QUALITY PSYCHIATRY

6800 NW 9th Blvd Ste 2
Gainesville, FL 32605

1717 SW Newland Way
Lake City FL, 32025

Phone: 352-478-4700
Fax: 352-225-3399

Psychiatry Intake Form

Today's date:_____

Name: _____Preferred Name: _____

DOB: _____ Race: _____ Ethnicity: _____

Gender Identity: _____ Preferred Pronouns: _____

Address: _____

Cell phone: _____ Home phone: _____

Email Address: _____

OK to message or leave voicemails: Yes No

Preferred local pharmacy:_____

Medication Allergies: _____

Reasons or Concerns for visit: _____

_____

_____

Medical History

What medications are you currently prescribed or taking? (Please include daily, as-needed or over- the-counter medications):

Medication	Reason	Adverse Effects

What medical conditions do you have?

_____

_____

_____

What prior surgeries have you had?

_____

_____

_____

History of head trauma/ TBI?

_____

_____

GYN History? (if applicable)

_____

_____

Do you have a primary care provider? If so, whom:_____
Approximate date of last blood work or physical exam: _____

Psychiatric History

Have you ever been seen by a psychiatrist, therapist or counselor? Please elaborate below:

Modality:	Was the treatment helpful?

Have you ever been hospitalized as a result of your mental health condition? (Inpatient, residential,etc)? If so, please specify where and when.

_____

_____

_____

_____

Have you ever had thoughts of harming yourself or suicidal thoughts, plan or attempts?

Previous Currently Never

Do you have firearms access? Yes No

Other than your current medications, have you taken any other psychiatric medications or supplements for the treatment of your mental health condition(s)?

Medication	Reactions? Was it helpful?

Substance Use History:

How often have you used the following substances?:

	Not Applicable	Date of last use	Number of times used in the last month
Tobacco			
Alcohol			
Marijuana			
Synthetic cannabis (K2, Spice)			
Cocaine			
Opioids (Percocet, Heroin, morphine, etc)			
Benzos (Klonopin, Xanax, Ativan, etc)			
PCP, LSD MDMA (Ecstasy)			
Caffeine			
Other			

Have you ever needed medical assistance/treatment for substance use?

_____

Social History

Relationship Status: Married Widowed Single Separated Partnered Divorced

If married, for how long? _____ Past marriages? _____

Home environment and people living in home:

_____

Do you have Children? If so, genders and ages: _____

_____

Highest level of education completed: _____

Student experience/grades_____

Occupation/place of work: _____

Retired: ___ Disability____ Unemployed____ Other_____

Other jobs/ careers you've had in the past: _____

_____

Would you describe yourself as a religious or spiritual person? Yes No

If so, what religion or belief system are you most closely aligned?

_____

Any cultural or identity influences on receiving care and daily life? Yes No

If so, briefly describe:

_____

Social Supports: (circle all that are available to you for support when you need it)

Family Friend(s) Community/social groups Faith/church Support Groups

Primary support(s) _____

Stressors (circle all that apply significantly):

Relationships friendships work/boss financial parenting family legal

Other stressors: _____

Any concerns regarding your safety? Home____ Work_____ Other_____

Are you free to leave situations or people as needed for your safety and wellbeing? Yes No

Have you had any past or current legal problems (arrests, DUI, filing reports/complaints against others)? If yes, please describe:

_____

Any history of being a party to or exposed to domestic violence?

Childhood _____ Adulthood _____ Currently _____

Any history of exposure to traumatic events? Yes No

Family History

Please list any biological relative who has been diagnosed with the following conditions. If adopted indicate under Other:

Substance Abuse Disorder: _____

Anxiety: _____

Depression: _____

Bipolar Disorder: _____

Schizophrenia/ other psychosis: _____

Autism Spectrum Disorder: _____

ADD/ ADHD: _____

Learning Difficulties: _____

Other: _____

_____

Safety

Are you currently experiencing thoughts of suicide?

_____

Do you have current thoughts of self-injury or taken action to self-injure without the intent to end your life? _____

Have you had suicide attempts in the past? If so, please include when and method:

_____

Have you physically harmed or tried to hurt others in the past?

_____

Are you currently or have you experienced any of the following (please check)?:

__ Low Energy

__ Poor focus/ Memory difficulty

__ Nightmares/ Problems Sleeping

__ Flashbacks/ Hearing or seeing things

__ Seeing things others don't see

__ Unusually good mood

__ Difficulty in maintaining work and social engagements

__ Abuse (physical, emotional, sexual)

__ Panic attacks

__ Anxiety

__ Fidgeting

__ Racing thoughts

__ Repetitive behavior

__ Anger

__ Relationship changes

__ Impulsivity control

__ Sexual concerns

Please list any additional information you believe is important here:

_____

_____

_____

_____

_____

_____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things.	0	1	2	3
2. Feeling down, depressed, or hopeless.	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much.	0	1	2	3
4. Feeling tired or having little energy.	0	1	2	3
5. Poor appetite or overeating.	0	1	2	3
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television.	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you 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 in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

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

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over 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's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

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

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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Acknowledgement and Authorization

Name: _____DOB:

- I have read and understand the HIPAA/Privacy Policy for Quality Neurology LLC.
- I acknowledge that Quality Neurology LLC participates in a two-way record sharing portal with other providers/pharmacies that will enable records/medications to be sent and viewed if you are a mutual patient, unless otherwise stated by patient not to portal share records.
- I hereby assign my insurance benefits to be paid directly to the Healthcare Provider.
- I authorize Quality Neurology LLC to release medical information required to process my claim.
- I have read and understand the Financial Policy for Quality Neurology LLC.
- I authorize Quality Neurology LLC to obtain access to my medication history.
- I give my consent for care and treatment provided by Quality Neurology LLC.
- Please select the appropriate consent to allow patient data exchange with the networks enabled through the Interoperability Hub

☐ Opted in: Send and Receive Documents Opted out ☐

By signing below, you acknowledge that you have read and understand the policies listed above.

_____

Patient Signature

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Exposure Notification

Letter to Patients about COVID-19 Exposure While Visiting Health Care Facilities

Dear Patient,

Exposure to other people, even those who do not have any symptoms, including health care providers, includes the risk of exposure to the COVID-19 Virus. The virus is thought to spread mainly from person to person, mostly between people who are in close contact with one another (within about 6 feet), through respiratory droplets produced when an infected person coughs or sneezes. The virus may also be transmitted when touching a contaminated surface and then touching your face.

Visiting health care facilities, like any other location where many people gather or visit, does create a greater risk of exposure to COVID-19 virus. Quality Neurology, LLC follows the Department of Health guidelines to reduce the risk of transmission of COVID-19 virus in hospitals and clinics.

Please be aware of symptoms including fever, sore throat, coughing, difficulty breathing, headaches and muscle aches. Please contact your primary care doctor if you have any of these symptoms and let your provider know that you have visited a health care facility.

By signing this letter, you acknowledge that Quality Neurology, LLC provides the option of Telehealth in lieu of in office appointments and cannot be held liable for possible exposure during your visit.

_____ _____

Patient Signature Date

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Authorization to Release Medical Information

I hereby Request and Authorize:

Lucas Beerepoot, MD, Lindsay Falk, APRN, Elizabeth Goldberg APRN, and/or Rachelle Sansing, APRN of Quality Neurology

To Obtain From: _____

_____

The Following Information: ☐ All PHI IN Medical Records

☐ Other: _____

From the Medical Records of:

Patient Name:

_____

Date of Birth:

_____

Last 4 Digits of Social Security Number:_____

For the Purpose of: Continuation of Care

All INFORMATION HEREBY AUTHORIZED, MAY BE OBTAINED FROM THIS AGENCY AND WILL BE HELD STRICTLY CONFIDENTIAL AND CANNOT BE RELEASED BY RECIPIENT WITHOUT MY WRITTEN CONSENT. I UNDERSTAND THAT THIS AUTHORIZATION MAY INCLUDE SENSITIVE INFORMATION, SUCH AS COMMUNICABLE DISEASES/INFECTIONS, ALCOHOL OR DRUG USAGE/ABUSE, AND PSYCHOLOGICAL ISSUES.

_____

Patient Signature Date

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The terms of this Notice of Privacy Practices ("Notice") apply to Quality Neurology LLC, its affiliates, and its employees. Quality Neurology LLC will share protected health information of patients as necessary to carry out treatment, payment, and health care operations as permitted by law. We are required by law to maintain the privacy of our patients' protected health information and to provide patients with notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of this Notice for as long as it remains in effect. We reserve the right to change the terms of this Notice as necessary and to make a new notice of privacy practices effective for all protected health information maintained by Quality Neurology LLC. We are required to notify you in the event of a breach of your unsecured protected health information. We are also required to inform you that there may be a provision of state law that relates to the privacy of your health information that may be more stringent than a standard or requirement under the Federal Health Insurance Portability and Accountability Act ("HIPAA").

USES AND DISCLOSURES OF YOUR PROTECTED HEALTH INFORMATION:

Authorization and Consent: Except as outlined below, we will not use or disclose your protected health information for any purpose other than treatment, payment or health care operations unless you have signed a form authorizing such use or disclosure. You have the right to revoke such authorization in writing, with such revocation being effective once we actually receive the writing; however, such revocation shall not be effective to the extent that we have taken any action in reliance on the authorization, or if the authorization was obtained as a condition of obtaining insurance coverage, other law provides the insurer with the right to contest a claim under the policy or the policy itself.

Uses and Disclosures for Treatment: We will make uses and disclosures of your protected health information as necessary for your treatment. Doctors and nurses and other professionals involved in your care will use information in your medical record and information that you provide about your symptoms and reactions to your course of treatment that may include procedures, medications, tests, medical history, etc. Quality Neurology participates in a two-way record sharing portal with other providers that will enable records to be sent and viewed if you are a current patient with them, unless otherwise stated by patient not to portal share records.

Uses and Disclosures for Payment: We will make uses and disclosures of your protected health information as necessary for payment purposes. During the normal course of business operations, we may forward information regarding your medical procedures and treatment to your insurance company to arrange payment for the services provided to you. We may also use your information to prepare a bill to send to you or to the person responsible for your payment. Quality Neurology may also share information with collection agencies, if we are unable to receive payment owed to us.

Other Uses and Disclosures: We are permitted and/or required by law to make certain other uses and disclosures of your protected health information without your consent or authorization for the following:

• Any purpose required by law;
• Public health activities such as required reporting of immunizations, disease, injury, birth and death, or in connection with public health investigations;
• If we suspect child abuse or neglect; if we believe you to be a victim of abuse, neglect or domestic violence;
• To the Food and Drug Administration to report adverse events, product defects, or to participate in product recalls;
• To your employer when we have provided health care to you at the request of your employer;
• To a government oversight agency conducting audits, investigations, civil or criminal proceedings;
• Court or administrative ordered subpoena or discovery request;
• To law enforcement officials as required by law if we believe you have been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law; • To coroners and/or funeral directors consistent with law;
• If necessary to arrange an organ or tissue donation from you or a transplant for you;
• If you are a member of the military, we may also release your protected health information for national security or intelligence activities.

RIGHTS THAT YOU HAVE REGARDING YOUR PROTECTED HEALTH INFORMATION:

Access to Your Protected Health Information: You have the right to copy and/or inspect much of the protected health information that we retain on your behalf. For protected health information that we maintain in any electronic designated record set, you may request a copy of such health information in a reasonable format, if readily producible. Records will not be emailed to personal email addresses but will be available for pick up in the office or mailed to recipient. Requests for access must be made in writing and signed by you or your legal representative. You may a "Patient Access to Health Information Form" from the front office person. You will be charged a reasonable copying fee and actual postage and supply costs for your protected health information. If you request additional copies you will be charged a fee for copying and postage.

Right to Notice of Breach: We take very seriously the confidentiality of our patients' information, and we are required by law to protect the privacy and security of your protected health information through appropriate safeguards. We will notify you in the event a breach occurs involving or potentially involving your unsecured health information and inform you of what steps you may need to take to protect yourself.

Paper Copy of this Notice: You have a right, even if you have agreed to receive notices electronically, to obtain a paper copy of this Notice.

For Further Information: If you have questions, need further assistance regarding or would like to submit a request pursuant to this Notice, you may contact the Quality Neurology LLC Privacy Officer by phone at (352) 478-4700 or at the following address: 6800 NW 9th Blvd Suite 2 Gainesville, Fl. 32605. This Notice of Privacy Practices is also available on our Quality Neurology LLC web page at www.qualityneurology.com

_____

Signature Print name Date

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Gainesville, FL 32605

1717 SW Newland Way
Lake City FL, 32055

Phone: 352-478-4700
Fax: 352-225-3399

QUALITY PSYCHIATRY

Medical Disclosure Form

Name:_____ DOB:_____

I hereby authorize the disclosure of my Quality Neurology medical information to the following individuals:

Name/Relationship:

_____

Name/Relationship:

_____

Name/Relationship:

_____

Emergency Contact *Please list name and phone number*

_____

Do you have an Advance Directive? ___ Yes ___ No

If yes, please provide name and contact information of designated individual.

_____

_____

_____

Patient Signature

QUALITY PSYCHIATRY

Quality Psychiatry Policies and Treatment Consent

Client's Rights and Responsibilities:

As a client you have the right to choose a provider who nest suits your needs and purposes. Please be advised that you may ask questions about treatment at any time, and you may also choose to terminate/end treatment at any time and for any reason. It is important that you read the professional disclosure statement and office policies below prior to selecting Quality Psychiatry for care to ensure that our practice will be a good fit for your needs. One of the most important influences for treatment success is the goodness-of-fit between practitioner and client. If a therapeutic match is not meeting your needs, we will be happy to provide you with resources for other mental health care professionals in your community.

Initials: _____

New Clients:

It is very important for your provider to have your initial client paperwork completed and available at the beginning of your initial appointment. The paperwork provides background information and context from which an appropriate evaluation of your concerns and a plan can be developed. If you have had blood work or an EKG in the past 6-12 months, it is wonderful to have copies of these as well. **Without complete intake paperwork, valuable appointment time is lost gathering this information rather than understanding your concerns and developing a plan of care with you**. Therefore, it is essential that you complete the intake forms and return them by the **end of the business day prior** to your appointment. Failure to provide this may result in your initial appointment being rescheduled, at the discretion of the provider.

Initials: _____

Emergencies and Crises:

Our office and providers work to check messages and calls during business hours and respond at our earliest availability. However, we are unable to intervene in crises and emergency situations during non-business hours. If you have a life-threatening emergency immediately call **911**(medical emergency), **988**(psychiatric emergency), the Crisis Hotline or go to the emergency room.

Initials: _____

Forms:

Completion of any forms needed will be determined on a case-by-case basis. Clients must have been seen in the last **30 days** and have engaged in regular appointments for a **minimum of 3 months** to have form completion considered. Forms may take up to 14 days to complete. Each form has a **$100 completion fee** and is due before the form is returned to the client. We **do not** complete disability claims, competency assessments, court related assessments. These are best done by specialists with training specific to those areas of need. If you have a question about a type of form you need completed, please feel free to inquire with your provider.

Initials: _____

Self-pay clients:

Upon request, you can be provided an itemized statement to submit to your insurance for out-of-network coverage. In many instances, you may be reimbursed for all or some of the portion of your visit**. New client appointments are $450, 60 minute follow up appointments are $350, 30 minute follow up appointments are $200.**

All clients:

Appointment times are reserved especially for **you**. We strive to begin our appointments as close as possible to your actual appointment time consistently so that you can count on us respecting your time. Therefore, no-shows, same day cancellations, or reschedules with less than 24 hours' notice will be charged a fee of **$100**. There will be no charge for cancellations made 24 hours in advance.

Late arrival for appointments will be considered a "No Show" or missed appointment after a **quarter of the appointment time** has passed with no contact being made. If extenuating circumstances occur and office is notified that arrival for appointment will be delayed, it is the discretion of the provider regarding availability of visit time or rescheduling the appointment. Clients who repeatedly arrive late/reschedule/No Show may be referred to another practice.

Initials: _____

_____

Printed Name

_____ _____

Patient Signature Date