Psych Pointe of Florida

PATIENT INFO

FIRST NAME		M.I.	LAST NAME
EX Male Female	DOB:		OCIAL SEC NO.
DRIVER'S LICENSE NO.		HOW DID YOU HEAR ABOUT US?	
TREET ADDRESS			ÄPT NO.
ITY			IP CODE
HOME PHONE		May we leave a message?	Yes
ELL PHONE		May we leave a message?	Yes
ORK/OTHER PHONE		May we leave a message?	Yes
EMAIL ADDRESS		May we email you?	Yes
EMPLOYER NAME(S) & ADDRESS(ES):			

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 CONTACT

NAME	RELATIONSHIP	PHONE NUMBER

AUTHORIZATION & CONSENT FOR TREATMENT

By signing below, I hereby authorize the providers of this facility to provide treatment according to my medical diagnosis and/or mental health.

×

PATIENT SIGNATURE (PARENT/GUARDIAN SIGNS IF PATIENT IS UNDER 18) DATE

OFFICE USE ONLY

DATE OF INTAKE	PATIENT PROVIDER(s)	CHART ID NO.

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 the 1-4 days before your appointment to remind you of your appointment; however, it is ultimately your responsibility to remember your own appointments. ALL APPOINTMENTS MUST BE CANCELED 24-HOURS 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 your insurance for this visit and follow-ups? Yes No

INSURANCE COMPANY	PROVIDER TELEPHONE NO.
MEMBER ID #	GROUP #
PRIMARY INSURANCE HOLDER'S NAME	PRIMARY INSURANCE HOLDER'S DATE OF BIRTH
PRIMARY INSURANCE HOLDER'S SOC SEC #	ATIENT'S RELATIONSHIP TO PRIMARY INSURANCE HOLDER
UTHORIZATION # (IF APPLICABLE)	UTHORIZED # OF VISITS

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

×

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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 (PARENT/GUARDIAN SIGNS IF PATIENT IS UNDER 18) DATE

of'

MEDICAL HISTORY

Please check all of these that you have now (present) and/or have had in the past. If it occurred in the past, please indicate the age when it was happening.

PRESENT	PAST	AGE		PRESENT	PAST	AGE	
			head injury				bed-wetting/soiling
			unconsciousness				arthritis
			high fevers				back problems
			loss of appetite				cancer
			weight gain/loss				tuberculosis
			frequent headaches				stomach problems
			seizures				liver trouble
			fainting/dizziness				hepatitis/jaundice
			stroke				kidney trouble
			crying spells				bowel problems
			heart trouble				bladder problems
			rheumatic fever				diabetes
			high blood pressure				thyroid problems
			chest pain				unusual bleeding
			asthma				gynecological problem
			shortness of breath				premenstrual syndrome
			hives/rashes				pos for AIDS antibody
			sleep disorders				sexual dysfunction
			nightmares				other:
			night sweats				other:

REASON FOR SCHEDULING YOUR APPOINTMENT TODAY

How long has this been a problem?

MENTAL HEALTH TREATMENT HISTORY

DOCTOR or THERAPIST NAME/LOCATION	DATES SEEN FROM	TO	PROBLEM

PAST HOSPITALIZATIONS

HOSPITAL NAME/LOCATION	DATES SEEN FROM	TO	REASON FOR HOSPITALIZATION

1. Are you currently taking any prescription or over-the-counter (OTC) medication? No
   Yes, please list:

MEDICATION	DOSAGE	FREQUENCY/TIMES	PRESCRIBED (LIST DOCTOR) OR OTC?

2. Have you ever been prescribed psychiatric medication? C] No Yes, please list:

MEDICATION	DOSAGE	FREQUENCY/TIMES	PRESCRIBED (LIST DOCTOR) OR OTC?

3. How would you rate your current physical health? (Please check one)

   ☐ Poor Unsatisfactory Satisfactory Good C] Very good

   Please list any health problems you are currently experiencing:

   ____

4. How would you rate your current sleeping habits? (Please check one)

   ☐ Poor Cl Unsatisfactory C] Satisfactory Good Very good

   Please list any specific sleep problems you are currently experiencing:

   ____

5. How many times per week do you generally exercise? ________

   What types of exercise do you participate in?

   ____

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

   ____

7. Are you currently experiencing overwhelming sadness, grief, or depression? No Yes If yes, for approximately how long?

8. Are you currently experiencing anxiety, panic attacks, or have any phobias? No C] Yes

If yes, when did you begin experiencing this? ______________________________

9. Are you currently experiencing any chronic pain? No a Yes
If yes, please describe: ______________________________

of?

10. Do you drink alcohol more than once a week? Cl No a Yes
11. How often do you engage in recreational drug use? (Please check one)

☐ Daily C] Weekly C] Monthly Cl Infrequently Never

12. Are you currently in a romantic relationship? No Yes If yes, for how long?

____

On a scale of 1-10, how would you rate your relationship? ________________

13. Are you currently employed? No Yes

If yes, what is your current employment situation?

____

Do you enjoy your work? Is there anything stressful about your current work?

____

14. Do you consider yourself to be spiritual or religious? No a Yes
If yes, please describe your faith or belief: ______________________________

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

____

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

____

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.).

	YES	NO	LIST FAMILY MEMBER (e.g. father, mother, sibling,etc.)
Alcohol/Substance Abuse			

Anxiety		
Depression		
Bipolar/Mania		
Domestic Violence		
Eating Disorders		
Obesity		
Obsessive Compulsive Disorder		
Schizophrenia		
Suicide Attempts		

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 follows:

Duty to Warn & 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 health care 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 clients' 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 includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

BY SIGNING BELOW, 1 AGREE TO THE ABOVE LIMITS OF CONFIDENTIALITY AND UNDERSTAND THEIR MEANINGS AND ?AMIFICATIONS.

PATIENT SIGNATURE (PARENT/GUARDIAN SIGNS IF PATIENT IS UNDER 18) DATE

ACKNOWLEDGEMENT OF PRIVACY PRACTICES:

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. o 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 form Dr Quadri — there will be a $25 fee to call in medications to the pharmacy.
- If an appointment is cancelled the same day/with less than 24 hours notice, there Will be a $50 'No Show/Missed Visit' fee. (Please be advised that appointment reminder calls 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.

Patients Signature   Date

I understand that under the Health Insurance Portability & 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 to

- Conduct, plan, and direct my treatment and follow-up 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 health care 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 web site
(www.milleniapsych.com) to obtain a current copy of the Notice of Privacy Practices.

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

OR

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

____

PATIENT SIGNATURE (PARENT/GUARDIAN SIGNS IF PATIENT IS UNDER 18) DATE

PSYCH POINTE OF FLORIDA

MEDICATION CONSENT

PT. NAME: ________________________________ **DOB:** __________________________

SSRIS/SNRIS

Risks, benefits and side effects including risk of fails, nausea, weight gain, abdominal pain, cardiac arrhythmias, liver toxicity and liver failure. Seratonin Syndrome, teratogenicity, vomiting and headaches discussed, and patient gives full informed consent.

ANTIPSYCHOTICS:

Risks, benefits and side effects including of abdominal pain, nausea, QT prolongation, EPS, TD'S, AIMS, Metabolic syndrome, prolactinemia, galactorrhea, gynecomastia, weight gain, vomiting, liver toxicity and liver failure and headaches discussed, and patient gives full informed consent.

MOOD STABILIZER:

Risks, benefits and side effects including of fails, rash, Steven Johnson's syndrome, metabolic syndrome, prolactinemia, galactorrhea, weight gain, vomiting, renal/liver toxicity and renal/liver failure and headaches discussed, and patient gives full informed consent.

STIMULANT/WELLBUTRIN

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

BENZO'S/VISTARIL

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

Patient's Name: ______________________ Signature: ______________________________ Date: __________

Parent/Guardian's Name: _________________ Signature: ______________________________ Date: __________

Parent/Guardian's Name: _________________ Signature: ______________________________ Date: __________

Prescriber Name: ___________________ Signature: ______________________________ Date: __________

Psych Pointe of Florida
5979 Vineland Road Ste. # 109 Orlando, FL 32819 – P: 407-270-7702 F: 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, CAP

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 #: ___________________________ Fax: _________________________

the following information pertaining to myself:

_____ history/initial consultation

_____ psychiatric evaluation/medication history

_____ treatment summary & progress notes

_____ diagnosis & lab reports

_____ psychiatric & 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 the information has already been released).

____________________________	____________________________	________________
Print name	**Signature of Client**	**Date**

Mood Disorder Questionnaire (MDQ)

The MDQ can help your doctor determine what type of mood disorder you may be experiencing.

Your Name: ______________________ Date: ______________

Instructions: Please check one answer for each question.

1. Has there ever been a period of time when you were not your usual self and...

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

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

3. How much of a problem did any of these cause you—like being unable to work; having family, money, or legal troubles; getting into arguments or fights?

O **No problem** O **Minor problem** O **Moderate problem** O **Serious problem**

–Adapted with permission from Robert M. A. Hirschfeld, MD.

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Depression Questionnaire

Answer the questions below and share them with your doctor if you believe you are suffering from symptoms of depression.

Please note that this questionnaire is not a formal diagnostic tool or substitute for medical advice. Only a doctor can diagnose and treat depression.

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	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. Moving or speaking so slowly that other people have noticed, or being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way*	☐	☐	☐	☐

***If you or someone you know is having suicidal thoughts, talk to someone who can help. Call your doctor or 1-800-273-TALK (8255).**

A person with depression must have 5 or more of the symptoms listed above, which must be present for at least 2 weeks and represent a change from previous functioning. At least one of the symptoms must be either question 1 or 2.

Source: American Psychiatric Association. *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition. Washington, DC: American Psychiatric Association; 2013.

If you checked off any of the problems above, 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

Adapted from The Patient Health Questionnaire-9.

Talking with your doctor can be an important first step toward learning more about depression and available treatment options.