Angela E. Partida, M.D.

3355 W. Alabama, Suite 1180
Houston, Texas 77098

Patient's Legal Name_____

Preferred Name (if different): _____

Date of Birth: _____ Age: _____ Gender: _____ Preferred Pronouns: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Email address: _____

Cell Phone: _____ May we leave a message? _____

Emergency Contact: _____ Relationship: _____ Phone: _____

How were you referred to us? _____

Primary Care Physician: _____

Phone Number: _____ Date of last visit: _____

Please list all known medical problems: _____

_____

_____

Allergies: _____

Current Medications: _____

_____

_____

Method of contraception: _____ If applicable, date of last menstrual period_____

Family Psychiatric History: _____

Marital Status (needed if we assist you in filing with your insurance): ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of Partner or Spouse:

_____

Children: _____

Do you have guns in your home? ☐ Yes ☐ No

Alcohol Use: drinks/week_____ Tobacco Use: cigarettes/day_____ smokeless tobacco_____

Other Substances (cannabis, CBD, …) _____

Past Psychiatric History:

Last Psychiatrist: _____

Reason for termination of relationship: _____

Prior Diagnosis: _____

Hospitalizations: _____

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Authorization to release information and assignment of insurance benefits

Dr. Angela Partida is not contracted with any insurance plan and has opted out of Medicare. If we assist you in filing with insurance for out of network benefits you authorize the release of any information necessary to process an insurance claim and authorize payment directly to Dr. Angela E. Partida. **I understand that I am financially responsible for all charges including missed appointments and appointments cancelled without giving 48 hour notice.** I have read and understand these statements.

Signature_____ Date_____

Acknowledgement of Receipt of Privacy Notice

By signing this form you are agreeing that you have received a copy of the Privacy Notice for this office, which describes how we use and disclose your health information. You have the right to refuse to sign this acknowledgement, in which case we must document our good faith effort to obtain acknowledgement and the reason why it was not obtained.

Signature_____ Date_____

Acknowledgement of Receipt of Office Policies and Procedures

By signing this form you are acknowledging that you have received a copy of our Office Policies and Procedures and agree to follow our policies as outlined in the document. Specifically, you accept financial responsibility for appointments missed or canceled without 48 hour notice.

Signature_____ Date_____

Termination of the patient-physician relationship

If you are contemplating terminating our relationship please inform me of your concerns so I can try to address them. If you do decide to terminate our relationship, please inform me of your decision so I can have your records forwarded to your new provider.

Under certain circumstances I will assume that you have decided to terminate our relationship. If you fail to show up for a scheduled appointment and do not contact our office within 30 days or if you do not schedule a follow up appointment within 6 months of your last scheduled appointment, I will assume that you have decided to terminate our relationship.

Under certain circumstances I may decide to terminate our relationship. This decision will only be reached after careful consideration and after a discussion with you. Written notification will be provided.

If you have any questions please contact:

Dr. Angela E. Partida
3355 W. Alabama, Ste. 1180
Houston, TX 77098
Phone 713-528-0426
Fax 713-942-0542

Office Policies and Procedures

This document contains important information about professional services and our business policies. Please read it carefully and note any questions you have so that you can discuss them with me.

Appointments

Following an initial assessment period, which can be from one to three sessions, we can then decide if I will be able to provide the services you need. The frequency and scheduling of appointments will be determined during this evaluation period.

Once an appointment is scheduled, you will be expected to pay for the reserved time unless you give us 48 hours advance notice of cancellation. Insurance will not pay for missed appointments or appointments cancelled without 48 hour notice. If you miss more than three appointments without giving 48 hour notice you may no longer be eligible for services at this office.

Professional Fees

We will discuss fees during your initial evaluation. The fees for my services are $490 for the initial evaluation appointment, $325 - 375 for 45 minute psychotherapy appointments, and $245 to 295 for 20-30 minute medication management appointments depending on level of complexity. Form fees are as follow: Doctor statement or Letter $100 and above, FMLA Forms $100. The fee for any other type of service will be provided to you at the time of scheduling. You will be notified before any changes to my fees become effective.

You will be responsible for paying my fee in its entirety. I am not an in network provider for any insurance plan. You may use your receipt to file for out of network reimbursement with your insurance.

Billing and Payments

You will be responsible for payment for any services provided by me. Payments may be made by check, cash or credit card.

Please note that you will be expected to pay at the time of service unless another agreement has been made.

Reimbursement for out of network benefits will be your responsibility but we will assist you in any way we can.

Contacting our office

You may reach us by calling 713-528-0426. Our office hours are Monday through Friday from 8:30am to 4pm. Any messages left on our voicemail will be answered by the next business day. If you need to contact me outside of our business hours please follow the instructions on our telephone greeting.

Professional Records

The law and standards of the mental health profession require that I keep treatment records. You are entitled to have access to your records. I can also prepare a summary for you instead. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. If you wish to see your records, it is recommended that you review them with me so that we can discuss the contents. Certain requests for information will incur a fee depending on the professional time spent responding to your request.

Confidentiality

In general the law protects the privacy of all communications between a patient and a mental health professional, and this office can only release information about you and your treatment to others with your written permission. There are some exceptions including the following:

- In some legal proceedings involving child custody and those in which your emotional condition is an important issue, a judge may order my testimony if he/she determines that the issues demand it.

- I may be obligated to take action in a situation where I have to protect others from harm. For example, if I believe a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency.

- If a patient threatens to harm himself/herself or others, I may be obligated to seek hospitalization for him/her or contact family members or others who can help provide protection. This rarely occurs, however, if it does, I will make a good faith effort to fully discuss it with you before taking any action.

- Information requested by insurers or Medicare for reimbursement of services provided.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

Adverse Childhood Experience (ACE) Questionnaire

Finding your ACE Score ra hbr 10 24 06

While you were growing up, during your first 18 years of life:

1. Did a parent or other adult in the household **often** …
   Swear at you, insult you, put you down, or humiliate you?
   or
   Act in a way that made you afraid that you might be physically hurt?
   Yes No If yes enter 1 _____

2. Did a parent or other adult in the household **often** …
   Push, grab, slap, or throw something at you?
   or
   Ever hit you so hard that you had marks or were injured?
   Yes No If yes enter 1 _____

3. Did an adult or person at least 5 years older than you **ever**…
   Touch or fondle you or have you touch their body in a sexual way?
   or
   Try to or actually have oral, anal, or vaginal sex with you?
   Yes No If yes enter 1 _____

4. Did you **often** feel that …
   No one in your family loved you or thought you were important or special?
   or
   Your family didn't look out for each other, feel close to each other, or support each other?
   Yes No If yes enter 1 _____

5. Did you **often** feel that …
   You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you?
   or
   Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?
   Yes No If yes enter 1 _____

6. Were your parents **ever** separated or divorced?
   Yes No If yes enter 1 _____

7. Was your mother or stepmother:
   Often pushed, grabbed, slapped, or had something thrown at her?
   or
   Sometimes or often kicked, bitten, hit with a fist, or hit with something hard?
   or
   Ever repeatedly hit over at least a few minutes or threatened with a gun or knife?
   Yes No If yes enter 1 _____

8. Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?
   Yes No If yes enter 1 _____

9. Was a household member depressed or mentally ill or did a household member attempt suicide?
   Yes No If yes enter 1 _____

10. Did a household member go to prison?
    Yes No If yes enter 1 _____

Now add up your "Yes" answers: _____ This is your ACE Score