Dr. S. F. Hancock, DNP., ARNP, PMHNP-BC.
877-396-5133 / 888-POB-PSYC Fax: (520) 526-9962
customerservices@pobpsychiatry.com
www.pobpsychiatry.com

POB REGISTRATION- CONFIDENTIAL HISTORY - MUST BE FILLED BEFORE APPOINTMENT

Date _____________ Are You a New Patient? _________ Update_____________

Patient Information SS#_________________________ DL#________________

____
Patient's Last Name First Name Middle (MI) Date of Birth (DOB) Age

____
Sex: Male(M) Female (F) Other (O): Please Specify Marital Status (S, M, D, Separated)

____
Spouse Name, if married. List significant other here if you want them involved in your care

____
Street Address (Apt #)

____
Address (Include City, State, Zip code)

____
Primary Phone Alternate Phone Work / Cell Phone

____
Email Address

Is it Ok to do ALL or Any of the following: (Answer Yes or No) (on the Primary Phone #/ Email)?
Text ______ Call and Leave a Message on Answering Service ________
Send Email______ Call and Leave a Message with whoever picks up_______

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____
Who Referred You? Referred by (If Online, please tell us- E.g. Psychology Today, Yelp, Yahoo search engines etc.

____
Emergency Contact Name Relationship Phone #

____
Employer (If Unemployed -Type Unemployed and Status. E.g. SSI, Retired)

IF THE PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING FOR GUARDIANSHIP.

____
Mother's Name Her Date of Birth (DOB) Her Phone#
____
Father's Name His Date of Birth (DOB) His Phone#

____
Who Does Child Live With? Are parents living together? Yes OR No

____
Legal Guardian (Please provide copy of Court order)

Patient History

Reason for visit:
____
____
____
____
____
____

Are you allergic to any food or medicine? List them or write NA
____
____
____

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Please list any medications you are currently taking: (Dosages if possible)

Medicine Dosage Frequency For what?

____
____
____
____

Medications used before. Side effects and/no if they worked.

____
____

Any Surgical History / Medical Hospitalization(s)? (List below) **:** (Women do not need to add Normal pregnancies or childbirth) **Type NA if Not Applicable**

What Type? Year

____
____
____

Any Medical History? E.g. Asthma, Diabetics, Neurological etc. **Type NA if Not Applicable**

____
____
____

Have you had previous Psychiatric Treatment, Substance Abuse, Alcohol Dependence? Yes / No (If YES, List Where? Inpatient Hospitalization; Outpatient Hospitalization) **Type NA if Not Applicable**

Where? Reason Month/Year

____
____
____

Any family history for mental health, substance abuse or alcohol dependence?

____
____

The Following is Applicable Only to Female patients:

Date of last menstrual period___________________________ Method of contraception__________________________

Number of pregnancies____________________

Vaginal deliveries ___ Caesarean ____ Full term ____ Pre-term ____ Abortion___ Miscarriages____

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Social History

Do you drink alcohol?
Y / N / Used to? What? How much?
____
____

Do you smoke?
Y / N / Used to? What? How much?
____
____

Have you used or do you use recreational drugs?
Y /N / Used to? What kind?
____
____

Are you in group? E.g. NA, AA etc. (Yes / No) _______ How many times a week, a month) _________

Are you sexually active? Y/N______
Sexual Orientation_______________
Have you had flu shot? ___________
Over 65? Had Pneumococcal vaccine?
____
Concerned about your weight? _____

Last bloodwork? Date _____________

Health History: You & Your Family

Condition	You	Relative/Relationship
Mood DOs		
Psychosis		
Depression		
Anxiety		
Thyroid DO		
Obesity		
HBP		
Heart Disease		
Diabetes		
Back Pain		
Cancer		
Asthma		
High Cholesterol		
Kidney Disorder		
Eating DO		
Substance Abuse		
Alcohol Dependence		
Bipolar DO		
Developmental Delay		
Schizophrenia		
Other		

Psychiatric Medications used by relative known or NA
____
____
____

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Any history of the following?

Sexual abuse _____ Physical abuse _______ Violence ______ Trauma _________
Drug / Alcohol abuse_____ Parental Control______ Medical Problems ________________
Other _________________ ____________________ _______________ ________________

Sleep Hygiene:
Do you have problem falling. staying, or both? ____
Any Suicide Ideations or homicidal thoughts? Yes / No. When?
____
Any Intent or Plans? Yes/ No. Explain or NA:
____
____

Any history of the following?

Suicidal thoughts, attempts, plans ___ Self-harm ___ Depression ___
Loss of interest in sex ___ Violent or aggressive behavior ____ Seizures ___
Legal problems ____ Impulsiveness ____ Risky behaviors ____
Binge drinking ___ Appetite /weight gain /loss ____ Excessive anxiety ____
Delusions ____ Hallucinations ___ Memory disturbances ____
Laxative abuse ____ Self-induced vomiting ____ Insomnia _____
Hypersomnia ____ Hypervigilance _____ Startle _____
Using illegal(street) drugs ____ Excessive Use of prescription drugs ____

Name and Phone # of Previous Psychiatric Practitioner: (if any). If none, type NO
____
Date Last Seen: ___________________

May we contact your last practitioner Yes / No _____(If yes please complete the attached Authorization for Release of Medical Records so we may obtain Records)

Are you currently under the care of a primary care physician or a family nurse practitioner?
Name and phone # of Physician or Family Nurse Practitioner:
____
Date Last Seen:____________________

Authorization for Release of Information from Medical Records
Patient Name: ________________________ Birth Date: ____________
Date Requested: (Expires upon request by patient) ____________

I hereby authorize Pool of Bethesda™ Psychiatric Health to release/receive the following information from my medical record to/from: _____________

All APPLY UNLESS SPECIFIED
Complete Medical record or any part thereof ? Medical History (TYPE YES or NO) ____________
Psychological Report or Psychiatric Assessment (TYPE YES or NO) ____________
Laboratory Reports (TYPE YES or NO) ____________
Physician Orders or Progress Notes (TYPE YES or NO and which one?) ____________
Other (Please Specify) ____________

I understand and agree that the information I am authorizing to be released may include mental health information, HIV/AIDS test results, diagnosis, treatment and related information, drug test results, and genetic testing.
I further understand that I may revoke or cancel this authorization at any time by notifying the doctor's office in writing.
I give consent for providers and staff to text, Skype, or Face-time, and understand the integrity of security solely relies on the standard methods of the program's protocols.

To the Party receiving this information:
This information has been disclosed to you from records whose confidentiality may be protected by federal law. If so, federal regulations (42CFR part2) prohibits you from making any further disclosure of it without specific written consent of the person to whom it pertains. A general authorization for Release of Medical Information is not sufficient for this purpose.

I release and agree to hold **Pool of Bethesda™ Psychiatric Health,** its agents, employees and representatives harmless from all liability associated with the release of confidential patient information, I understand that **Pool of Bethesda Psychiatric Health** cannot be responsible for the use of re-disclosure by a third party.

Patient Print Name _________________________
Please type your name to sign below_________________________ Date ____________

☐ I am the parent/guardian of this patient

Witness Print Name _________________________
Please type your name to sign below _________________________ Date ____________

☐ I am the parent/guardian of this patient

Primary Insurance Information
If you are not insured, please type NA to ALL of the Questions
Patient Name: _________________________ DOB: ____________
Policy Holder's Name: _________________________ Policy Holder's Employer: ____________
Insurance: ____________ Insured S.S. # ____________
Relationship to Patient: (1)Self (2)Spouse (3)Child (4)Other: Specify ____________
Subscriber ID Number: ____________ Group Number: ____________

Thank you for choosing **Pool of Bethesda Psychiatric Health,** to service you and your family's behavioral health needs. We are pleased you chose us to provide your care. We will do our best to provide you with high quality care, respect and support in a non-judgmental way.
Please read our polices entirely and do not hesitate to ask for clarification**. Please initial each policy in the space provided to indicate that you have read and understand Pool of Bethesda Psychiatric Health policy on that subject.** If you have any concerns, please bring them to our attention immediately.

Office Hours:
Monday-Fri 9:00 am - 5:00 pm **mostly by appointment only**
Special Hours: Saturday / Sunday 9:00 am - 3:00 pm
(hours are subject to change)
https://www.pobpsychiatry.com/new-patient-registration-form/

Call-In Policy
To uphold the quality of care and fairness to all, provider will not take time out of appointments to accept or return patient's phone calls. **If you feel you must speak with your provider, please make an appointment to allow your provider to give you the care and attention you deserve.**

Please sign or print your name below stating that you understand our policy.

Please type your name to sign below ____________ Date____________

☐ I am the parent/guardian of this patient

Mark "X" before I.......

______I the undersigned, have insurance coverage with ____ **(Name of Health Plan)** and assign directly to **Pool of Bethesda Psychiatric Health** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges, whether or not paid by insurance. I hereby authorize the use of this signature, initials and/or electronic dating on all my insurance submissions. In cases where it is discovered that I am no longer eligible for insurance, I am automatically converted to CASH patient. I hereby authorize the use of this signature on all my expected / due payments. Whatever method of payment on record will be charged with the balance left or I will be billed via email/patient portal (if set up), or mail. I am expected to send such payment if method of payment (credit card) not billable due to lack of funds, I have up to 15 days to mail in check.

Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

OR

______ I the undersigned, do not have insurance coverage. I testify that I am a CASH ONLY patient and assign directly to **Pool of Bethesda Psychiatric Health** all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges. I hereby authorize the use of this signature, initials and/or electronic dating on all my expected / due payments. I hereby authorize the use of this signature on all my expected / due payments. Whatever method of payment on record will be charged with the balance left or I will be billed via email/patient portal (if set up), or mail. I am expected to send such payment if method of payment (credit card) not billable due to lack of funds, I have up to 15 days to mail in check.

Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

Assignment and Release

I certify that all information is true and accurate. You are required to notify the office of any changes if you are an insurance holder or cash only patients.

PLEASE PRINT YOUR NAME BELOW AS A SIGNATURE.
Please type your name to sign below _________________________ Date ____________

☐ I am the parent/guardian of this patient

Pharmacy Name, Address, Telephone# ____________

Notify your provider if you have any of the following:

1. Notify your provider if there are any significant changes in your psychiatric or mental condition.
2. Notify your provider if you suspect or know that you are pregnant, or plan to become pregnant in the near future. Pregnancy may affect your treatment recommendations.
3. If you feel you are at risk of hurting yourself or others, **please go immediately to the nearest ER and bring your hospital discharge paperwork with you to your next follow-up appointment.**
4. If your medication makes you drowsy or slows your reaction time, refrain from driving and notify your provider.
5. Notify your provider if your medications cause any significant side effects.
6. It is advised to not drink alcohol or do illicit drugs while taking psychiatric medications.
At this time, we require random blood/urine drug screens at the discretion of the provider if you are prescribed any controlled substances (sleep aids, ADD/ADHD, or anxiety medications).
7. We are here to help you, do not hesitate to call if you have any questions or concerns.

Please sign or print your name below.
Please type your name to sign below _________________________ Date ____________

☐ I am the parent/guardian of this patient

Email and Cell Phone/Texting Policy

Always be aware that email is not a confidential route of communication. We cannot guarantee that email messages will be received or responded to in a timely fashion. As such, email is not an appropriate way to communicate confidential or urgent information. Due to your privacy/confidentiality, this office will not conduct treatment through text or email messages. Conducting treatment via email/text, violates **Pool of Bethesda Psychiatric Health** commitment to privacy and confidentiality and may lead to misunderstanding. Our policy is to meet and discuss your question and concerns or possibly schedule a Tele-Psych meeting. Emails will only be used if our practice specifically requests specific information by email and is expecting it. **Pool of Bethesda Psychiatric Health** does not communicate by text except maybe to send appointment reminders. Texting is intrusive during sessions with other patients, is not guaranteed privacy/confidentiality, and is **NOT** a means of contacting the Provider.

Pool of Bethesda Psychiatric Health participates in meaningful use. These means that by providing your email address, you may automatically be registered for our patient portal. This will allow you to have 24/7 access to your medical records and patient information.

Please sign or print your name below stating that you understand our policy
Please type your name to sign below _________________________ Date ____________

☐ I am the parent/guardian of this patient

Telephone Policy
We take pride in answering your call-in person whenever possible. However, there are times when increased call volumes prevents us from speaking with you directly. We are a small office and our staff may not always be available to answer every phone call. Please leave a clear, short message with your name, phone number and a brief reason for your call on our answering machine. Office staff will contact you as soon as possible regarding your call, if necessary. If there is an emergency outside of office hours, call 911 immediately. If you get a recording, please:

- Do not call more than once per day for the same issue.

- Keep your message as brief as possible. Call 911 for urgent calls.

- Allow up to 48 hours for a call back.

- Mental health issues will not be addressed over the phone, unless it is part of the scheduled Tele-psychiatry experience. Please make an appointment.

- Office Staff will be polite and respectful. They deserve the same in return.

- Calls may be recorded for quality control purposes.

- **Abusive or nonstop calls are cause for termination of service. No shows over 2 consecutive ones are grounds for dismissal. All threats are reported.**

Answering Service
There is NO emergency answering service or on call psychiatric provider. In the event of an emergency or if urgent care is needed, please proceed to your nearest emergency room or call 911 for assistance. This office is only responsible for caring for your mental health concerns. As such, will not comment on primary care , pain management or otherwise.
Please sign here stating that you understand our policy
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

Office Courtesy
- Due to safety reasons, please consume all foods and beverages before getting in our waiting area. It will be best not to bring your children to your appointment, so that you and the clinician will be able to concentrate on your quality care. If you chose to bring your children to our office, it's your responsibility to keep your children safe.
- Patients under the age of 18 must be accompanied by a parent or legal guardian to each and every appointment. This is required to discuss the minor's condition, issues, progress, and treatment, as well as obtain authorization for treatment. If a parent or legal guardian is not present, the appointment will be cancelled, and the child will not be seen. When this occurs, a late cancellation fee will be assessed and must be paid before a follow up appointment will be made.
- Parents are responsible for their children's behavior, at all times, in the waiting room, restroom, and office. If a minor's behavior is deemed too disruptive by office staff, they will be asked to leave immediately. Any and all damages to our office will be billed to the parent. The appointment will be cancelled. When this occurs, a late cancellation fee will be assessed and must be paid before a follow up appointment will be made. No food or drinks are allowed in the office. No smoking. Our office is a non-smoking facility. No pets are allowed in the office, except for **service and emotional support animals**.

Please sign here stating that you understand our policy
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

Requests for Prescription Refills
We handle all refills during your regular scheduled appointments. If a medication refill becomes necessary, please provide us with your pharmacy phone number, medication name and how you are currently taking your medication. Note that **refill requests may not be honored if follow-up appointments have not been kept or scheduled.** We will require you to make an appointment, and then we will call in enough medication to last until your appointment. **We do not accept fax requests from your pharmacy**. You need to contact us directly for prescriptions refills. **There is a $100 fee for medication refill requests between appointments**. Controlled substances (stimulants or benzodiazepines) **WILL NOT BE REFILLED** until the date the prescription is due to run out **and you are attending your scheduled**

appointment. You understand that it is your responsible in ensuring that you are scheduled to see the provider before your medication runs out. No impromptu accommodation is provided as other patients are scheduled.
Please sign here stating that you understand our policy
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

Confidentiality
Your medical records are strictly confidential. For this reason, no information concerning you as a patient is released without your written consent. Disclosure of information to anyone such as another doctor, an attorney and/or a family member must be requested by written authorization by you, the patient. In an emergency when you, the patient, are at imminent risk of death or serious medical consequence, we will release minimal, critically relevant information to assist in preventing dire medical consequences that may result if that relevant information is not released. In the case of a minor, their legal guardian must sign the authorization. The clinician is legally bound to break doctor-patient confidentiality in cases of threat of harm to self or others and in reports of child or elderly abuse.
Please sign here stating that you understand our policy
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

Legal Testimony
Legal matters requiring the testimony of a mental health professional can arise, however, can be damaging to the relationship between a patient and his/her provider. As such, we recommend that you hire an independent forensic mental health professional for such services. **We DO NOT** provide court-related counseling/mental or behavioral health services. If we are subpoenaed to appear in court related matters charges will be $500 per hour (please pay upfront). You will need to find you own Forensic Psychiatrist/Psychologist if requested for any Court Related/Legal Matters.

Please sign here stating that you understand our policy
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

Maintaining Patient Status
In our area of healthcare, it is very important that you be seen on a regular basis. At the end of each appointment, you will be told when to schedule a follow-up appointment. We recommend you schedule your **follow-up appointment minimum 10 working days before your medication** runs out to get the most convenient time for you. If you fail to keep and/or maintain follow-up appointments for a period of 3 weeks or 2 months (whichever one comes first) or greater, we will assume that you have terminated the patient-provider relationship.

Please sign here stating that you understand our policy
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

Appointments
Initial visits are 60 to 90 minutes in duration to determine a diagnosis. After diagnostic evaluation, recommendations are made for your care. You are informed of treatment options, effectiveness, probabilities, risks and benefits, and cost. Follow-up appointments may be scheduled from 15 minutes to 30 minutes, depending on your needs, the service being provided, and the individual practitioner. We require that you follow-up regularly either in person or by video conference (as allowed by your health plan) to monitor your response to medications and adverse effects you may experience, if you are being treated. You must follow-up at least every 2 weeks at on-start, then 3-4 weeks subsequently or 2-3 months (at the provider's discretion) to qualify for continued medication, but some visits may occur using video conference. **There will be one courtesy confirmation call to remind you of your upcoming appointment**. You are

responsible for your scheduled appointments and will be responsible for any fees incurred from missed or late arrivals, regardless of any reason.

Please sign here stating that you understand our policy

Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

Payments/Financial Policy

Currently we are in network with several insurance companies, including Blue Cross Blue Shield, United Healthcare, Cigna, Medicare and Medicaid (please our website for full list of ALL the health plans). If your health plan is not listed please inquire by first calling your health plan, then letting us know. **It is your sole responsibility in ensuring that we are within your health plan network.** Please note that while we are credentialed with ACCESS, we may not be in network within the health plan which manages it. For example, as of the revision of this registration form, while we are credentialed with ACCESS, we are not in network with AzCOMPLETE. We are working expeditiously to credential our practice with other payers, but others may wish to be CASH ONLY patients, who will be informed to switch over to their health plans when credentialing is complete. Whatever is paid as their cash patients will not be reflected on deductible of health insurance once we are credentialed with your insurance. To ensure your account is fully paid, it will be your obligation. Secondary Insurance will ONLY be accepted if the EOB is forwarded to them from the primary insurance. We do not submit claims to secondary payers and cash balances not forwarded must be paid. **Our cash patients** are expected to make a payment (via online at least 5 - 10 days before the visit) before you are seen by a provider. If you owe deductibles and co-payment, you will be required to pay in full your outstanding bill before you are seen again. If you are unable to pay for your service, you will be asked to reschedule, whether you are on controlled substance or not. There is no guarantee that you will be seen on time, it is first come, first serve.

For your convenience, we accept cash, credit/debit cards (Visa, MasterCard, American Express and Discover). If a personalized letter is requested, an additional **charge of $ 35 (per letter)** will be applied depending on the extent of the letter needed/requested. The letter is at the sole discretion of the provider. Our relationship with you is that od trust, we ask that you abide by the payment policy. We understand you may be uncomfortable paying via internet. We have worked relentlessly to ensure that our website is secure. We therefore seek your cooperation in this matter

PLEASE NOTE THAT ALL FEES ARE NON-REFUNDABLE!

Please sign here stating that you understand our policy

Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

Prior Authorization/Quantity Overrides/Non-Formulary
Issues with Insurance Companies Regarding Medications

Our provider prescribes medication based on your condition/illness. Sometimes your insurance company limits the availability or free access to certain medications. The insurance company may want additional clinical information from the prescribing physician. These types of restrictions are between you and your insurance company.

- Due to increasing demand and the time-consuming necessity to complete the forms we will have to **charge $30.00** for each medication if it requires a prior authorization **and is due at time of the request**.

- **Letters of Medical Necessity if a Prior Authorization is denied** are **$50.00 per letter** that may need to be submitted **and is due at time of the request**. This charge does not guarantee that your insurance will approve coverage of medication. You will need to contact your insurance company if you are denied coverage of your medication. Please allow applicable processing time for your request. Prior authorizations will be handled in the order they are received and can take **10-14 business days** to be processed.

Please sign here stating that you understand our policy

Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

FMLA Forms/Medical Reports/Correspondence/Disability Forms
While medical reports to insurance companies and employers are necessary for you to access benefits, they are not medically necessary for your treatment. Therefore, we charge for these additional tasks. Please **allow 7 to 14 days** for completion of your requests after we have all the appropriate releases and/or information to complete the forms. We must have a signed release from you, the patient to release information to anyone else. This includes family members, other doctors, insurance companies, and employers. Please make sure you sign our release form at the time of your request. We must have clear instructions as to what method the information will be conveyed to the other party, i.e. fax, mail, telephone. We need complete fax numbers, phone numbers and/or addresses. There is a charge associated with medical records which is as follows **$50.00 for the first 20 pages, and $2.00 per additional page.** We require prepayment for these services. **We DO NOT Complete Disability Assessment/Determination Forms of Any Type.**

Please sign here stating that you understand our policy
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

FMLA forms $50 Letter $35. Please sign here stating that you understand policy
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

CONTROLLED SUBSTANCE POLICY

We are committed to doing all we can to treat your psychiatric illness. In some cases, sedatives benzodiazepines and/or psycho-stimulants may be prescribed. These medications are strictly regulated by both state and federal guidelines. This agreement is to protect both you and **Pool of Bethesda™ Psychiatric Health** providers by establishing guidelines, within the laws, for the proper controlled substance use. As part of your treatment, your provider may order these medications for you. Many of these medications can have serious side effects if they are not managed properly. Please read the following agreement **CAREFULLY** and ask your provider if you have any questions:

1. All controlled substances have a potential risk of dependency, addiction, abuse and side effects. You agree to follow exact dosing instructions prescribed by my healthcare provider.
2. You agree to keep all appointments required by your healthcare provider. If you miss an appointment, you understand that a follow up must be made before any prescriptions will be refilled or changed. If a prescription is stolen, it will be refilled with a copy of a filed police report of theft. If a prescription is lost, it will NOT BE REFILLED. It is your responsibility to keep track of your medications.
3. You agree to maintain **all prescriptions at the same pharmacy**, unless reasonable circumstances occur. Should the need arise to change pharmacies our office must be informed.
4. The prescribing provider has permission to discuss all diagnostic and treatment details with the dispensing pharmacists or other professionals who provide your health care for the purpose of maintaining accountability.
5. If the responsible legal authorities have questions concerning your treatment, as this might occur if you were obtaining medication at several pharmacies, all confidentiality is waived, and these authorities may be given full access to your records.
6. **Early refills will not be given**. Renewals are based on keeping scheduled appointments. Please do not phone for prescriptions after hours or on weekends. NO CONTROLLED SUBSTANCES WILL BE FILLED DURING EVENINGS, WEEKENDS OR HOLIDAYS **OUTSIDE OFFICE HOURS**!

Medication refills will only be addressed for patients that have kept scheduled appointments. It is important to keep your scheduled appointment to ensure that you receive timely refills. **Refills will NOT be provided if a scheduled appointment has been missed. Over consumption of controlled substance-medication prescribed whether once or more times is grounds for dismissal. If after checking the PDMP, and this provider discovers that you are receiving opioids concomitantly, this provider reserves the right to release you from the practice without medication coverage as it posts a risk. You agree that in this case, the provider may or may not provide 7 days coverage at the end of such dismissal. YOU WILL BE ENCOURAGED TO GO TO A FREE CLINIC, URGENT CARE OR ER IN YOUR NEIGHBORHOOD TO SEEK FURTHER ASSISTANCE. In very rare cases where a patient must be on both opioids and benzos, it is the sole responsibility of the patient to get a letter from pain management clinic or**

suboxone/methadone clinic that they are alright with patient being on both. Patient will have a choice to have his/her PCP or pain management clinic take over the management of the benzos for care continuity.
This provider reserves the right to seek alternative treatment other than controlled substance.

Please sign or print your name below.
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

7. You agree to not consume excessive amounts of alcohol in conjunction with prescribed controlled substances. Additionally, you agree not to purchase, obtain or use any illegal drugs; urine drug screens may be requested, and your cooperation is required. Presence of unauthorized substances will result in your discharge from services and the controlled substance not being filled by this provider.
8. If your healthcare provider is out of the office, you understand that prescriptions **will not** be filled until they return. **YOU WILL BE ENCOURAGED TO GO TO A FREE CLINIC, URGENT CARE OR ER IN YOUR NEIGHBORHOOD TO SEEK FURTHER ASSISTANCE.**
9. You affirm that you have full right and power to sign and be bound by this agreement, and that any misuse of my medications will be reported to the appropriate authorities and you will be terminated from this practice with very minimal refill e.g no more than 7 days of controlled substance, if at all, depending on the severity of situation.
10. **We will not prescribe any benzodiazepines if you are on any long-term pain medications, Methadone, or Suboxone. If you were placed on benzos alongside these medications, YOU WILL NOT BE SEEN BY OUR PEOVIDER(s), unless with a letter described above (and still at the discretion of the provider- in cases when the patient is already being tapered off).**
11. You agree that you have read and fully understand the controlled substance policy and that you CONTRACTUALLY AGREE NOT TO FILL PRESCRIPTIONS FOR ANY OTHER SEDATIVES, BENZODIAZEPINES or PSYCHO-STIMULANTS by another provider and any breach will result in termination of services per **Pool of Bethesda™ Psychiatric Health.**

Please sign or print your name below.
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

Controlled Substances
Controlled Substances (i.e., benzodiazepines, sedatives, and stimulants.) are very useful, but have potential for misuse; therefore, they are controlled by local, state and federal government. You, the client understand that the main treatment goal is to improve ability to function and/or work. In consideration of that**, you,** the client agrees to: Not-use illicit/recreational/experimental drugs. Patient **further** understands that using illicit/recreational/experimental drugs will impact progress and counter act with prescribed medications; continuous use after warning **can be cause for your care to be terminated immediately and may be reported to authorities.** We may randomly ask that all of our patient over the **age of 15 years old,** submit urine pregnancy and/or drug testing. This test is not mandatory, and you may refuse to have this test done, but the doctor may request it at any time for any patient and your cooperation is required. We participate in Arizona Prescription Drug Monitoring Program (Electronic-Arizona Online Reporting of Controlled Substances). This is a database tool we use to improve patient care by safe prescribing, in addition to reducing drug abuse and diversion.
Please sign here stating that you understand our policy
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

You have 24 hours before your appointment time to cancel or reschedule.

No-Show Policy
Follow-ups/previous patients:
1) After missing two appointments, you will receive a verbal warning.

2) If a 3rd appointment is scheduled, you will receive a warning letter and be **charged a $100.00 no show fee.**

3) After a 4th missed appointment the patient will be terminated by **Pool of Bethesda Psychiatric Health,** being referred to your health-plan for recommendations for other providers. This provider is not obligated to continue seeing you as there is a breach in provider-patient relationship.

Please sign here stating that you understand our policy
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

CONSENT FOR TREATMENT WITH PSYCHOACTIVE MEDICATIONS
It is my sole responsibility to ask questions and request more information if I need to regarding nature of the disease and all medications that will be prescribed to me, during my treatment at **Pool of Bethesda Psychiatric Health.** If I am not satisfied, I can refuse to accept any treatment including medications without negative actions on the part of staff. I am also aware that before leaving after each office visit, I have the right to ask questions regards to following:

- The nature of mental and physical condition, a description of the proposed course of treatment with medication(s) and the expected beneficial effects on condition, because of treatment with the medication(s).

- The probable health and mental health consequences of not taking medications, including the occurrence, increase or reoccurrence of symptoms of mental illness.

- The existence of generally accepted alternative forms of treatment, if any, that could reasonably be expected to achieve the same benefits as the medication(s) and why the physician rejects the alternative treatment.

- The fact that side effects of varying degrees of severity are a risk of all medications. The relevant side effects of the medication(s) being prescribed including any side effects which are known to frequently occur in most individuals; any side effects to which the individual may be predisposed; and the nature and possible occurrence of the potentially irreversible symptoms of tardive dyskinesia in some individuals taking neuroleptic medication in large dosages and/or over long periods of time; metabolic side effects such as weight gain and hyperglycemia including development of Diabetes Mellitus. The need to advice staff immediately if any of these side effects occurs.

Please sign here stating that you understand our policy
Please type your name to sign below ________________________ Date ____________

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WOMEN OF CHILDBEARING YEARS ONLY
Risks of using these medications in pregnancy including drug interaction which would interfere with the effectiveness of my birth control pill in current/future use, and the necessity to use alternate birth control measures. If pregnant or breast feeding, I agree to discuss with my obstetrician or pediatrician before starting the medication(s). It is my sole responsibility to receive complete explanation of psychoactive medication(s) before starting by means of: oral explanation or printed material and I understand that I may withdraw this consent at any time, refused to take certain medications and/ or can request for alternative treatment.

I have read, understood and I consent for treatment with psychoactive/psychotropic medications
Printed Name and Date ________________________
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
****You have the right to refuse to sign this Acknowledgement****
Pool of Bethesda Psychiatric Health has provided you a copy of its Notice of Privacy Practices. The Notice of Privacy Practices explains your privacy rights as a patient and includes a complete description of the uses/or disclosures of 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 the treatment
- Obtain payment for that treatment; Conduct normal healthcare operations

The Practice has explained to me that the Notice will be available to me in the future at my request and that I have a right to obtain a copy of the Notice prior to signing this consent. I have been encouraged to read the Notice carefully prior to my signing this consent. My signature below indicates that I have been provided a copy of the Notice of Privacy Practices by **Pool of Bethesda Psychiatric Health**. The Practice has given me the opportunity to ask any questions about this notice and all my questions have been answered. You acknowledge that you have received or been offered a Notice of Privacy Practices prior to any service being provided to you by Mind Health Psychiatry, and you consent to the use and disclosure of your medical information as set forth herein.

Please sign here stating that you understand our policy
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

If any of these risks occur, the treatment might need to be stopped.

- The consultation may be viewed by medical and non-medical persons for evaluation, informational, research, educational, quality, or technical purposes.
- I understand the examination may be videotaped for internal quality review or as might be required by my health coverage plan; however, the video images will only be used for those purposes unless further authorized below.
- I will not receive any royalties or other compensation for taking part in this telemedicine consult or associated with any use by **Pool of Bethesda Psychiatric Health**
- I understand I can make a complaint to management at **Pool of Bethesda Psychiatric Health**
- I understand I can make a complaint of my provider to the Arizona Board of Nursing by: calling (602) 771-7827 or by emailing a request to compliaints@azbn.gov.

I, the undersigned patient, do hereby understand and state that I agree to the above consent.

I certify that this form has been fully explained to me. I have read it or have had it read to me. I understand and agree to its contents.

Please sign here stating that you understand our policy
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

Informed Consent for Treatment
This consent applies to a verity 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 **Pool of Bethesda Psychiatric Health** for evaluation, diagnosis and/or treatment of my mental health. I give consent and authorize my provider(s) or his assignees to perform and/or perform all exams, test, procedure and any other deemed necessary or advisable for the evaluation, diagnosis and treatment of my mental

health condition. This consent is valid for each visit I make **Pool of Bethesda Psychiatric Health**, unless revoked by me in writing. I acknowledge that **Pool of Bethesda Psychiatric Health** is committed to protecting the confidentiality of my medical record information in accordance with applicable laws and regulations. However, to provide treatment to me and to conduct billing and other health care operation activities, **Pool of Bethesda Psychiatric Health** requires permission to disclose my medical records to certain individuals and entities. Therefore, I give consent and authorize **Pool of Bethesda Psychiatric Health** to disclose any of 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 personal who are involved in providing or managing my health care. Disclosure to these individuals occur through the sharing of paper medical records and through access to electronic systems, 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 **Pool of Bethesda Psychiatric Health** 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 which I give written authorization to receive my Medical Records on a form provided by **Pool of Bethesda Psychiatric Health** or such other forms acceptable to **Pool of Bethesda Psychiatric Health.**

- Any other person or entity that is required 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 **Pool of Bethesda Psychiatric Health,** its agents or employees liable for any damages as a result of disclosing my Medical Records in accordance with this consent.

II. FINANCIAL RESPONSIBILITY: (Cash Only / Self-pay)
Cost: New Patient- $$$ Inquire within for updates fees **Follow-ups-$$$$ Inquire within for updates fees**

In consideration of services rendered or to be rendered to the patient, I accept financial responsibility and agree to pay for all charges and expenses incurred or to be incurred. I further understand that payment is due upon request by **Pool of Bethesda Psychiatric Health. I am responsible for all my balance.** 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. I have received a copy of the practice policy.

III. FEDERAL AND STATE PROGRAMS:
Pool of Bethesda Psychiatry accepts Medicare and "some" Medicaid programs.

IV. PRACTICE POLICIES:
By signing the Patient Registration and Consent for Treatment form (Consent), I acknowledge that I have been offered a copy of the practice policies of **Pool of Bethesda Psychiatric Health.**

V. EFFECT OF CONSENT:
By signing the 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 supersedes all prior consents or other authorization forms signed by me pertaining to issues discussed herein. I acknowledge that signing the Consent is a condition of treatment by **Pool of Bethesda Psychiatric Health** and alteration of any/or refusal to sing this form will result in denial of treatment, I understand that I may revoke this consent at any time,

except to the extent that **Pool of Bethesda Psychiatric Health** has initiated actions based on the form. Any revocation of the consent may result in termination of patient care in accordance with the state law.
If signing as the legal representative, I represent to **Pool of Bethesda Psychiatric Health** that I am the legal representative of the patient. Should my legal authority terminate, I agree to provide written notification to **Pool of Bethesda Psychiatric Health.**

Please sign here stating that you understand our policy
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

Informed Consent for Treatment

I have read, initialed and understand the general policies and procedures of Pool of Bethesda Psychiatric Health
Printed Name: ________________________
Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

Relationship (if other than the patient): ________________________

By signing, I acknowledge that I will adhere and agree to all office policies. I am willing to continue with my evaluation or treatment.

Printed Name: ________________________

Please type your name to sign below ________________________ Date ____________

☐ I am the parent/guardian of this patient

Relationship (if other than the patient): ____________

OFFICE USE ONLY BELOW

Benefit Phone Number: ____________

Co-Pay Amount: ____________

DED Amount: ____________

Patient Health Questionnaire (PHQ-9)

	Not at all	**Several days**	**More than half the days**	**Nearly everyday**
1. Over the *last 2 weeks,* how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things				
b. Feeling down, depressed, or hopeless				
c. Trouble falling/staying asleep, sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching television.				
h. 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.				
i. Thoughts that you would be better off dead or of hurting yourself in some way.				
2. If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take	**Not difficult at all**	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
care of things at home, or get along with other people?				

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it's hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				

THE MOOD DISORDER QUESTIONNAIRE

	YES	NO
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?		
...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 you didn't really miss it?		
...you were much 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?		
3. How much of a problem did any of this cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please circle one response only.		
No Problem / Minor Problem / Moderate Problem / Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?		
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?		

PERSONALITY QUESTIONAIRE

Below are ten horizontal lines with four words on each line, one in each column. In each line, put the number "4" next to the word that best describes you in that line; a "3" next to the word that describes you next best; a "2" to the next best word, and a "1" by the word that least describes you. On each horizontal line of words, you will then have one "4", one "3", one "2", and one "1".

For example: One choice for the first line of words would be as follows:

3 Likes Authority 4 Enthusiastic 2 Sensitive Feelings 1 Likes Instructions

1. ____ Likes Authority	____ Enthusiastic	____ Sensitive Feelings	____ Likes Instructions
2. ____ Takes Charge	____ Takes Risks	____ Loyal	____ Accurate
3. ____ Determined	____ Visionary	____ Calm, Even Keel	____ Consistent
4. ____ Enterprising	____ Very Verbal	____ Enjoys Routine	____ Predictable
5. ____ Competitive	____ Promoter	____ Dislikes Change	____ Practical
6. ____ Problem Solver	____ Enjoys Popularity	____ Gives In To Others	____ Factual
7. ____ Productive	____ Fun-Loving	____ Avoids Confrontations	____ Conscientious
8. ____ Bold	____ Likes Variety	____ Sympathetic	____ Perfectionist
9. ____ Decision Make	____ Spontaneous	____ Nurturing	____ Detail-Oriented
10. ____ Persistent	____ Inspirational	____ Peacemaker	____ Analytical

AUDIT-C ASSESSMENT TOOL

Questions	0	1	2	3	4	Score
1. How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4 or more times a week	
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more	
3. How often do you have six or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily	
					Total	

Adult ADHD Self-Report Scale Symptom Checklist (ASRS-v1.1)

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months.	**Never**	**Rarely**	**Sometimes**	**Often**	**Very Often**
PART A					
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires an organisation?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
Part B					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you’re in a conversation, how often do you find yourself finishing the sentences of the people you are talking to before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn-taking is required?					
18. How often do you interrupt others when they are busy?					