Psych Pointe of Florida

PATIENT INFORMATION

FIRST NAME:		**M.I.**	**LAST NAME**		
SEX: **Male** **Female**	**DOB:**		**SOCIAL SECURITY NUMBER:**		
DRIVER'S LICENSE NUMBER:			**HOW DID YOU HEAR ABOUT US?**		
STREET ADDRESS:					
CITY:			**STATE:**	**ZIP CODE:**	
HOME PHONE:			**MAY WE LEAVE A MESSAGE?**	YES	NO
CELLPHONE:			**MAY WE LEAVE A MESSAGE?**	YES	NO
HOME PHONE:			**MAY WE LEAVE A MESSAGE?**	YES	NO
EMAIL ADDRESS:			**MAY WE EMAIL YOU?**	YES	NO
EMPLOYER NAME AND ADDRESS:					
EMPLOYER's CITY:			**EMPLOYER's STATE:**	**EMPLOYER's ZIP CODE:**	

IF UNDER 18: NAME OF PARENT(S)/GUARDIAN(S)

FIRST NAME:	**M.I.**	**LAST NAME:**
RELATIONSHIP:	**PHONE NUMBER:**	
FIRST NAME:	**M.I.**	**LAST NAME:**
RELATIONSHIP:	**PHONE NUMBER:**	

EMERGENCY CONTACTS

NAME:	**RELATIONSHIP:**	**PHONE NUMBER:**
NAME:	**RELATIONSHIP:**	**PHONE NUMBER:**

AUTHORIZATION AND CONSENT FOR TREATMENT: By signing below, I hereby authorize the providers of this facility to provide treatment according to my medical diagnoses and/or mental health.

× _____ _____

PATIENT SIGNATURE/GUARDIAN IF PATIENT UNDER 18 **DATE**

OFFICE USE ONLY		
DATE OF INTAKE:	**PATIENT PROVIDER(S):**	**CHART ID NUMBER:**

Psych Pointe of Florida

BILLING GUIDELINES

BILLING GUIDELINES: Please read the following information carefully and initial in the spaces provided to acknowledge you understand your responsibility.

- ✓ We will collect your deductible, copay, or percentage (if PPO) at the time of service. Please be prepared to pay with cash, debit card/credit card (Visa, MasterCard or Discover).
- ✓ Please bring all insurance information with you to your visit. Please be aware of your insurance benefits before you come in to our office as it is ultimately your responsibility for anything not covered by insurance.
- ✓ You will need to contact your insurance company to find out if you need to obtain authorization for Mental Health services. If you obtain an authorization number, please bring it with you to your first visit.
- ✓ If your insurance changes, you will need to advise us immediately as your new insurance might not pay if the company requires an authorization for services.
- ✓ If your insurance company gives you a limited number of visits, you will need to keep track of how many of those visits you have used.
- ✓ Your insurance will send you an explanation of benefits defining what they have paid to our office. If you do not agree with the explanation of benefits, you will need to contact your insurance company.
- ✓ Please be aware that as a courtesy, we try to call 1-4 days before your appointment to remind you of your appointment; however, it is ultimately your responsibility to remember your own appointment. All appointments must be cancelled 24 hours or more in advance or GUARANTOR WILL BE CHARGED THE STANDARD OFFICE FEE. This includes any "No-Show" appointments. This fee must be paid before seeing the doctor for your next visit.

ASSIGNMENT OF INSURANCE:

ARE YOU USING INSURANCE FOR THIS VISIT AND FOLLOWUPS?	**YES**	**NO**
INSURANCE COMPANY:	PROVIDER TELEPHONE NUMBER:	
MEMBER ID:	GROUP NUMBER:	
PRIMARY INSURANCE HOLDER'S NAME	PRIMARY INSURANCE HOLDER'S DATE OF BIRTH	
PRIMARY INSURANCE HOLDER'S SSN:	PATIENT'S RELATIONSHIP TO PRIMARY INSURANCE HOLDER	
AUTHORIZATION NUMBER (IF APPLICABLE)	AUTHORIZED NUMBER OF VISITS:	

INSURANCE AGREEMENT: In making this assignment, I am aware, I understand, and I agree if payment is not received from my insurance company within 45 days of the date of service, I am fully responsible for the entire balance.

× _____ _____

PATIENT SIGNATURE/GUARDIAN IF PATIENT UNDER 18 — DATE

SELF-PAYMENT AGREEMENT: If not using insurance, I have agreed to accept full responsibility for payment of any charges incurred at this facility, and I have agreed to pay for these services in full at time of service.

× _____ _____

PATIENT SIGNATURE/GUARDIAN IF PATIENT UNDER 18 — DATE

Psych Pointe of Florida

MEDICAL HISTORY

PAST MEDICAL HISTORY: Please check all that you have now or have had in the past. If it occurred in the past, please indicate the age when it happened.

NOW	PAST	AGE	
			Head injury
			Unconsciousness
			High fever(s)
			Loss of appetite
			Weight gain/loss
			Frequent headaches
			Seizures
			Fainting/dizziness
			Stroke
			Crying spells
			Heart trouble
			Rheumatic fever
			High blood pressure
			Chest pain
			Asthma
			Shortness of breath
			Hives/rashes
			Sleep disorders
			Nightmares
			Night sweats

NOW	PAST	AGE	
			Bedwetting/soiling
			Arthritis
			Back problems
			Cancer
			Tuberculosis
			Stomach problems
			Liver trouble
			Hepatitis/jaundice
			Kidney trouble
			Bowel problems
			Bladder problems
			Diabetes
			Thyroid problems
			Unusual bleeding
			Gynecological problems
			Premenstrual syndrome
			HIV and/or AIDS positive
			Sexual dysfunction
			Other:
			Other:

REASON FOR SCHEDULING YOUR APPOINTMENT:

HOW LONG HAS THIS BEEN A PROBLEM?

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MENTAL HEALTH HISTORY

MENTAL HEALTH TREATMENTS:

DOCTOR OR THERAPIST	NAME/LOCATION	START	STOP	REASON

PAST HOSPITALIZATIONS:

HOSPITAL NAME AND LOCATION	FROM	TO	REASON

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ADDITIONAL PERSONAL HISTORY

1. **Current Psychiatric Medications**: Are you currently prescribed psychiatric medication?

   Yes _____ No _____

If "yes," please list.

PSYCHIATRIC MEDICATION	DOSAGE	HOW OFTEN	PRESCRIBING DOCTOR or OTC

2. **Other Medications**: Are you currently taking any other prescription or over-the-counter (OTC) medications not listed above?

   Yes _____ No _____

If "yes," please list.

MEDICATION	DOSAGE	HOW OFTEN	PRESCRIBING DOCTOR or OTC

3. **Prior Psychiatric Medication Trials**: Have you been tried on any previous psychiatric medications?

   Yes _____ No _____

If "yes," please list.

NAME	WHEN	EFFECT/RESPONSE/REACTION

4. How would you rate your current physical health?

___ **POOR** ___ **UNSATISFACTORY** ___ **SATISFACTORY** ___ **GOOD** ___ **VERY GOOD**

Please list any health problems you are currently experiencing: _____

_____

_____

5. How would you rate your current sleeping habits?

___ **POOR** ___ **UNSATISFACTORY** ___ **SATISFACTORY** ___ **GOOD** ___ **VERY GOOD**

Please list any specific sleeping problems you are currently experiencing: _____

_____

_____

6. How many times per week do you generally exercise? _____

   What types of exercise do you participate in?

_____

_____

_____

7. Please list any difficulties you experience with your appetite or eating patterns:

_____

_____

_____

8. Are you currently experiencing overwhelming sadness, grief, or depression?

____ YES ____ NO If yes, for approximately how long? _____

_____

9. Are you currently experiencing anxiety, panic attacks, or have any phobias?

____ YES ____ NO If yes, when did it begin? _____

_____

10. Are you currently experiencing chronic pain?

____ YES ____ NO If yes, please describe? _____

_____

11. Do you drink alcohol more than once a week?

____ YES ____ NO How much/how often? _____

_____

12. How often do you engage in recreational drug use?

____ DAILY ____ WEEKLY ____ MONTHLY ____ INFREQUENTLY ____ NEVER

13. Are you currently in a romantic relationship?

____ YES ____ NO If yes, how long? _____

On a scale of 1 to 10, how would you rate your relationship? _____

14. Are you currently employed?

____ YES ____ NO Please describe your employment status: _____

If employed: Do you enjoy your work? _____

Any particular stressors at your work? _____

_____

15. Do you consider yourself to be spiritual or religious?

____ YES ____ NO If yes, please describe your faith or beliefs. _____

_____

_____

16. What do you consider to be some of your strengths?

_____

_____

_____

_____

17. What do you consider to be some of your weaknesses?

_____

_____

_____

_____

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FAMILY MENTAL HEALTH HISTORY

In the section below, please identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

Condition	Yes	No	Family Member(s)
1. Alcohol/Substance Abuse			
2. Anxiety			
3. Depression			
4. Bipolar/Mania			
5. Domestic Violence			
6. Eating Disorders			
7. Obesity			
8. Obsessive-Compulsive Disorder			
9. Schizophrenia			
10. Suicide Attempts			
11. Other:			

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ACKNOWLEDGEMENT OF PRIVACY PRACTICES

LIMITS OF CONFIDENTIALITY: Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follow:

- Duty to Warn and Protect

  When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In case in which the client discloses or implies a plan for suicide, the healthcare professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

- Abuse of Children and Vulnerable Adults

  If a client states or suggests that he or she is abusing a child or vulnerable adult or has recently abused a child or vulnerable adult or a child or vulnerable adult is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

- Prenatal Exposure to Controlled Substances

  Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

- Minors/Guardianship

  Parents or legal guardians of non-emancipated minor clients have the right to access the client's records.

- Insurance Providers (When Applicable)

  Insurance companies and other third-party payers are given information that they request regarding services to clients. The information that may be requested include but is not limited to types of service, dates and times of service, diagnoses, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

By Signing Below, I agree to the above-mentioned limits of confidentiality, and I understand their meanings and ramifications:

× _____ _____

Patient Signature/Parent or Guardian if under 18 **Date**

Psych Pointe of Florida

5979 Vineland Road, Suite 109, Orlando, FL 32819
Phone: 1-407-270-7702; Fax: 1-407-270-7705
Email: PsychPointeFL@Gmail.com

Syed Quadri, MD
Randie Morillow, LCSW
Michael Kellogg, LMHC

January 2016

Dear Patients:

This is a formal memo to all patients regarding new office policies and confirmation of previous policies that will be enforced as of January 2016.

- All letters needed from the doctor will have a fee of **$25**. All forms/paperwork needed **MUST** be approved by the doctor and will have a fee of **$200**. No Exceptions.

- The doctor does **not** fill out anything for Disability/Social Security benefits or anything court ordered.

- If a patient runs out of medication and does not come in for their routine appointment with the doctor—upon approval from Dr. Quadri—there will be a **$25** fee to call in medications to the pharmacy.

- If an appointment is cancelled the same day/less than 24 hours' notice, there will be a **$50** No-Show/Missed Visit fee. Please be advised, appointment reminder calls, when they occur, are a courtesy.

- Be aware that the doctor may order a urine drug screen at any time based on treatment and medications.

By signing this memo, you agree to the above terms/policies of this practice.

× _____ _____

Patient Signature/Parent or Guardian if under 18 **Date**

Psych Pointe of Florida

HIPAA PRIVACY AND SECURITY POLICIES

I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information (PHI). I understand that this information can and will be used for the following:

- Conduct, Plan, and Direct my treatment and followup among the multiple healthcare providers who may be involved in that treatment - directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations, and I understand that you are not required to agree to my requested restrictions, but if you do agree, then you are bound to abide by such restrictions.

By signing below, I acknowledge that the Notice of Privacy Practices contains a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices and that I may contact this organization at any time or visit our website, www.milleniapysch.com, to obtain a current copy of the Notice of Privacy Practices.

_____ I have requested and received a copy of the organization's Notice of Privacy Practices.

OR

_____ I have declined a copy of the organization's Notice of Privacy Practices.

× _____ _____

Patient Signature/Parent or Guardian if under 18 **Date**

Psych Pointe of Florida

MEDICATION CONSENT

NAME: _____ **DOB:** _____

SSRIs/SNRIs

Risks, benefits, and side effects—including risk of falls, nausea, weight gain, abdominal pain, cardiac arrhythmias, liver toxicity and liver failure, serotonin syndrome, teratogenicity, vomiting, and headaches—were discussed, and the patient gives full informed consent.

ANTIPSYCHOTICS

Risks, benefits, and side effects—including abdominal pain, nausea, QT prolongation, extrapyramidal symptoms (EPS), tardive dyskinesia (TD), abnormal involuntary movements (AIMs), metabolic syndrome, hyperprolactinemia, galactorrhea, gynecomastia, weight gain, vomiting, liver toxicity and liver failure, and headaches—were discussed, and the patient gives full informed consent.

MOOD STABILIZERS

Risks, benefits, and side effects—including falls, rash, Stevens-Johnson syndrome, metabolic syndrome, hyperprolactinemia, galactorrhea, weight gain, vomiting, renal/liver toxicity and renal/liver failure, and headaches—were discussed, and the patient gives full informed consent.

STIMULANTS/WELLBUTRIN

Risks, benefits, and side effects—including risks of falls, nausea, weight gain, abdominal pain, loss of sleep, loss of appetite, psychosis, palpitations, increased risk of sudden death, liver toxicity, and liver failure—were discussed, and the patient gives full informed consent.

BENZODIAZEPINES/VISTARIL

Risks, benefits, and side effects—including falls, nausea, vomiting, abdominal pain, drowsiness, tolerance, addiction, loss of appetite, psychosis, palpitations, increased risk of sudden death, liver toxicity, and liver failure—were discussed, and the patient gives full informed consent.

	×	
PATIENT'S NAME	**SIGNATURE**	**DATE**
	×	
PARENT/GUARDIAN'S NAME	**SIGNATURE**	**DATE**
	×	
PARENT/GUARDIAN'S NAME	**SIGNATURE**	**DATE**
	×	
PRESCRIBER'S NAME	**SIGNATURE**	**DATE**

Psych Pointe of Florida

5979 Vineland Road Suite #109; Orlando, FL 32819
Phone: 407-270-7702 Fax: 407-270-7705
◇ Syed O. Quadri, MD ◇ Tachaeana Anderson, ARNP ◇
◇ Tonya King, ARNP ◇ Willem Limage, ARNP ◇
◇ Salema Watts, ARNP ◇ Randie Morillo, LCSW ◇
◇ Michael Kellogg, LMHC ◇ Michael Gilman, MS ◇

AUTHORIZATION TO RELEASE/EXCHANGE CONFIDENTIAL INFORMATION

This form cannot be used for the re-release of confidential information provided to the Counseling Center by other individuals or agencies. Such requests should be referred to the original individual or agency.

I, _____ authorize the Psych Pointe of Florida to:

_____ Release to: _____
_____ Obtain from: _____
_____ Exchange with: _____

Address: _____
Phone Number: _____ Fax Number: _____

The following information related to myself:

_____ History/Initial Consultation
_____ Psychiatric Evaluation
_____ Treatment Summary and Progress Reports
_____ Diagnosis and Lab Reports
_____ Psychiatric and Psychological Test Results
_____ Dates of Treatment Attendance
_____ Other: Specify: _____

For:

_____ Evaluation/Assessment and/or Coordinating Treatment Efforts
_____ Other: Specify: _____

This consent will automatically expire three (3) years after the date of my signature as it appears below or on the following earlier date, condition, or event.

I understand I have the right to refuse to sign this form and that I may revoke my consent at any time (except to the extent that information has already been released).

_____	× _____	_____
PATIENT'S NAME	**SIGNATURE**	**DATE**

Both the manic and the depressive symptoms of bipolar disorder can have a negative impact on your life, your relationships, even your job.[1] Talking to your doctor about all your symptoms is an important first step to finding out whether you have bipolar disorder. Answering the questions on this form, and discussing the responses with your doctor, may help you do that. It will take about 5 minutes to fill it out. It is not meant for self-diagnosis, so please bring it with you to your next appointment.

Mood Disorder Questionnaire

Name: _____ Date: / /

Please answer the questions as best you can by putting a check in the appropriate box.

1. Has there ever been a period of time when you were not your usual self and ...	Yes	No
... you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
... you were so irritable that you shouted at people or started fights or arguments?		
... you felt much more self-confident than usual?		
... you got much less sleep than usual and found that you didn't really miss it?		
... you were more talkative or spoke much faster than usual?		
... thoughts raced through your head or you couldn't slow your mind down?		
... you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
... you had much more energy than usual?		
... you were much more active or did many more things than usual?		
... you were much more social or outgoing than usual; for example, you telephoned friends in the middle of the night?		
... you were much more interested in sex than usual?		
... you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
... spending money got you or your family into trouble?		

2. If you checked Yes to more than one of the above, have several of these ever happened during the same period of time?	Yes	No

3. How much of a problem did any of these cause you? (like being unable to work; having family, money, or legal troubles; and/or getting into arguments or fights)	No Problem	Minor Problem	Moderate Problem	Serious Problem

Reference: 1. Hirschfeld RMA, Lewis L, Vornik LA. *J Clin Psychiatry*. 2003;64(2):161-174.

The Mood Disorder Questionnaire (MDQ) was developed by Robert M. A. Hirschfeld, MD (University of Texas Medical Branch), and published in the *Am J Psychiatry*. (Hirschfeld RMA, Williams JBW, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry*. 2000;157(11):1873-1875.)

UNB124696 06/19

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**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

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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

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