatric reasons? ☐ No ☐ Yes (please specify below)

Date	Hospital:	Diagnosis:

Medication History

Current Medications

Please list **ALL** medications you are **currently** taking (including birth control, vitamins, supplements, and any other over the counter medications).

Name	Dose	Frequency

Historical Medications

Please list any previous or failed medications:

Name	Dose	Frequency

Medication Agreement

To ensure optimal psychiatric care I, _____, agree to notify Dr. Tierney of any and all medications I am currently taking including any medication changes. I agree to take all prescribed medications as directed by Dr. Tierney.

_____ _____

Signature Date

Financial Policies

Office Fees & Services

Please contact the office to inquire about our fees regarding appointments. For any inquiries or questions regarding forensic services and fee schedules please contact the office.

Private Pay Provider

This office is not a Medicare/Medicaid provider. This office does not accept any form of insurance. Claims cannot be submitted to Medicare or Medicaid. Claims may be submitted to all other insurance companies by you, the patient, after your visit. **Note:** Your insurance company may not reimburse you, however you are still financially responsible for the full amount of the session.

Payment Policy

We make every effort to keep down the cost of your medical care. You can help us by paying for all all charges at the time of your visits. Payments for services are charged directly to the patient and the patient is responsible for the payment in full due at the time services are rendered. For your convenience, we accept, cash, checks, and credit cards (Visa, Mastercard, Discover, and American Express). Returned and/or bounced checks will be charged an additional $35.00 handling fee.

Controlled Substance & Prior Authorizations

For all controlled prescription refills outside of a session will be charged a $20 fee. This is due to DEA regulated reports that need be completed before a prescription can be submitted for fill. If a medication prescribed by Dr. Tierney is not covered by your insurance a form known as A Prior Authorization may be submitted on your behalf in efforts to get coverage. All Prior Authorizations will be charged a $50 completion and processing fee. If a Prior Authorization is denied an additional $50 may be charged if an appeal or petition is attempted or required.

Cancellations & No Shows

Appointments that are cancelled ***less than 24 hours*** in advance will be charged for the time blocked. Appointments that are missed will also be charged.

STATEMENT OF FINANCIAL AGREEMENT

I, the undersigned, have read the above policies and understand that all medical charges incurred by me and/or my dependents for services rendered by John G. Tierney, MD. are my financial responsibility. I also hereby agree to any outstanding account balances due **within 60 days** of the time of service. All court fees, attorney fees, or other fees necessary to collect this account are payable by me. I understand that all services are being performed in Bexar County, Texas.

Responsible Party

_____ _____

Print Name Relationship to Patient

_____ _____

Signature Date