***PSYCHIATRIC ASSOCIATES OF NC, PA***
***(please complete entire form so we may better assist you)***

***CLINICIAN:*** ____________________ ***Date of Appt:*** ________________

PATIENT NAME: _________________________________________________________
Last First MI

ADDRESS: ____________________________ CITY _______________ ST ______ZIP______

***Courtesy appointment reminders are sent via email 48 hours prior to your appointment***

***Email*** ________________________________________________________________

Home# __________________ Work #________________Cell # __________________________

Age __________ Birthdate ____________________ Sex ______ Marital Status ____________

Employer: _______________________ Occupation: __________________ Education:_________

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Person Responsible for Bill: _____________________________ Relationship: _________________

Spouse/Parent: ___________________ Address: ___________________________________________

Employer:________________________________ Work #____________________________________

Children (name/age): ____________________ ___________________ _________________

Siblings (name/age) : ____________________ ___________________ _________________

Nearest Relative not Living with You : _________________________ Phone _________________

In Case of Emergency call: _________________________________ Phone: ____________________

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Primary Physician: ____________________________ Phone ___________________________

Referred by: ____________________________________________

Current Medications: _______________________________________________________

Past Illness or Allergies _______________________________________________________

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Primary Insurance Co: ____________________________________________________________

(**If Your Mental Health is thru another company, please include that information as well.**) ________________

Customer Service PH #: ___________________Mental Hlth PH # if different: ______________________

Subscriber id # ___________________________________ Group # ______________________________

***(In order to file your claims, we MUST have the PRIMARY policy holders name and DOB-If you do not have this information, it will hold up your claim being sent in for payment)***

***Policy Holders Name:*** _______________________ Policy Holders SSN: _________________________

***Policy Holder DOB:*** ________________ Policy Holder Address: ________________________________

***SECONDARY INSURANCE AUTHORIZATIONS AND FILING ARE PATIENT'S RESPONSIBILITY***

***(our office DOES NOT file out-of-network insurance or secondary claims)***

# FINANCIAL POLICY

Thank you for choosing us as your psychiatric provider. We are committed to your treatment being successful. Please understand that payment of your bill is considered part of your treatment. The following is a statement of our Financial Policy, which we require that you read and sign prior to treatment.

*All patients must complete our INFORMATION FORMS before seeing the doctor. FULL PAYMENT is due at time of service. We accept cash, checks, visa or MasterCard.*

REGARDING INSURANCE:
Our policy varies according to type of insurance. Unless your insurance is one in which we accept co-pays, we require payment in full at time of service. You will be given a receipt in which you can file the insurance. If we are not a contract provider with your carrier, you are responsible for full payment. Deductibles will deny claims. If you have a calendar year deductible, you are responsible in paying each visit in full until you have met that obligation with the carrier. Co-payments are to be paid each visit. Please notify the office if you have a change in coverage. Authorizations for your first visit are your responsibility.

USUAL AND CUSTOMARY RATES:
Our practice is committed to providing the best treatment for our patients, and we charge the usual and customary rate for our area. You are responsible for payment, regardless of any insurance companies arbitrary determination of usual and customary rates or non-charges.

MISSED APPOINTMENTS:
Unless cancelled, at least 24 hours (business day) in advance, our policy is to charge the normal office visit rates, as your insurance will not pay for missed appointments. We do try to call you a day prior to confirm your appointment, but please realize that this is only a courtesy call. You are ultimately responsible for remembering your appointment day and time. Please help us serve you better by keeping your appointments.

STATEMENT OF ACCOUNTS:
Each visit, your check out receipt will show whether there is a balance due. Insurance sometimes take a while to collect. The office staff will notify you at your visit if there is a balance due.

Please let us know if you have any questions or concerns. I have read the policy and agree to the terms.

____________________________________ __________________

(Signature of Patient or Responsible Party) DATE

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***ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES***

## *SEE COPY IN OFFICE LOBBY*

***** You May Refuse To Sign This Acknowledgement*****

*I, __________________________________, have read or received a copy of this office's Notice of Privacy Practices.*

______________________________________
*{Please Print Name}*

__________________________________
*{Signature}*

______________________________________
*{Date}*

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***For Office Use Only***

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*We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:*

__ *Individual refused to sign*

__ *Communications barriers prohibited obtaining the acknowledgement*

__ *An emergency situation prevented us from obtaining acknowledgement*

__ *Other (Please Specify)*

# Psychiatric History of Present Illness

Patient Name Date of Birth

Please briefly describe your reason for seeking psychiatric treatment:

Please describe your symptoms (include duration, onset, triggers if any):

How are you functioning at home, work, school, etc?

If you are currently taking medications, what are they? Have the medications been helpful? Are there any side effects?

What are your current stressors?

Please answer yes or no to the following screening questions:

| Question | | |
|---|---|---|
| Do you feel depressed? | | Y/N |
| Are you experiencing changes in your sleep? | Y/N | |
| Are you experiencing changes in your appetite or eating habits? | Y/N | |
| Are you self-critical? | Y/N | |
| Do you have thoughts of death or suicide? | Y/N | |
| Do you cry frequently? | | Y/N |
| Are you having difficulty concentrating or remembering things? | Y/N | |
| Do you feel tired or withdrawn? | | Y/N |
| Have you lost interest in usually enjoyable activities? | | Y/N |
| Have you ever experienced a period of unusually elevated or extremely irritable mood? | Y/N | |
| Have you ever experienced decreased need for sleep? | Y/N | |
| Do you worry excessively? | Y/N | |
| Do you ruminate or obsess over certain ideas? | | Y/N |
| Do you feel the urge to do things to relieve your anxiety? | Y/N | |
| Do you have sleep disturbance? | | Y/N |
| Do you have muscle tension? | Y/N | |
| Do you have difficulty focusing? | | Y/N |
| Do you experience nightmares? | | Y/N |
| Do you often feel irritable or overwhelmed? | Y/N | |
| Do you ever have experiences that seem bizarre or unreal? | Y/N | |
| Do you experience things that others around you do not? | Y/N | |
| Do you have thoughts that others find unbelievable or bizarre? | Y/N | |
| Do you have difficulty with losing your place in conversation? | Y/N | |
| Do you have trouble focusing while reading or working? | Y/N | |
| Do you act impulsively or speak out of turn? | | Y/N |
| Do you struggle with lack of organization? | Y/N | |
| Do you have difficulty completing tasks or with procrastination? | Y/N | |

Do you consume far fewer calories than what you consider to be adequate? Y/N
Are you concerned about your weight? Y/N
Do you ever induce vomiting or use laxatives due to concern about your weight? Y/N
Do you have difficulty in relationships? Y/N
Do you struggle with intense emotions? Y/N
Do you think you perceive things differently than most other people? Y/N
Are you impulsive? Y/N
Are you easily frustrated? Y/N
Do you ever hurt yourself intentionally? Y/N
Do you use any drugs? Y/N
Do you drink alcohol? (if no, then skip the last 3 questions) Y/N
Do you feel the need to reduce your alcohol intake? Y/N
Do you feel guilty about your alcohol consumption? Y/N
Do you ever feel annoyed by others' comments about your drinking? Y/N
Do you ever need alcohol first thing in the morning? Y/N

# *PATIENT HEALTH QUESTIONNAIRE (PHQ-9)*

**NAME: ______________________________________DATE: ____________________**

**Over the last *2 weeks*, how often have you been bothered by any of the following problems?**

***(use "✓" to indicate your answer)***

| | | Not at all | Several days | More than half the days | Nearly every day |
|---|---|---|---|---|---|
| 1. | Little interest or pleasure in doing things | 0 | 1 | 2 | 3 |
| 2. | Feeling down, depressed, or hopeless | 0 | 1 | 2 | 3 |
| 3. | Trouble falling or staying asleep, or sleeping too much | 0 | 1 | 2 | 3 |
| 4. | Feeling tired or having little energy | 0 | 1 | 2 | 3 |
| 5. | Poor appetite or overeating | 0 | 1 | 2 | 3 |
| 6. | Feeling bad about yourself – or that you are a failure or have let yourself or your family down | 0 | 1 | 2 | 3 |
| 7. | Trouble concentrating on things, such as reading the newspaper or watching television | 0 | 1 | 2 | 3 |
| 8. | Moving or speaking so slowly that other people have noticed. Or the opposite – being so figety or restless that you have been moving around a lot more than usual | 0 | 1 | 2 | 3 |
| 9. | Thoughts that you would be better off dead, or of hurting yourself | 0 | 1 | 2 | 3 |
| | | Add columns: | | | |

**TOTAL:**

**(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card)**

| | | |
|---|---|---|
| 10. | If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all ____<br>Somewhat difficult ____<br>Very difficult ____<br>Extremely difficult ____ |

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