SOUTHERN PSYCHIATRY ASSOCIATES

Date:

PATIENT INFORMATION					
Patient's last name:	First:	Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms. ❑ Dr.	Marital status (circle one) Single / Mar / Div / Sep / Wid
Ethnicity: ❑White ❑American Indian ❑ Native Hawaiian ❑ African American ❑Asian ❑Hispanic/Latino			Language:		
Social Security No:	Birth date:	Sex:	Cell Phone:	Home Phone:	
Street address:		City/State:		Zip Code:	
Email:					
Credit Card Number:	Security Code:		Expiration Date:		
Occupation:	Employer:		Employer phone no.:		
Primary Physician:	Phone:		Fax:		
Preferred Pharmacy:	Phone:		Fax:		

INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Please indicate primary insurance	❑ Blue Cross Blue Shield	❑ United Health Care	❑ Humana	❑ Medicare	❑ Health springs
❑ Champ VA	❑ Cigna	❑ Aetna	❑ Other		
Subscriber's name:	Subscriber's S.S. no.:	Birth date: / /	Group no.:	Policy no.:	Co-payment: $
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	
Name of secondary insurance (if applicable):	Subscriber's name:		Group no.:	Policy no.:	
Patient's relationship to subscriber:	❑ Self	❑ Spouse	❑ Child	❑ Other	

IN CASE OF EMERGENCY			
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize Southern Psychiatry Associates or insurance company to release any information required to process my claims.			
Patient/Guardian signature		*Date*	

Policies

Informed Consent for Treatment

I give consent for myself or my legal dependent to be treated at Southern Psychiatry Associates, including but not limited to: evaluation, psychotherapy, medication management, or testing. I may at any time decline specific recommendations.

Initial: _________

After Hours Phone Calls

Southern Psychiatry Associates does not have a 24 hour on call physician available. If you experience an emergency and it can not wait until the next business day, pease call 911 or go to the nearest emergency room for evaluation. Our office hours are Monday through Friday 8 AM to 4:30 PM.

Initial: _________

Tools for your Visit

Dr Sadler is a board-certified psychiatrist who is trained both medicines and psychotherapy. Depending on the circumstances, he may use both tools to help in your recovery. All interventions will be billed through your insurance and you are responsible for any non-covered payments.

Initial: _________

Payment for Services

Southern Psychiatry Associates will directly bill your Insurance company following your appointment. Your copayment, deductible and/or any balances will be collected and is required at the time of your appointment. If we are not billing an insurance company for your visit, the full payment for service will be due at the time of your appointments. Southern Psychiatry Associates accepts Cash, Credit/Debit Cards, and Checks as a form of payment. All checks are deposited within 24 hours of your appointment. If we receive a returned check, you will be responsible for the check amount plus the $35 NSF Fee.

Initial: _________

Cancellation and/or No-Show Policy

Southern Psychiatry Associates requires a 24-hour notice to cancel or reschedule your appointment. New patients are charge $100, and existing patients are charged $50. The fee will be billed on the day of your appointment to the Credit/Debit Card on file. After the 3rd no-show, you will be then released from our practice, and if requested a referral will be provided.

Initial: _________

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization. We also call to provide reminders of upcoming appointments.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child or elder abuse or neglect or mandatory government agency audits or investigations (such as the social work licensing board or the health department)
- Required by Court Order

- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person (self or other), or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission

We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing at our office.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based fee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing or by phone wit with Southern Psychiatry Associates or myself or with the Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. We will not retaliate against you for filing a complaint.

The effective date of this 9/1/18

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Southern Psychiatry Associates to use and disclose my protected health information to carry out treatment, payment, and health care operations.

I have the right to review the Notice of Privacy Practices prior to signing this consent.

Southern Psychiatry Associates reserves the right to revise the Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained at any time by contacting the office.

With this consent, Southern Psychiatry Associates may call my home or other alternative location and leave a message or voicemail in reference to any items that assist them in carrying out treatment, payment, or health care operations. This includes, but not limited to: appointment reminders, insurance items, laboratory results, and calls pertaining to my clinical care.

With this consent, Southern Psychiatry Associates may mail to my home or other alternative location with any items that assist in carrying out treatment, payment, to health care operations, as long as they are marked "Personal and Confidential."

With this consent, Southern Psychiatry Associates may e-mail my home or other alternative location with any items that assist in carrying out treatment, payment, to health care operations.

I have the right to request that Southern Psychiatry Associates restrict how it uses or discloses my protected health information. The practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

I may revoke my consent in writing, except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Southern Psychiatry Associates may decline to provide treatment to me.

Southern Psychiatry Associates has my permission to discuss my protected health information with:

Name	Relationship	Phone

☐ I decline permission to verbally discuss medical information

Print Name: ____________________ Date of Birth: ____________________

Signature: ____________________ Date: ____________________

Controlled Substance Agreement

The purpose of this agreement is to prevent any misunderstandings about controlled substances. This is to help both you and your doctor to comply with the law regarding controlled pharmaceuticals.

- I understand that this Agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor undertakes to treat me based on this Agreement.
- I understand that if I break this Agreement, my doctor will stop prescribing these controlled medicines.
- In this case, my doctor may taper off the medicine over a period of several days, as necessary, to avoid withdrawal symptoms. Also, a drug-dependence treatment program may be recommended.
- I will communicate fully with my doctor all medications that I am prescribed will in the care of Southern Psychiatry Associates.
- I will not use any illegal controlled substances, including methamphetamines, cocaine, etc.
- I will not share, sell or trade my medication with anyone.
- I will not attempt to obtain any controlled medicines, including opioid pain medicines, controlled stimulants, or antianxiety medicines from any other doctor.
- I will safeguard my controlled medicine from loss or theft. Lost or stolen medicines will not be replaced, and the medicines will not be refilled early.
- I agree that refills of my prescriptions will be made only at the time of an office visit or during regular office hours. No refills will be available during evenings or on weekends.
- I agree to follow these guidelines that have been fully explained to me. All my questions and concerns regarding treatment have been adequately answered.
- I authorize the doctor and my pharmacy to cooperate fully with any city, state or federal law enforcement agency, including this state's Board of Pharmacy, in the investigation of any possible misuse, sale, or other diversion of my pain medicine.
- I authorize my doctor to provide a copy of this Agreement to my pharmacy.
- I agree to waive any applicable privilege or right of privacy or confidentiality with respect to these authorizations.
- I agree that I will submit to a urine test if requested by my doctor to determine my compliance. Southern Psychiatry Associates use Compass Lab Services for confidential urine testing. It allows the Physician to offer superior care by enabling them to manage your medications and reduce the potential for drug to drug interactions.
- If abuse of medications is suspected, Southern Psychiatry Associates reserves the right to stop prescriptions immediately or provide a brief taper of medication depending on the situation.

Patient Name [Please Print]: ________________________________ Date: ____________________

Patient Signature: ____

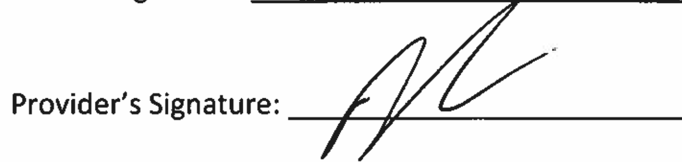
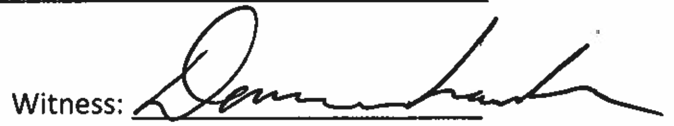
Provider's Signature: Witness:

Southern Psychiatry Associates

If you are taking opioid pain medicines (eg. Morphine, Norco, Loratab, Hydrocodone, Etc..), Southern Psychiatry will no longer continue to prescribe benzodiazepines (eg. Klonopin, Valium, Xanax etc...). Also, if you are currently a patient and taking both those medicines and cannot come off pain medicines we will work with you to help, safely take you off the benzodiazepines. Please make sure the treating provider is aware if you are on a chronic opioid prescription, so we can address this topic during your appointment.

Patient Name [Please Print]: ______________________________ Date: ___________________

Patient Signature: ____

Provider's Signature:  Witness: 

Initial Assessment

Name: ______________________________ **Sex: M / F** **DOB:** ______________________

List all prescriptions & over the counter medication you take. (Including Dosage & Strength)

_________________________________ _________________________________

_________________________________ _________________________________

_________________________________ _________________________________

Please list any drug allergies you may have below:

____

Do you use tobacco products? ___Yes ___No

Do you use marijuana, cocaine or methamphetamine? ___Yes ___No

Have you attempted suicide before? ___Yes ___No

Have you had any psychiatric hospitalizations? ___Yes ___No

Please check any symptoms or experiences you have had in the last month:

___Falling or Staying Asleep

___Anxiety or Irritability

___Abuse of Laxatives

___Self-Mutilation or Cutting

___Racing Thoughts

___Forgetfulness or Memory Loss

___Depressed Mood / Sadness

___Inattentive or Hyperactivity

___Binge Eating

___Flashbacks or Nightmares

___Hearing Voices or Seeing Things

___Alcohol or Substance Abuse

Please check new or ongoing stressors in your life:

___Relationship or Marital Issues

___Loss of Job

___Verbal or Physical Abuse

___Chronic Illness

___Death of Family

___Car Accident

___Retirement

___Poor School or Work Performance

___Other: ____

Name: ______________________________

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, 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 <u>any</u> problems, how <u>difficult</u> 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**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.