Preston Hollow Psychiatry, PLLC

Patient Registration and Consent for Treatment

This consent applies to a variety of patient situations. Due to practical limitations, alterations are not accepted. If you have any questions regarding this consent form, office management will be happy to assist you.

I. Consent for Treatment

I, _____, am presenting myself to Preston Hollow Psychiatry, PLLC (PHP) for evaluation, diagnosis and/or treatment of my medical condition. I give consent and authorize my physician(s) or his designees to order and/or perform all exams, tests, procedure, and any other care deemed necessary or advisable for the evaluation, diagnosis and treatment of my medical condition. This consent is valid for each visit I make to PHP, unless and until revoked by me in writing.

I acknowledge that PHP is committed to protecting the confidentiality of my medical record information in accordance with applicable laws and regulations. However in order to provide treatment to me and to conduct billing and other health care operation activities, PHP requires permission to disclose my medical records to certain individuals and entities. Therefore, I give consent and authorize PHP to disclose any or all of my medical record information, including but not limited to treatment information, insurance and other financial information and information about communicable diseases such as human immunodeficiency virus (HIV), and acquired immunodeficiency syndrome (AIDS), alcohol and substance abuse, mental health diagnosis and treatment, and laboratory test results ("Medical Records"), to the following individuals and entities:

--physicians and other health care personnel who are involved in providing, coordinating or managing my health care. Disclosure to these individuals occurs through the sharing of paper medical records and through access to electronic systems. I understand that my Medical Records will be accessible through an electronic medical record that permits access to others in the office of PHP and covering Physicians. All individuals with access to the electronic medical record must have proper security clearance and must comply with confidentiality policies restricting access to purposes related to patient care;

--my health insurance plan, Medicaid, Medicare, or any other person or entity that may be responsible for paying or processing payment for my medical treatment;

--employees, agents, representatives, volunteers or contractors of PHP for the purpose of conducting health care activities including but not limited to administration, billing, compliance, quality assurance, risk management, credentialing and any other appropriate health care facility activities or operation;

--any person or entity to whom I give written authorization to receive my Medical Records on a form provided by PHP or such other form acceptable to PHP; and

--any other person or entity that is required or permitted by law to have access to my Medical Records.

I understand that the disclosure of my Medical Records may be necessary before my insurer will pay for the cost of my medical treatment. I agree not to hold PHP, its agents or employees liable for any damages as a result of disclosing my Medical Records in accordance with this consent.

II. Assignment of Benefits/Causes of Action

In consideration of services rendered or to be rendered to the patient, I assign and transfer to PHP, up to the amount of my total financial obligation to PHP, all right, title and interest in benefits payable out of any third party action, or out of recovery under the uninsured motorist provisions or out of the medical payment provisions of any automobile insurance policy(ies), or out of any other insurance proceeds that I am entitled to recover. I further authorize PHP to pursue on my behalf any claim I may be entitled to pursue before the Crimes Victims Compensation Division of the Texas Industrial Accident Board in the event my treatment is necessitated by injuries received as the result of a violent crime, but in no event shall this be construed to be an obligation of PHP. I understand that this agreement in no way restricts me or my dependents' independent rights to pursue any such claim before the Crimes Compensation Division of the Texas Industrial Accident Board

III. Financial Responsibility

In consideration of services rendered or to be rendered to the patient, I accept financial responsibility and agree to pay for any and all charges and expenses incurred or to be incurred. I further understand that payment is due upon request. Unless PHP has a contract with my insurance carrier that states otherwise, I am responsible for my remaining balance after reasonable collection efforts have been pursued with my insurance company. If my account becomes delinquent and it is necessary for my account to be referred to attorneys or collection agencies, I will pay all charges that are my obligation, reasonable attorney's fees and other collection expenses.

IV. Federal and State Programs

If I am eligible for health care benefits under any federal or state program, including but not limited to Medicare or Medicaid, I certify that the information given by me in applying for payment under any such programs, including Title XVIII and XIX of the Social Security Act, is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or intermediaries or carrier any information needed for any federal or state program related claims. I request that payment of authorized benefits be made to PHP on my behalf. I understand that I am responsible for all applicable health insurance deductible and co-insurance amounts under these programs.

V. Accidental Exposure of Health Care Worker

I understand that Texas Law provides, and I give consent, that I may be tested for possible exposure to certain communicable disease, including but not limited to the human immunodeficiency virus (HIV), the virus associated with AIDS, hepatitis B and C, and syphilis. Such testing will be conducted pursuant to applicable laws and can include but is not limited to the following situation, 1) if a health care worker is exposed to my blood or other bodily fluid.

VI. Effect of Consent

By signing this Patient Registration and Consent for Treatment form (Consent), I acknowledge that I have read and understand the information contained in this Consent. I accept the terms of this Consent, either on behalf of myself as the patient, or on behalf of the patient as an authorized legal representative of the patient.

This Consent supercedes all prior consents or other authorization forms signed by me pertaining to the issues discussed herein. I acknowledge that signing this Consent is a condition of treatment by PHP, and alteration of and/or refusal to sign this form will result in denial of treatment. I understand that I may revoke this Consent at any time, except to the extent that PHP has initiated actions based on this Form. Any revocation of this Consent may result in termination of patient care in accordance with the state law.

If signing as the legal representative, I represent to PHP that I am the legal representative of the patient. Should my legal authority terminate, I agree to provide written notification to PHP.

Patient's Printed Name	Patient's Signature	Date
Legal Representative's Name	Legal Representative's Signature	Date

Preston Hollow Psychiatry, PLLC

Notice of Privacy Practices

Acknowledgement of Receipt Form

Your signature below indicates that you have been offered a copy of Preston Hollow Psychiatry, PLLC's Notice of Privacy Practices. If you have any questions about the Notice of Privacy Practices, please call the Preston Hollow Psychiatry, PLLC's Privacy Officer at 469-484-4260.

I have been offered the Notice of Privacy Practices.

_____

Patient Signature Date

_____

Print Patient Name Date

_____

Legal Guardian or Patient Representative Signature Date

_____

Print Legal Guardian or Patient Representative Date

_____

Relationship to Patient and Description

For Office Use Only:

Preston Hollow Psychiatry, PLLC will make a good faith effort to obtain a written acknowledgement of receipt of the Notice provided to the individual. If the patient is unwilling and or unable to sign this acknowledgment, Preston Hollow Psychiatry, PLLC must document its good faith efforts to obtain such acknowledgement and record the reason why the acknowledgement was not obtained.

Reason:_____

Notice Mailed to Patient Date:_____ Signature:_____

Patient Information Form

Name:_____ Hm Phone:_____ Wk Phone:_____

Address:_____ City:_____ State: _____ Zip Code:_____

Cell Phone:_____ Email Address:_____

Drivers Lic. Nbr:_____ Birth Date:_____ Soc. Sec. Nbr._____

Marital Status:_____ Employer:_____

Spouse's/Partner's Name:_____ Wk Phone:_____

How were you referred:_____

Whom may we contact in the case of an emergency:

Name:_____ Phone Nbr:_____

Name:_____ Phone Nbr:_____

Person responsible for payment: Self_____ Spouse_____ Other_____

****If spouse or other please complete the following section****

Name:_____ Relationship:_____

Address:_____ Home Phone:_____

City:_____ State:_____ Zip Code:_____ Wk Phone:_____

I understand and agree that (regardless of my insurance status), I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information in this packet and have completed the above answers. I certify this information is true and correct to the best of my knowledge. I will notify you of any changes in my status or the above information.

_____ _____

Signature Date

_____ _____

Parent (if minor) Date

Preston Hollow Psychiatry, PLLC

Check those that apply.

Race		
Caucasian ❑	African American ❑	Asian American ❑
Hispanic ❑	Native American ❑	Other ❑
Religion		
Protestant ❑	Catholic ❑	Jewish ❑
Muslim ❑	Hindu ❑	Other ❑
Residence		
house ❑	apartment ❑	room ❑
dormitory ❑	hotel ❑	hospital ❑
other ❑		
Gender	**Marital Status**	
female ❑	never married ❑	living cooperatively ❑
male ❑	Married/partner ❑	divorced ❑
Occupation	If married, how many times?	If divorced, how many times?
	1 2 3 Other	1 2 3 Other
	separated ❑	widow/widower ❑
	marriage annulled ❑	other ❑
Education (please specify highest level completed)		
High school and earlier (circle one)	College/university (circle one)	Graduate school (circle as many as apply)
6th or earlier 7th 8th	1 2 3 4/4+	MA/MS MBA JD
9th 10th 11th 12th	BA/BS None	MD PHD Other None

Please state the principal reason you are requesting a consultation or treatment.

If necessary, use another sheet of paper.

Please describe your illness from the time of your first symptom to the present. Provide as many dates, names, and addresses of psychiatrists, psychologists, and/or social workers who have treated you as you can. Also, please provide the kinds of treatment you have received, including names of medications and your response to them.

If necessary, use another sheet of paper.

Suicide

Check if you have ever thought about suicide. ☐

If "yes," when was the last time?

Check if you have ever attempted suicide. ☐

If "yes," when and how?

Check if you have thoughts about suicide now. ☐

Injury to Others

Check if you have ever thought about hurting someone else. ☐

If "yes," when was the last time?

Check if you have ever hurt someone else. ☐

If "yes," when and how?

Check if you are thinking about hurting someone now. ☐

Recent Stressful Life Events

Check any of the following events that have occurred during the last 2 years.

- married ☐
- engaged ☐
- separated ☐
- divorced ☐
- serious argument resulting in prolonged distress ☐
- breakup of important relationship ☐
- child left home ☐
- death of spouse, other ☐
- bad health (behavior) of family member ☐
- difficulties with family member ☐
- personal injury, illness ☐
- sexual difficulties ☐
- difficulties, changes at school or work ☐
- retired, lost job ☐
- changed residence ☐
- legal difficulties, multiple traffic tickets ☐
- owe considerable amounts of money ☐

Comments

Drinking (Alcohol Use)	
How many drinks do you consume in the average day?	
At what time of day do you have your first drink?	
What is the most you have had to drink in a 24-hour period during the last year?	
Check if you ever felt that you were, or someone told you that you were, drinking too much?	☐
If "yes," under what circumstances?	

Drugs of Abuse Check if you have taken any of the following drugs.	
none	☐
marijuana	☐
amphetamines/speed	☐
heroin/opiates	☐
PCP	☐
LSD/hallucinogens	☐
cocaine/crack	☐
barbiturates/sedatives/downers	☐
If you checked one or more of the drugs, under what circumstances did you take it(them)?	
When did you most heavily use drugs?	
When was the last time you took such drugs?	

Personal History Check any items that apply to you and explain.	
Mother's pregnancy with you was abnormal	☐
Mother's delivery of you was abnormal	☐
Check if during childhood you—	
were afraid to go to school	☐
had difficulty with reading, writing, or arithmetic/math	☐
were truant	☐
failed or repeated a grade	☐
had frequent falls	☐
were awkward at games	☐
wet bed after age 5	☐
had tics	☐
had trouble with eyes	☐
were(are) left handed	☐
mispronounced words, had a lisp, stutter/stammer	☐
had nightmares, disturbed sleep, fear of the dark	☐
ran away from home	☐
were cruel to animals	☐
often lied to families or others	☐
set fires	☐
moved often	☐
were exposed to incest	☐
were promiscuous	☐

Comments

Family History			Major Illnesses
Name	Age[1]	Occupation[2]	List all major illnesses, including psychiatric, neurologic, alcoholism, drug abuse, suicide, and suicide attempts.
Mother			
Father			
Brothers			
Sisters			
Children			
Grandparents, uncles, and aunts (relationship)			

[1]*Or if deceased, age at death.* [2]*Or if deceased, cause of death.*

Medical History

Weight and Height

What is your current weight in pounds? lbs.

Check if your weight has increased or decreased by more than 10 pounds during the last 5 years. ☐

If checked, explain circumstances.

What is your height in inches? in.

Sleep

Check if you—

have difficulty falling asleep ☐

have difficulty waking up and falling back to sleep ☐

are tired upon waking ☐

have bad dreams, wet bed, sleepwalk, or other sleep disturbances ☐

Smoking

Check if you smoke. ☐

If checked, how much and for how long?

Caffeine

Check if you drink coffee, tea or colas. ☐

If checked, how much?

Check if you believe you are sensitive to caffeine. ☐

Allergies

List all allergies. Be sure to include medication allergies.

Comments

Medical Problems	
Age when first occurred	List all past and present medical problems as well as any surgery or accidents.

Females–Menstrual History	
Check if your periods are irregular.	❑
If checked, explain.	
What is the duration of your periods?	
What is the date of your last period?	
Check if there is any pain or discomfort with your periods.	❑
Check if your moods, depression, irritability, and/or irrationality change with your periods.	❑
If checked, how?	
Check if you are taking an oral contraceptive.	❑
If checked, which one and for how long?	
If taking an oral contraceptive, check if it affects your mood.	❑

Comments

Current Medications and Dosages:

The terms "Preston Hollow Psychiatry, PLLC," "we" and "our" refer to Preston Hollow Psychiatry, PLLC, a professional limited liability corporation.

If you have any questions about this notice, please call the Preston Hollow Psychiatry, PLLC privacy officer at 469-484-4260.

Preston Hollow Psychiatry, PLLC is required by law to provide you with this notice and to abide by the terms of its current notice.

October 1, 2007

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

PLEASE REVIEW IT CAREFULLY.

WHAT IS THIS NOTICE?

This notice tells you:
How we use and release your health information. . Your rights concerning your health information. . Our responsibilities to protect your health information.

TO WHOM DOES THIS NOTICE APPLY?

This notice applies to all members and employees of Preston Hollow Psychiatry, PLLC.

WHAT ARE OUR RESPONSIBILITIES TO YOU?

Your health information is personal. We are required by law to protect the privacy of your health information and will only release your health information as allowed by law or with special written permission (authorization) from you. We use the least amount of health information needed to do our work. Only those who need your health information to provide services are allowed to use it. We protect your information whether verbal, on paper or electronic.

WHEN IS THE NOTICE EFFECTIVE?

This notice is effective on October 1, 2007. Preston Hollow Psychiatry, PLLC reserves the right to change this notice after the effective date. We reserve the right to make the revised notice apply for all health information that we already have about you, as well as any information we receive in the future. The current notice will be available on our Web site at www.PrestonHollowpsychiatry.com.

Business Activities - We may use or release your health information to perform internal business activities. Examples include: business planning, computer systems maintenance, legal services and customer service.

OTHER PURPOSES

Required By Law - Sometimes we must report some of your health information to legal officials or authorities, such as law enforcement officials, court officials, governmental agencies or attorneys. Examples include: reporting suspected abuse or neglect, reporting domestic violence or certain physical injuries, or responding to a court order, subpoena, warrant or lawsuit request.
Public-Health Activities - We may be required to report your health information to authorities to help prevent or control disease, injury or disability. Examples include: reporting certain diseases, injuries, birth or death information; information of concern to the Food and Drug Administration; or information related to child abuse or neglect. We may also have to report to your employer certain work-related illnesses and injuries so that your workplace can be monitored for safety.
Health Oversight Agencies - We may be required to release health information to authorities so they can monitor, investigate, inspect, discipline or license those who work in the health-care system, or for governmental benefit programs.

Activities Related to Death - We may be required to release health information to coroners, medical examiners and funeral directors so they can carry out their duties related to your death. Examples include: identifying the body, determining the cause of death, or, in the case of funeral directors, carrying out funeral preparation activities.
Organ, Eye or Tissue Donation - In the event of your death, we may release your health information to organizations involved with obtaining, storing or transplanting organs, eyes or tissue to determine your donor status.

HOW DO WE USE AND RELEASE YOUR HEALTH INFORMATION?

Preston Hollow Psychiatry, PLLC has to use and release some of your health information to conduct its business. The following section explains some of the ways we are permitted to use and release health information without authorization from you.

USE AND RELEASE OF YOUR HEALTH INFORMATION WITHOUT YOUR AUTHORIZATION:

TREATMENT PURPOSES
While we are providing you with health-care services, we may need to share your health information with other health-care providers or other individuals who are involved in your treatment. Examples include: doctors, hospitals, pharmacists, therapists, nurses and labs that are involved in your care.

PAYMENT PURPOSES
Preston Hollow Psychiatry, PLLC may need to share a limited amount of health information to obtain or provide payment for the health-care services provided to you. Examples include:
Eligibility – Preston Hollow Psychiatry, PLLC may contact the company or government program that will be paying for your health care. This helps us determine if you are eligible for benefits, and if you are responsible for paying a co-payment or deductible.

Claims – Preston Hollow Psychiatry, PLLC and businesses we work with share health information for billing and payment purposes. For example, your doctor must submit a claim form to get paid, and the claim form must contain certain health information.

HEALTH-CARE OPERATIONS PURPOSES
Preston Hollow Psychiatry, PLLC may need to share your health information in the course of conducting health-care business activities that are related to providing health care to you. Examples include:
Quality Improvement Activities – Preston Hollow Psychiatry, PLLC may use and release health information to improve the quality or the cost of care. This may include reviewing the treatment and services provided to you. This information may be shared with those who pay for your care, or with other agencies that review this data.

Health Promotion and Disease Prevention - We may use your health information to tell you about disease prevention and health-care options. For instance, we may send you health-care information on issues such as women's health, cancer or asthma.

Case Management and Referral - If you have a health problem or a health-care need is identified by you or one of your providers, you may be referred to an organization such as a home health agency, medical-equipment company or other community or government program. This may require the release of your health information to these agencies.

Appointment Reminders – Preston Hollow Psychiatry, PLLC may use your health records to remind you of recommended services, treatments or scheduled appointments.

Business Associates - There are some services provided at Preston Hollow Psychiatry, PLLC through contracts with business associates such as medical transcription services and record storage. We require business associates to protect your health information.

Audits – Preston Hollow Psychiatry, PLLC may use or release your health information to make sure that its business practices comply with the law and Preston Hollow Psychiatry, PLLC's policies. Examples include audits involving quality of care, medical bills or patient confidentiality.

Research Purposes - At times, we may use or release health information about you for research purposes; however, all research projects require a special approval process before they begin. This process may include asking for your authorization. In some instances, your health information may be used but your identity is protected.

To Avoid a Serious Threat to Health or Safety - As required by law and standards of ethical conduct, we may release your health information to the proper authorities if we believe, in good faith, that such release is necessary to prevent or minimize a serious and approaching threat to anyone's health or safety.

Military, National Security or Incarceration/Law Enforcement Custody - We may be required to release your health information to the proper authorities so they may carry out their duties under the law. This may be the case if you are in the military or involved in national security or intelligence activities, or if you are in the custody of law-enforcement officials.

Worker's Compensation - We may be required to release your health information to the appropriate persons to comply with the laws related to workers' compensation or other similar programs that provide benefits for work-related injuries or illness.

USE AND RELEASE OF YOUR HEALTH INFORMATION REQUIRING YOUR AUTHORIZATION

Persons Involved in Your Care - In certain situations, we may release health information about you to persons involved with your care, such as friends or family members. We may also give information to someone who helps pay for your care. You have the right to approve such releases, unless you are unable to function, or if there is an emergency.

WHEN IS YOUR AUTHORIZATION REQUIRED?

Except for the types of situations listed above, we must obtain your authorization for any other types of releases of your health information. If you provide us authorization to use or release health information about you, you may cancel that authorization in writing at any time. Any authorization you sign may be cancelled by following the instructions described on the authorization form. You may receive more information about this by contacting the privacy officer.

WHAT ARE YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION?

Preston Hollow Psychiatry, PLLC wants you to know your rights regarding your health information.

Right to Receive This Notice of Privacy Practices... You have the right to receive a paper copy of this notice at any time. You may obtain a copy of the current notice in all clinical areas or by visiting our Web site at www.kipqueenanmd.com.

Right to Request Confidential Communications... You have the right to ask that Preston Hollow Psychiatry, PLLC communicate your health information to you in different ways or places. For example, you can ask that we only contact you by telephone at work, or that we only contact you by mail at home. We will do this whenever it is reasonably possible. You can find out how to make such a request by contacting the clinic manager or the privacy officer.

Right to Request Restrictions...You have the right to request restrictions or limitations on how your health information is used or released. We have the right to deny your request. You may obtain information on

how to ask for a restriction on the use or release of your information by contacting the clinic manager or the privacy officer.

Right to Access - With a few exceptions, you have the right to review and receive a copy of your health information. Some of the exceptions include:

Psychotherapy notes;
Information gathered for court proceedings;
And any information your provider feels would cause you to commit serious harm to yourself or to others.

You can get a copy of your health information by submitting a request in writing to Preston Hollow Psychiatry, PLLC. The phone number is 469-484-4260. We may charge you a fee to copy and/or mail your health record to you. If you are denied access to your health record for any reason, Preston Hollow Psychiatry, PLLC will tell you the reasons in writing. We will also give you information about how you can file an appeal if you are not satisfied with our decision.

Right to Amend - You have the right to ask that Preston Hollow Psychiatry, PLLC's information in your health record be changed if it is not correct or complete. You must provide the reason why you are asking for a change. You may request a change by sending a request in writing to Preston Hollow Psychiatry, PLLC. The phone number is 469-484-4260. We may deny your request if:

We did not create the information;
We do not keep the information;
You are not allowed to see and copy the information; or
The information is already correct and complete.

Right to a Record of Releases - You have the right to ask for a list of releases of your health information by sending a request in writing to the privacy officer at the address at the end of this notice. Your request may not include dates before October 1, 2007. If you request a record of releases more than once per year, Preston Hollow Psychiatry, PLLC may charge a fee for providing the list. The list will contain only information that is required by law. This list will not include releases for treatment, payment, health-care operations or releases that you have authorized

WHAT CAN YOU DO IF YOU HAVE A COMPLAINT ABOUT HOW YOUR HEALTH INFORMATION IS HANDLED?

If you believe that your privacy rights have been violated, you may file a complaint with Preston Hollow Psychiatry, PLLC or with the Secretary of Health and Human Services. To receive help in filing a complaint with Preston Hollow Psychiatry, PLLC, you may contact our privacy officer at the address at the end of this notice. You will not be denied treatment or penalized in any way if you file a complaint.

PRIVACY OFFICER CONTACT INFORMATION

Preston Hollow Psychiatry, PLLC
Marty N. Bennett, MD – Privacy Officer
10000 N. Central Expressway, Suite 1420
Dallas, TX 75231
469-484-4260

Consent to Receive Text Messages from Preston Hollow Psychiatry Group

(Member's non-Lifeline Cell Phone)

By signing below, I authorize Preston Hollow Psychiatry Group through its vendor Practice Fusion to contact me by SMS text message to serve me better. Preston Hollow Psychiatry Group will send me text messages through Practice Fusion.

I understand that message/data rates may apply to messages sent through Practice Fusion to my cell phone and that I may receive up to 10 texts per month.
My text/mobile phone number is: (__) _____. Patient Initials_____

I know that I am under no obligation to authorize Preston Hollow Psychiatry Group to send me text messages as part of this program.

I may opt-out of receiving these communications from Practice Fusion at any time.

Name: _____

Signature: _____

Date: ____/_____/_____

Consent for Release of Information

_____ Date of Birth_____/_____/_____
Name (Last) (First) (Middle)

I hereby authorize:

Marty N. Bennett, MD
Preston Hollow Psychiatry Group, PLLC **Phone: 469-484-4260**
16479 Dallas Parkway, #320 **FAX: 469-484-4265**
Addison, TX 75001

To disclose/exchange records and/or information concerning the person named above to/with:

_____ (___)_____-_____ (___)_____-_____
Individual/Agency/Organization Phone Fax

_____
Address: Street, City, State, Zip Code

I understand that when the information I requested is given to or requested from the individual/agency/origination named above, they will know that the person is or has been receiving mental health services.
This disclosure of information is required for the following purposes: ☐ **Evaluation** ☐ **Treatment Plan**

☐ **Other:**_____

And shall be limited to the following types of information (check one or more):

☐ Discharge Summary(ies)	☐ Treatment Plan(s)	☐ Verbal Progress Report
☐ Clinical Assessments(s)	☐ Physician's Orders	☐ Comprehensive Diagnosis & Evaluation(s)
☐ Education Record(s)	☐ Psychiatric Evaluations(s)	☐ Social History(ies)

☐ **Other:**_____

The information to be release is for the services provided during the period (Specify exact or approximates):

From: _____ **To**_____

Understand that I may withdraw this consent at any time except to the extent that action has already taken. If not withdrawn, it shall end one year from the date of signature, unless another date, event or condition is specified below.

_____ _____
Signature of person receiving services Date

_____ _____
Signature of parent/guardian/managing conservator, if applicable Date

_____ _____
Signature of witness if person unable to sign (Document reason in progress notes) Date

No Show and Late Cancellation Policy

It is office policy to charge for any appointment that is missed or canceled with less than 24 hours of notice that you will not be keeping your appointment time. Please note that as a courtesy to you, the first time you either miss an appointment or fail to give a minimum of 24 hours notice of cancelation, the charge will on be $35. After that, missed or late cancellation appointments will be billed at $90 for the second missed appointment, then the full price of the appointment thereafter. For insurance patients, this fee is not covered by your carrier.

I have been given a copy of the No Show. Cancelation, and General Office Policy.

Signiture_____ Date_____/_____/_____

The Quick Inventory of Depressive Symptomatology (16-Item) (Self-Report) (QIDS-SR16)

Name or ID: _____ Date: _____

CHECK THE ONE RESPONSE TO EACH ITEM THAT BEST DESCRIBES YOU FOR THE PAST SEVEN DAYS.

During the past seven days...

1. Falling Asleep:

☐ 0 I never take longer than 30 minutes to fall asleep.

☐ 1 I take at least 30 minutes to fall asleep, less than half the time.

☐ 2 I take at least 30 minutes to fall asleep, more than half the time.

☐ 3 I take more than 60 minutes to fall asleep, more than half the time.

2. Sleep During the Night

☐ 0 I do not wake up at night.

☐ 1 I have a restless, light sleep with a few brief awakenings each night.

☐ 2 I wake up at least once a night, but I go back to sleep easily.

☐ 3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.

3. Waking Up Too Early:

☐ 0 Most of the time, I awaken no more than 30 minutes before I need to get up.

☐ 1 More than half the time, I awaken more than 30 minutes before I need to get up.

☐ 2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.

☐ 3 I awaken at least one hour before I need to, and can't go back to sleep.

4. Sleeping Too Much:

☐ 0 I sleep no longer than 7-8 hours/night, without napping during the day.

☐ 1 I sleep no longer than 10 hours in a 24-hour period including naps.

☐ 2 I sleep no longer than 12 hours in a 24-hour period including naps.

☐ 3 I sleep longer than 12 hours in a 24-hour period including naps.

During the past seven days...

5. Feeling Sad:

☐ 0 I do not feel sad.

☐ 1 I feel sad less than half the time.

☐ 2 I feel sad more than half the time.

☐ 3 I feel sad nearly all of the time.

Please complete either 6 or 7 (not both)

6. Decreased Appetite:

☐ 0 There is no change in my usual appetite.

☐ 1 I eat somewhat less often or lesser amounts of food than usual.

☐ 2 I eat much less than usual and only with personal effort.

☐ 3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

- OR -

7. Increased Appetite:

☐ 0 There is no change from my usual appetite.

☐ 1 I feel a need to eat more frequently than usual.

☐ 2 I regularly eat more often and/or greater amounts of food than usual.

☐ 3 I feel driven to overeat both at mealtime and between meals.

Please complete either 8 or 9 (not both)

8. Decreased Weight (Within the Last Two Weeks):

☐ 0 I have not had a change in my weight.

☐ 1 I feel as if I have had a slight weight loss.

☐ 2 I have lost 2 pounds or more.

☐ 3 I have lost 5 pounds or more.

- OR -

9. Increased Weight (Within the Last Two Weeks):

☐ 0 I have not had a change in my weight.

☐ 1 I feel as if I have had a slight weight gain.

☐ 2 I have gained 2 pounds or more.

☐ 3 I have gained 5 pounds or more.

The Quick Inventory of Depressive Symptomatology (16-Item) (Self-Report) (QIDS-SR16)

During the past seven days...

10. Concentration / Decision Making:

☐ 0 There is no change in my usual capacity to concentrate or make decisions.

☐ 1 I occasionally feel indecisive or find that my attention wanders.

☐ 2 Most of the time, I struggle to focus my attention or to make decisions.

☐ 3 I cannot concentrate well enough to read or cannot make even minor decisions.

11. View of Myself:

☐ 0 I see myself as equally worthwhile and deserving as other people.

☐ 1 I am more self-blaming than usual.

☐ 2 I largely believe that I cause problems for others.

☐ 3 I think almost constantly about major and minor defects in myself.

12. Thoughts of Death or Suicide:

☐ 0 I do not think of suicide or death.

☐ 1 I feel that life is empty or wonder if it's worth living.

☐ 2 I think of suicide or death several times a week for several minutes.

☐ 3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

13. General Interest

☐ 0 There is no change from usual in how interested I am in other people or activities.

☐ 1 I notice that I am less interested in people or activities.

☐ 2 I find I have interest in only one or two of my formerly pursued activities.

☐ 3 I have virtually no interest in formerly pursued activities.

During the past seven days...

14. Energy Level:

☐ 0 There is no change in my usual level of energy.

☐ 1 I get tired more easily than usual.

☐ 2 I have to make a big effort to start or finish my usual daily activities (for example, shopping, homework, cooking, or going to work).

☐ 3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

15. Feeling Slowed Down:

☐ 0 I think, speak, and move at my usual rate of speed.

☐ 1 I find that my thinking is slowed down or my voice sounds dull or flat.

☐ 2 It takes me several seconds to respond to most questions and I'm sure my thinking is slowed.

☐ 3 I am often unable to respond to questions without extreme effort.

16. Feeling Restless:

☐ 0 I do not feel restless.

☐ 1 I'm often fidgety, wringing my hands, or need to shift how I am sitting.

☐ 2 I have impulses to move about and am quite restless.

☐ 3 At times, I am unable to stay seated and need to pace around.

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.)

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