605 S. Lewis Street
New Iberia, LA 70560
(337) 465-1195

Date: ____________________

Patient's Full Name: ____________________ DOB: ____________

Address: ____________________ City: ____________ ST: ____ ZIP: ______

Cell (Text Reminders): ____________________ Alt Ph: ____________________

(You will receive a text reminder 24 hours prior to your scheduled appointment)

SSN: ____________________ Marital Status: single married widowed divorced separated (circle one)

Sex: ___ Male ___ Female

Primary Insurance

Carrier Name: ____________________ Member ID: ____________________

Policyholder Name: ____________________ DOB: ____________ Policyholder: ___ Self ___ Spouse

Secondary Insurance

Carrier Name: ____________________ Member ID: ____________________

Policyholder Name: ____________________ DOB: ____________ Policyholder: ___ Self ___ Spouse

Preferred Pharmacy

Pharmacy: ____________________ Phone: ____________________

Address: ____________________ City: ____________ ST: ____ ZIP: ______

Medication Allergies: ____

____

List Current Meds: ____

____

Primary MD: ____________________ PH: ____________________

Emergency Contact

Name: ____________________ Relation: ____________ PH: ____________

Name: ____________________ Relation: ____________ PH: ____________

Referral Information

Please tell us who we should thank for telling you about our service?

___ Patient ___ Physician ___ Facility ___ Print or other Ad Name: ____________________

____ ____________________

Signature of Patient **Date**

I understand that my signature is my attestation that the information that I have given is current and accurate.

Your Information. Your Rights. Our Responsibilities.

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.

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

Get an electronic or paper copy of your medical record	• You can ask to see or get an electronic or paper copy of your medical record and other health information we have about you. Ask us how to do this. • We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
Ask us to correct your medical record	• You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. • We may say "no" to your request, but we'll tell you why in writing within 60 days.
Request confidential communications	• You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. • We will say "yes" to all reasonable requests.

continued on next page

Your Rights *continued*

Ask us to limit what we use or share	• You can ask us **not** to use or share certain health information for treatment, payment, or our operations.
	  • We are not required to agree to your request, and we may say "no" if it would affect your care.
	• If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer.
	  • We will say "yes" unless a law requires us to share that information.

Get a list of those with whom we've shared information	• You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. • We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.
Get a copy of this privacy notice	• You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
Choose someone to act for you	• If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. • We will make sure the person has this authority and can act for you before we take any action.
File a complaint if you feel your rights are violated	• You can complain if you feel we have violated your rights by contacting us using the information on page 1. • You can file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting **www.hhs.gov/ocr/privacy/hipaa/complaints/.** • We will not retaliate against you for filing a complaint.

_____ Please Initial Here

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions.

In these cases, you have both the right and choice to tell us to:	• Share information with your family, close friends, or others involved in your care • Share information in a disaster relief situation • Include your information in a hospital directory • Contact you for fundraising efforts *If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety.*
In these cases we *never* share your information unless you give us written permission:	• Marketing purposes • Sale of your information • Most sharing of psychotherapy notes
In the case of fundraising:	• We may contact you for fundraising efforts, but you can tell us not to contact you again.

Our Uses and Disclosures

How do we typically use or share your health information? We typically use or share your health information in the following ways.

Treat you	• We can use your health information and share it with other professionals who are treating you.	***Example:*** *A doctor treating you for an injury asks another doctor about your overall health condition.*
Run our organization	• We can use and share your health information to run our practice, improve your care, and contact you when necessary.	***Example:*** *We use health information about you to manage your treatment and services.*
Bill for your services	• We can use and share your health information to bill and get payment from health plans or other entities.	***Example:*** *We give information about you to your health insurance plan so it will pay for your services.*

continued on next page

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How else can we use or share your health information? We are allowed or required to share your information in other ways – usually in ways that contribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html.**

Help with public health and safety issues	• We can share health information about you for certain situations such as:
	  • Preventing disease
	  • Helping with product recalls
	  • Reporting adverse reactions to medications
	  • Reporting suspected abuse, neglect, or domestic violence
	  • Preventing or reducing a serious threat to anyone's health or safety

Do research	• We can use or share your information for health research.
Comply with the law	• We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.
Respond to organ and tissue donation requests	• We can share health information about you with organ procurement organizations.
Work with a medical examiner or funeral director	• We can share health information with a coroner, medical examiner, or funeral director when an individual dies.

Address workers' compensation, law enforcement, and other government requests	• We can use or share health information about you:
	  • For workers' compensation claims
	  • For law enforcement purposes or with a law enforcement official
	  • With health oversight agencies for activities authorized by law
	  • For special government functions such as military, national security, and presidential protective services

Respond to lawsuits and legal actions	• We can share health information about you in response to a court or administrative order, or in response to a subpoena.

_____ Please Initial Here

Our Responsibilities

- We are required by law to maintain the privacy and security of your protected health information.
- We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information.
- We must follow the duties and privacy practices described in this notice and give you a copy of it.
- We will not use or share your information other than as described here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind.

For more information see: **www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.**

Changes to the Terms of This Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site.

This Notice of Privacy Practices applies to the following organizations.

How HIPAA[1] Allows Doctors to Respond to the Opioid Crisis

HIPAA regulations allow health professionals to share health information with a patient's loved ones in emergency or dangerous situations – but misunderstandings to the contrary persist and create obstacles to family support that is crucial to the proper care and treatment of people experiencing a crisis situation, such as an opioid overdose. This document explains how health care providers have broad ability to share health information with patients' family members during certain crisis situations without violating HIPAA privacy regulations.[2]

HIPAA allows health care professionals to disclose some health information <u>without</u> a patient's permission under certain circumstances, including:

- Sharing health information with family and close friends who are involved in care of the patient if the provider determines that doing so is in the best interests of an **<u>incapacitated or unconscious</u>** patient and the information shared is directly related to the family or friend's involvement in the patient's health care or payment of care.[3] For example, a provider may use professional judgment to talk to the parents of someone incapacitated by an opioid overdose about the overdose and related medical information, but generally could not share medical information unrelated to the overdose without permission.

- Informing persons in a position to prevent or lessen a **<u>serious and imminent threat to a patient's health or safety</u>**.[4] For example, a doctor whose patient has overdosed on opioids is presumed to have complied with HIPAA if the doctor informs family, friends, or caregivers of the opioid abuse after determining, based on the facts and circumstances, that the patient poses a serious and imminent threat to his or her health through continued opioid abuse upon discharge.[5]

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[1] "HIPAA" refers to the Health Insurance Portability and Accountability Act of 1996 and, for purposes of this guidance, the HIPAA privacy and security regulations.
[2] This guidance does not discuss the requirements of other federal or state laws that apply to individuals' health information, including the federal regulations that provide more stringent protections for the confidentiality of substance use disorder patient records maintained in connection with certain federally assisted substance use disorder treatment programs (42 CFR Part 2 implementing 42 U.S.C. §290dd–2). HIPAA does not interfere with other laws or medical ethics rules that are more protective of patient privacy.
[3] *See* 45 CFR §§ 164.510(b)(1)(i) and 164.510(b)(3).
[4] *See* 45 CFR § 164.512(j)(1)(i).
[5] HIPAA still requires that a disclosure to prevent or lessen a serious and imminent threat must be consistent with other applicable laws and ethical standards. 164.512(j)(1) . For example, if a state's law is more restrictive regarding the communication of health information (such as the information can only be shared with treatment personnel in connection with treatment), then HIPAA compliance hinges on the requirements of the more restrictive state law.

HIPAA respects individual autonomy by placing certain limitations on sharing health information with family members, friends, and others without the patient's agreement.

- For patients with decision-making capacity: A health care provider must give a patient the opportunity to agree or object to sharing health information with family, friends, and others involved in the individual's care or payment for care.[6] The provider is not permitted to share health information about patients who currently have the capacity to make their own health care decisions, and object to sharing the information (generally or with respect to specific people), *unless* there is a serious and imminent threat of harm to health as described above.[7]

HIPAA anticipates that a patient's decision-making capacity may change during the course of treatment.

- Decision-making incapacity may be temporary and situational, and does not have to rise to the level where another decision maker has been or will be appointed by law. If a patient regains the capacity to make health care decisions, the provider must offer the patient the opportunity to agree or object before any additional sharing of health information.[8]

  For example, a patient who arrives at an emergency room severely intoxicated or unconscious will be unable to meaningfully agree or object to information-sharing upon admission but may have sufficient capacity several hours later. Nurses and doctors may decide whether sharing information is in the patient's best interest, and how much and what type of health information is appropriate to share with the patient's family or close personal friends, while the patient is incapacitated so long as the information shared is related to the person's involvement with the patient's health care or payment for such care.[9] If a patient's capacity returns and the patient objects to future information sharing, the provider may still share information to prevent or lessen a serious and imminent threat to health or safety as described above.[10]

HIPAA recognizes patient's personal representatives according to state law.

- Generally, HIPAA provides a patient's personal representative the right to request and obtain any information about the patient that the patient could obtain, including a complete medical record.[11] Personal representatives are persons who have health care decision making authority for the patient under state law.[12] This authority may be established through the parental relationship between the parent or guardian of an un-emancipated minor, or through a written directive, health care power of attorney, appointment of a guardian, a determination of incompetency, or other recognition consistent with state laws to act on behalf of the individual in making health care related decisions.

For more information visit: https://www.hhs.gov/hipaa

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[6] *See* 45 CFR § 164.510(b)(2).
[7] *See* 45 CFR § 164.512(j)(1).
[8] *See* 45 CFR § 164.510(b)(2).
[9] *See* 45 CFR § 164.510(b)(1)(i).
[10] *See* 45 CFR § 164.512(b)(2).
[11] *See* 45 CFR § 164.502(g).
[12] *See generally* HHS Office for Civil Rights *Guidance on Personal Representatives* (providing a chart which explains who must be recognized as a personal representative and the legal exceptions applicable to unemancipated individuals and abuse, neglect and endangerment situations).

_____ Please Initial Here

HIPAA Helps Caregiving Connections

If you experience a substance use disorder, including opioid abuse, or a mental health crisis, HIPAA helps your doctors, nurses, and social workers to reconnect you with family, friends, and caregivers

If something has happened to you—an accident, injury, or overdose—HIPAA allows the EMTs, doctors, nurses, and social workers who help you, by notifying family, friends, or other caregivers about your location and general condition. First, your health care providers will determine whether you are able to agree to share this information or may have a personal representative to contact. If you are not able to make decisions or communicate due to incapacity (for example, if, following an opioid overdose, you are unconscious, delirious, or sedated), then your providers may use their professional judgment to determine that sharing certain information about your health condition is in your best interests. For example, if the health care providers know that your family, friends, or caregivers have been involved in your health care and you have not objected to the sharing of information with them in the past, your health care providers may contact those individuals and provide information that is needed for the purpose of notification (such as your location and general condition) or that is directly related to their involvement in your care or payment for care.

As another example, if you pass out while driving alone and are injured in a car accident, emergency medical personnel can use your identification and other personal information to find your family and notify them that you have been injured and are being transported to a nearby hospital. If you are conscious at the time of notification, they need tell you that's what they plan to do and give you the chance to object. On the other hand, if you are unconscious, they can make the notification without your permission, if they determine that it is in your best interests.

In another example, if you have a mental health condition and become disoriented or confused, so you are unaware of your surroundings or who you are, a police officer could contact the nearest hospital and the staff may call someone who has been your helping companion; or, if you are so disoriented that you are unable to make decisions, the medical staff may decide to check their records to find someone to contact on your behalf to find out more about your needs or health conditions, if they need the information to be able to care for you.

Being hurt or lost and unable to make decisions or communicate your needs is a difficult situation, and so is losing a sense of privacy about your personal health information, so HIPAA helps doctors, nurses, and social workers by allowing them to do what they do best: use their professional skill and judgment to find out what you want and need, and help reconnect you with those you know and trust--your family, friends, and others involved in your health.

_____ Please Initial Here

Patient HIPAA Acknowledgement and Consent Form

Patient Name: ______________________________________ DOB: _____________

______(Patient Initials) **Notice of Privacy Practices.** I acknowledge that I have received Vitality Addiction Solutions' (VAS) Notice of Privacy Practices which describes the way in which the practice may use and disclose my health information for its treatment, payment, and healthcare operations and other described and permitted uses and disclosures. I understand that this information may be disclosed electronically by the provider or the provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in VAS" Notice of Privacy Practices.

______(Patient Initials) **Release of Information.** I hereby permit Vitality Addiction Solutions (VAS), the practitioners and other professionals involved in my care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding prior treatment at other affiliated VAS facilities may be made available to subsequent VAS treating facilities for the purpose of care coordination or case management. Healthcare Information may be released to any person or entity liable for payment on the patient's behalf in order to verify payment questions or for any other purpose related to benefit payment. Healthcare information may also be released to my designee when the services delivered are related to a claim filed under Worker's Compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for laboratory reports, operative reports, physicians' progress notes, nurses' notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment, and discharge summaries.
- Federal and state law may permit this Vitality Addiction Solutions to participate in organizations with other healthcare providers, insurers, and/or other healthcare industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals that may include, but not be limited to improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information, aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that Vitality Addiction Solutions may be a member of one or more such organization. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information and/or conditions, chemical dependency conditions and/or infectious diseases including, but not limited to blood borne diseases such as HIV and/or AIDS.

Disclosures to friends and/or family members
DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHO?

I give permission to disclose my Protected Health Information (PHI) for the purposes of communicating results, finding treatment, care coordination, and decision-making to the individuals listed below:

Name	Relationship	Contact Number

Patient may revoke or modify this specific authorization and that revocation or modification MUST be in writing.

24-hour Cancellation & No Show Appointment Policy

Vitality Addiction Solutions provides a courtesy text to remind patients of their appointments. It is the responsibility of patient to call or cancel within **24 hours** of the scheduled appointment to avoid a no-show charge of $50.00 for follow-ups and $100.00 for new patients, to be paid in full by cash or credit card before the next visit can be scheduled. If your contact information changes between visits, it is the responsibility of the patient to contact our office to avoid any fees associated with a missed visit. Any outstanding fees must be paid before seeing **ANY** provider within the Vitality Addiction Solutions system.

There are circumstances in which exceptions may be made to this policy at the discretion of the administration.

After two (2) no-show appointments, the patient will be will be given warning of his or her discharge for non-compliance upon his or her third (3rd) no-show visit.

This policy is in place out of respect for our providers and for you, our patient. Cancellations with little notice are difficult to fill. By giving last minute notice, or no notice at all, you prevent someone else from filling that time slot. Please be courteous.

_____(Patient Initials) "No-Show" fees will be the responsibility of the patient. This fee is NOT covered by insurance and must be paid prior to your next appointment. Three or more "no-shows" in any 12 month period may result in termination from our practice.

By signing below, you acknowledge that you have read and understand the cancellation policy as described above by Vitality Addiction Solutions.

Thanks in advance for your kind cooperation.

_______________________________________ _________________

Signature Date

Credit Card Authorization Form (Keep on File)

Vitality Management Group **requires credit card information to be kept on file** for payment of all services and fees not covered by your insurance carrier. ***You must complete this authorization even if your office visits are covered completely by your insurance carrier, such as any of the Medicaid Bayou Health Plans.***

Fees can include, but are not limited to:

- Office visit fee
- Co-payment fee
- Insurance Deductible fee
- Late or No-show fee as per office policy
- Lab fee
- Office form request fee

A new form must be completed for each card kept on file. Vitality Addiction Solutions accepts Visa, Mastercard, Discover, and American Express.

Card Information

Card Type (Circle): Visa Mastercard Discover American Express

Name on Card: ______________________________

Card Number: ______________________________

EXP Date: ____________________ CVV: ____________________

Cardholder Signature: ____________________ Date: ____________________

A photo of your valid Driver's License or State or Federally issued Photo ID must accompany this form.

I authorize Vitality Addiction Solutions to charge the credit card listed above for payment of all services and fees. This credit card will be kept on file and will remain in effect until the expiration of the credit card account. Applicants may revoke this credit card authorization on file by submitting a written request to our corporate address at: Vitality Addiction Solutions, LLC, PO BOX 82599, Lafayette, LA 70598. A new form adding a credit card on file must be submitted if information such as credit card number, expiration date, or authorized user is amended. Applicant agrees to pay the cost for any returned or challenged payments.

Client Signature: ____________________ Date: ____________________

Informed Consent for Tele-Medicine Services

Patient Name: ____ Date: ________________

Address: ____

- I understand that tele-medicine is the use of electronic information and communication technologies by a healthcare provider to deliver services to an individual when he or she is located at a different location than the provider; and I hereby consent to allow Vitality Addiction Solutions to provide healthcare services to me via tele-medicine services.
- I understand that the law protects the privacy and confidentiality of medical information that also applies to tele-medicine services. As always, your insurance carrier will have access to your medical information for quality review/audit as well as for payment. Should you need access to your medical information, please contact our main office at (337)889-3682.
- I understand that I will be responsible for co-payments or co-insurances that apply to my tele-medicine visit.
- In the event of a technology failure, please contact our office to schedule an appointment. If you have an emergent need, please go to your nearest emergency room for assistance.
- I understand that I have the right to withhold or withdraw my consent to the use of tele-medicine in the course of my care at any time without affecting my right to future care or treatment.

If this consent is in force (has not been revoked). Vitality Addiction Solutions may provide healthcare services to me via tele-medicine without the need to sign another consent form.

____ ____________________________

Signature Date

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 could 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	____ +	____ +	____

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

TOTAL: ____________

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	________
Somewhat difficult	________
Very difficult	________
Extremely difficult	________

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A2663B 10-04-2005

Name: ______________________________ Date: ____________

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals ______ + ______ + ______ + ______ =

Total score ______

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. Forresearch information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Mood Disorder Questionnaire (MDQ)

Name: ______________________________ Date: ______________

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

	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 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 in 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? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, 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?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

Psychiatric Evaluation

Print Name: ______________________ Date: ____________

DOB: ______________________

Identifying Data: ______________________

CC: ______________________

HPI: ______________________

Vitals:

HT: ______ WT: ______

Specific trigger/ stressors: ______________________

Assoc. Sx: ______ Sx present / ↑ w/ recent new / upper stressors

______ Depression ______ Anxiety ______ Excessive worry ______ Panic attacks ↑ / ↓ Appetite

______ Helpless / hopeless / worthless ______ ↓ / poor / no energy ______ Anhedonia ______ Crying spells

______ Excessive daytime sleep ______ Sleep disturbance ______ Isolative ______ HI

______ Suicidal Thoughts (passive / no plan / plan) ______ Intent ______ Means

______ Self harm acts: Cutting / headbanging / other: ______________________

______ Mood swings / lability ______ Agitated/angered ______ Easily irritated ______ Restless

______ Aggressive: ______ Verbally ______ Physically ______ Explosive and/or destructive

______ **Manic SXS:** Euphoria / ↑ energy / risky behavior / rapid TH & speech / need for sleep (____HX/____freq/dur)

______ Hallucinations: AH / VH / TH ______ Delusions / Paranoia / Bizarre behavior

______ ↓ Memory ______ Forgetful ______ Easily distracted ______ ↓ Attention / Concentration / Focus

______ Procrastination ______ other ADHD behavior ______ Difficult task completion

______ Intensive thoughts ______ Obsessive thoughts / compulsions ______ Other

ALL OTHER ROS: ______ Negative ______ Other: ______________________

PAST PSYCH HX: Previous Psych DX: ______________________

Psychiatric Evaluation

Inpatient HX: ______________________________

Outpatient HX: ______________________________

Counseling: ______________________________

Suicide attempt HX: ______________________________

______ Cutting HX (______ or other self injurious acts) ______________________________

Substance HX:

______ Non-smoker ______ Smoker: ______ PPD X ______ Yrs ______ Smokeless Tobacco: ______ Yrs.

ETOH HX: ______________________________

Drug HX: ______________________________

Medical HX:

______ NKDA ______ Allergies/RX: ______________________________

____

____

Surgical HX: ______________________________

____

______ *Any personal (or FlyHX) of cardiac abnormalities or HX of abnormal cardiac conditions)

Current Medications:

____

____

____

Previous Medications Tried:

____

____

____

Psychiatric Evaluation

Social HX:

S / M / D / W ______ Lives alone ______ Lives w/: ______

Children: ______ Siblings, if child: ______

Education level: ______ Work HX: ______

Disabled: ______ Military HX: ______

Abuse HX:

______ Denies ______ Reports HX of: ______ Emotional ______ Physical ______ Sexual ______ Neglect

Legal HX: ______

School HX / Performance

(for children or adults currently attending)

Grade / School: ______ HX failed grades: ______

Current GPA: ______ HX of DX of learning disability: ______

Currently receives: ______ Special education ______ Additional aids, resources, IEP, other

Any suspensions/ expulsions for behaviors: ______

Developmental HX:

(for children only)

Pregnancy: ______ Term ______ Pre-term (______ weeks) Birth weight: ______

______ Complications ______ Developmental / milestones / delays

Family Psych HX:

Family HX of suicide: ______

Review of Systems

(Check if reviewed/ Negative unless circled; All other systems reviewed and negative unless otherwise noted)

___ **General:** Weight change fatigue fever chills night sweats
___ **Skin:** Itch rash lump bruises boil ulcer
___ **HEENT:** H/A sore throat vision changes dental caries/pain trauma neck pain
___ **Resp:** SOB wheeze cough hemoptysis asthma emphysema TB
___ **Cardiac:** Angina palpitation DOE orthopnea peripheral edema
___ **GI:** N/V diarrhea constipation pain dysphagia LBM: ______
___ **GU:** Dysuria incontinence retention pain/lesion frequency hematuria
___ **Ortho:** Muscle pain / Spasms joint pain lumbar pain cervical pain stiffness gout
___ **Neuro:** Seizures numbness tremors weakness dyskinesia aura EPS

Psychiatric Evaluation

Mental Status Exam

Appearance: ______ Alert/awake ______ Drowsy/sedated ______ Looks ↑ ↓ stated age

______ Weight appropriate/WNL ______ Overweight/obese ______ Underweight

______ Appropriate dress/groomed ______ Unkempt ______ Body odor ______ Appears manic

______ Sad/glum ______ Tearful ______ Anxious ______ Guarded ______ Bizarre

Mood:

______ Euthymic ______ Depressed ______ Elated/Euphoric ______ Irrtable/agitated ______ Other:

Affect:

______ Labile ______ Congruent ______ Depressed / Sad ______ Superficial ______ Constricted

______ Tearful ______ Incongruent ______ Worrisome / Anxious ______ Guarded / Flat ______ Bizarre / odd

Speech/Language:

______ Normal ______ Hyper-verbal ______ Pressured ______ Disjointed ______ Rambles

______ Slowed ______ Incoherent ______ Disorganized ______ Mumbled ______ Slurred

Thought Process:

______ Intact ______ Obsessive ______ Circumstantial ______ Worrisome ______ Racing / Delayed

______ Loose ______ Disorganized ______ Irrelevant / Illogical ______ Confused ______ Tangential

Risk of Harm:

______ No Risk ______ Passive th / wishes ______ Suicidal Thoughts N / Y Plan:

______ Convincingly agrees to satisfy contract ______ Intent ______ Access to means ______ -HI ______ +HI

Psychosis:

______ None ______ VH / TH / AH: ______ Non-commanding ______ Commanding: ____________________

______ Delusions ______ Paranoia ______ Grandiose / Bizarre ______ Persecutory ______ Somatic

Orientation: ______ Person ______ Place ______ Time ______ Situation

Memory: ______ Intact ______ Impaired (Immediate / Recent / Remote) ______ Cognitive Deficit

Knowledge: ______ Appropriate for education ______ Average ______ Above Average ______ Below Average

Attentiveness: ______ Intact ______ Fair ______ Limited ______ Impaired ______ Gravely impaired

Insight: ______ Good ______ Fair ______ Limited ______ Impaired ______ Gravely impaired

Judgement: ______ Good ______ Fair ______ Limited ______ Impaired ______ Gravely impaired

Behavior: ______ Appropriate ______ Shy ______ Anxious ______ Friendly ______ Hyperactive

______ Restless ______ Defiant ______ Odd ______ Withdrawn ______ Destructive ______ Manipulative

______ Demanding ______ Cooperative / Uncooperative ______ Compliant w/ meds / tx / visits ______ NC

Musculoskeletal: ______ Normal Gait / Strength / Tone ______ Other:

EPS / TD: ______ None ______ Positive

Signs of Intoxication or Withdrawl: ______ None ______ Positive

Psychiatric Evaluation

Assessment / Diagnosis

AXIS I: ______________________________

AXIS II: ______ Deferred or: ______________________________

AXIS III: ______ See PHMX or: ______________________________

AXIS IV: ______________________________

AXIS V: ______________________________

Plan of Care:

______ Educate patient (___ and parent / caregiver / or staff) re: medication instructions. Risks & benefits of medications, common SEs, Adverse Rxs, S/Sxs or SE of which to notify NP/MD immediately, or to seek Emergency care if NP/MD unavailable, including any worsening of symptoms such as depression, anxiety, agitation, or with any thoughts of suicide.

______ Patient to start (or continue) counseling with: ______________________________

______ Vanderbilt screening tools provided for both, parent and teacher, with instruction.

______ Other screening tool: ______________________________

______ Refer to psychology testing for: ______________________________

______ Refer to ______ medical ______ other: ______________________________

______ Lab work: ___ CBC ___ BMP/OPM ___ Liver Panel ___ TSH ___ Free T4 ___ Folate

___ Vit. D ___ B1 ___ B6 ___ B12 ___ Prolactin ___ CT of head w/o contrast

___ U/A w/ reflex ___ Valproic Acid ___ Lithium ___ Carbamazepine ___ Oxycarbazepine

Return in ______________________________
(or sooner, if needed)

____
Provider Signature

Therapy Add-On Note:

Today patient focused on: feelings of or about / Problems with or of:

**Therapist / Provider focused on:

_______ Assess type/severity of problem
_______ Gain insight /understanding
_______ Decrease symptoms
_______ Educate re: symptoms
_______ Decrease physical symptoms
_______ Address Substance abuse
_______ Other:

**Interventions Included

_______ Support
_______ Explore stress reduction techniques
_______ Encourage to vent feelings
_______ ID patterns / sources of behavior
_______ Confront & Reflect irrational beliefs
_______ IS sources of feelings
_______ Links to childhood experiences
_______ Validation

Melissa Guilbeau, PMHNP

Patient Name: ______________________________ Date: ______________

CPT	Description	CPT	Description	CPT	Description
99203	Eval New (30)	90832	Psych Ther (30)	90839	Psych Ther Crisis (60)
99204	Eval New (45)	90833	Psych Ther (16-37)	90853	Psych Ther Crisis (+30)
99205	Eval New (60)	90834	Psych Ther (45)	90785	Interactive Complexity
99213	Cont. Care (15)	90836	Psych Ther (45)	96372	Injection
99214	Cont. Care (25)	90837	Psych Ther (60)	80305	Urine Drug Screen
99215	Cont. Care (40)	90838	Psych Ther (60)	☐ IP	☐ Telemed/CV19
ICD-10	**Diagnosis**	**ICD-10**	**Diagnosis**	**ICD-10**	**Diagnosis**
F90.0	ADHD- Inattentive	F31.0	Bipolar Hypomanic	G24.01	Tardive Dyskinesia
F90.2	ADHD- Combined	F31.13	Bipolar Manic w/o Psy	F20.0	Schizophrenia Paranoid
		F31.2	Bipolar Manic w/Psy	F20.2	Schizophrenia Catatonic
F84.0	Autistic- D/O	F31.30	Bipolar Depressed	F20.9	Schizophrenia Undiff
F91.8	Other Conduct D/O	F31.4	Bipolar Dep w/o Psy	F25.0	Schizophrenia D/O BP
F84.9	Pervasive Dev. D/O	F31.5	Bipolar Dep w/Psy	F25.1	Schizophrenia Depressive
F63.81	Intermittent Ex. D/O	F31.63	Bipolar Mixed w/o Psy	F25.9	Schizophrenia Unspecified
F91.3	Oppositional Defiance	F31.64	Bipolar Mixed w/Psy	F29	Psychotic D/O NOS
F63.9	Impulse Control D/O	F31.81	Bipolar II	F40.01	Panic w/Agoraphobia
F51.05	Insomnia	F31.9	Bipolar D/O NOS	F40.10	Social Anxiety
F32.0	Depressive- Mild	F31.32	Bipolar I	F41.0	Panic w/o Agoraphobia
F32.3	Depressive- Severe	F43.11	PTSD	F41.1	General Anxiety
F32.9	Depressive D/O	F50.81	Binge Eating D/O	F41.9	Anxiety NOS
F33.1	Maj Dep/Rec/Mod	R63.0	Anorexia	F43.23	Adj D/O Mix Anx and Mood
F33.2	Maj Dep Re/Ser w/o Psy	F50.2	Bulimia Nervosa	F43.25	Adj D/O Mix Distur Emotion
F33.3	Maj Dep Re/Ser w/Psy	F14.20	Cocaine Use D/O	F93.0	Separation Anxiety
F34.1	Dysthymia	F19.99	Stimulant Use D/O	F42.9	Obsessive/Compulsive D/O
F11.20	Opioid Use D/O	F10.10	Alcohol Use D/O	F15.20	Amphetamine Use D/O
		F10.11	Alcohol Use D/O Remission	F12.90	THC Use D/O

Total Fee Paid: ____________ Follow Up Appointment: Telehealth: ____ weeks: __________

Office: ____ weeks: __________

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STOP HERE
Return
Paperwork
To Staff