Southern Psychiatry - New Patient Information and Consent

What is the reason for your visit?

Patient Information

Name (First, Middle, Last)	Date of Birth	Age	Social Security #	Birth Gender ☐ M ☐ F

Mailing Address	Apt #	City, State ZIP

Email Address	Primary Phone ☐	Ok to leave a voicemail message? Yes ☐ No ☐

Primary Care Provider (where you go for your routine medical care):
(Include Address and Phone #) ☐ None

Preferred Language	Race ☐ Black or African American ☐ Asian ☐ White ☐ Native Hawaiian or Other Pacific Islander ☐ Other ☐ American Indian/Alaska Native ☐ Prefer not to answer
Ethnicity ☐ Hispanic or Latino ☐ Not Hispanic or Latino	

Emergency Contact

Contact Name	Phone Number	Relationship to Patient

Guarantor/Responsible Party (person responsible for payment)

Legal Name of Responsible Party (First, Middle, Last)	Social Security #
Email Address (if different from the patient email above)	Date of Birth

Preferred Pharmacy

Pharmacy Name	Pharmacy Location and Phone #

Medical Insurance (please present your ID and insurance card to the receptionist)

PRIMARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone
SECONDARY Insurance Company Name	Policy Number/Member ID	Group Number
Insured Name	Insured Date of Birth	Patient Relationship to Insured ☐ Self ☐ Spouse ☐ Dependent
Insurance Company Address (usually on back of insurance card)		Phone

Accident/Injury Information

Is this a Worker's Compensation Case? ☐ **Yes** ☐ **No** ☐ **Not Applicable**

If so, what is the Date of Injury? _____

Case Manager (Name & Phone #): _____

- **Have you ever had Psychological Testing for ADHD, ADD, Autism, etc..?** ☐ **Yes** ☐ **No**
  If so, who performed the test: _____
  Date of testing: _____

Credit/Debit/HSA Card No.: _____ Exp: _____ CVV:_____

Patient Consent for Treatment

1. I voluntarily consent to any and all healthcare treatment and diagnostic procedures provided by Southern Psychiatry Associates and its associated physicians, clinicians and other personnel. I am aware that the practice of medicine and other healthcare professions is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations at Southern Psychiatry Associates.
2. I agree to be contacted via email or SMS with information related to my visit, like: a patient portal invitation, post-visit satisfaction survey, appointment or checkup reminders, health tips, or new services that relate to me or my family.
3. I consent to the use and disclosure of my/the patient's protected health information for purposes of obtaining payment for services rendered to me/the patient, treatment and health care operations consistent with Southern Psychiatry Associates Notice of Privacy Practices.
4. I authorize payment of medical benefits to Southern Psychiatry Associates physicians or their designee for services rendered.
5. I give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.

I have received a copy of the Notice of Privacy Practice and Financial Policy Notice. ☐ Yes ☐ No

X_____ _____

Patient or Authorized Person's Signature Date

Southern Psychiatry Associates

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 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

Southern Psychiatry Associates

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 cannot wait until the next business day, please 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 in both medicine 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 the service will be due at the time of your appointment. Southern Psychiatry Associates accepts Cash, Credit/Debit Cards, and Checks as a form of payment. All checks are deposited within 72 hours of your appointment. If we receive a returned check, you will be responsible for the check amount plus the $45 NSF Fee. All paperwork and letters that need to be completed by Southern Psychiatry are subject to a $150 fee. This fee is not reimbursed by your insurance company and is due at the time of completion.

Initial: _____

Cancellation and/or No-Show Policy

Southern Psychiatry Associates requires a 24-hour notice to cancel or reschedule your appointment. New patients are charged $150, and existing patients are charged $150. The fee will be billed on the day of your appointment to the Credit/Debit Card on file. After the 3rd no-show, you may be released from our practice, and if requested a referral will be provided.

Initial: _____

Consent for E-Prescribing

I have been made aware and understand that Southern Psychiatry Associates may use an electronic prescription system that allows prescriptions and related information to be electronically sent between my providers and my pharmacy. I have been informed and understand that my providers using the electronic prescribing system will be able to see information about medications I am already taking, including those prescribed by other providers. I give my consent to my providers to see this protected health information.

Initial: _____

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that Southern Psychiatry Associates retains the ownership rights to the images and/or recordings. I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Initial: _____

Southern Psychiatry Associates

Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent to Southern Psychiatry Associates to use and disclose my protected health information to carry out treatment, payment, and healthcare 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 is not limited to: appointment reminders, insurance items, laboratory results, and calls about 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, or payment, to health care operations, as long as they are marked "Personal or 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:** _____

Southern Psychiatry Associates

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 be 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 authorize Southern Psychiatry to do a "pill count" at any time of my medication.
- 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 the evenings or on weekends.
- I agree that if my prescriber needs to change the pharmacy of my controlled substance for any reason, a $25 pharmacy change fee will apply before the prescription is sent in.
- 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 prescriber to view the PDMP at any time to determine my compliance.
- 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 uses Acutis 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. I also agree to pay any costs associated with urine testing.
- 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 Signature: _____ Date: _____

Physician Signature: _____ Witnessed By: _____

Southern Psychiatry Associates

If you are taking opioid pain medicines (ex: 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.

Initial: _____

Adult and Adolescent ADHD Agreement and Rules for Controlled Medications/Stimulants:

1. ADHD treatment will require testing with a clinical psychologist. You can search for resources online or by calling your insurance company.
2. Completion of Cambridge Testing will be required. SPA will email this test to you, or you can take this test in the office if you do not have access to a computer.
3. Vital signs and drug screens will be collected before the initiation of medication and every 6 months. Drug screens can also be requested at any time at the discretion of the provider.
4. In-office visits will be required at least every 6 months or at any time, at the discretion of the provider.
5. Patient must not be on any other controlled substances, any illegal substances, or drinking alcohol.
6. Patient must disclose any emergent use/prescription of controlled medications.
7. Patient must see Dr. Sadler within 4 weeks of initiation of controlled medications or dose increase; and at least once per year for an in-office follow-up.
8. No partial prescriptions will be called in or filled early for any reason.
9. No medication changes will be made over the phone or prior to 28 days from the last fill.
10. Medications can be held at any time by the provider for any reason described above or at the discretion of the provider.
11. Other rules and stipulations can be changed at any time at the discretion of the provider if safety concerns arise.

Patient Signature: _____ Date: _____

Provider's Signature: _____ Witness: _____

Southern Psychiatry Associates

CONSENT FOR TELEHEALTH SERVICES FOR SOUTHERN PSYCHIATRY ASSOCIATES

1. I understand that my healthcare provider wishes me to engage in a telehealth consultation.
2. My health care provider explained to me how the video conferencing technology that will be used to affect such a consultation will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
3. I understand that a telehealth consultation has potential benefits including easier access to care and the convenience of meeting from a location of my choosing.
4. I understand there are potential risks to this technology, including interruptions, unauthorized access, and technical difficulties. I understand that my healthcare provider or I can discontinue the telehealth consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
5. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
6. I understand that my healthcare provider can request that telehealth services not be used for appointments and that I must be seen in the office for a face-to-face appointment for multiple reasons.

Patient Signature: _____ Date: _____

Provider's Signature: _____ Witness: _____

Initial Assessment

Name: _____ Sex: M / F DOB: _____

List all prescriptions and 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**

Do you have any history or current alcohol addiction? **___ 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: _____

Patient Stress Questionnaire*

PHQ9 & GAD7

Name: _____ Provider _____

Date:_____ Birthdate_____

Over the ***last two weeks***, how often have you been bothered by any of the following problems?
(please circle your answer & **check the boxes that apply to you**)

	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've been moving around a lot more than usual	0	1	**2**	**3**
9. ☐ Thoughts that you would be better off dead, or ☐ hurting yourself in some way	0	**1**	**2**	**3**
		add columns:			**Total**

(10)

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 is 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 columns:				**Total**

(8)

*adapted from PhQ 9, GAD7, PC-PTSD and AUDIT 1/24/11

Southern Psychiatry Associates

Request for Release of Information

Patient Name: _____ Date of Birth: _____ Sex: M / F

S.S.N. _____ Medical Record #: _____

I Hereby Authorize Southern Psychiatry Associates to:

Release To: _____ **OR** Obtain From: _____

Address: _____

Phone #: _____ Fax #: _____

Purpose for Release:

( ) Moving Away ( ) Transfer of Care ( ) At Request of Patient ( ) For Patient Care

Describe the information that is being released:

( ) Office/Treatment Notes ( ) Lab Reports ( ) Diagnosis ( ) Medications

( ) Entire Medical Records ( ) Last Office Visit ( ) Other: _____

Indicate the dates of service that is to be released: _____

I understand that if my records contain documentation of alcohol abuse, psychiatric conditions, drug abuse, or communicable diseases, this information will be released as part of my record.

I understand that if the person or facility receiving this information is not covered by federal privacy regulations; this information will no longer be protected and may be re-disclosed.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment.

I understand that I may revoke this authorization at any time, but the revocation will not apply to information that has already been released. Note: The revocation must be in writing and delivered to the above address of the person/identity of whom was to release information.

I understand that unless revoked, this authorization will expire 30 days after the date signed.

I understand that there may be a charge for obtaining the requested information. Related charges can be obtained by contacting the office.

I understand that I have the right to obtain a copy of this authorization.

Patient Signature: _____ **Date:** _____