New Patient Demographics

Date____________________

Patient Name____ DOB ________________________

Address____
(Street Address) (City, State, Zip Code)

Home Phone #______________________________ Cell Phone #___________________________________

Email____

Gender_____________ Marital Status _________________________________

Alcohol Use _________________ Tobacco Use ___________________ Illicit Drug Use __________________
(drinks/week) (cigarettes/day)

Work Information:

Employer Name_____________________________________ Occupation ___________________________

Employer Address ____

Work Phone # ______________________________________

Medical Information:

Referring Person ____________________________________ Phone # ______________________________

Primary Care Physician ____

Address ____ Phone # _____________________________

Emergency Contact Information:

Name ____ DOB ______________________

Phone # _________________________________ Relationship to Patient ___________________________

Why we are doing tele-psychiatry today:

Dr. Sher has been battling a condition called multiple sclerosis for over 20 years. This is a neurological illness that damages the part of the brain and spinal cord that controls walking, strength, and produces chronic fatigue. Due to the progression of this illness, she has decided to utilize tele-med or tele-psychiatry via a secure, HIPAA compliant video streaming service. She wanted to continue to treat and be there for her patients and this option gives her the best way to do so. Dr. Sher makes every effort to come into the office as much as her health condition allows. Psychiatry was Dr. Sher's calling and MS was the trigger. She loves what she does, and she enjoys helping those who want to overcome life's challenges. Because of her own personal struggles, Dr. Sher has developed a level of empathy that makes her a better doctor, mother, and psychiatrist. Please take this into consideration when joining our office and we appreciate your understanding in this matter.

If you have any questions or issues with this form of care, please let our front desk staff know and we will do our best to address any questions or concerns. Thank you for trusting us with your care and again, welcome to Sher Psychiatry & Associates. We look forward to seeing you today and we are excited about your brighter tomorrow.

I agree to meet with Dr. Sher in the office via Tele-Med video conference.

Patient Signature ____ **Date** ________________

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I authorize Sher Psychiatry staff to discuss my personal medical information with the following person(s) on my behalf. I understand that I can revoke this authorization at any time.

Name ______________________________ DOB ______________________

Address ______________________________ Phone # ______________________

Relationship to Patient ______________________

Name ______________________________ DOB ______________________

Address ______________________________ Phone # ______________________

Relationship to Patient ______________________

Name ______________________________ DOB ______________________

Address ______________________________ Phone # ______________________

Relationship to Patient ______________________

I authorize Sher Psychiatry staff to verify services and discuss my personal medical information with the following therapist(s) on my behalf. I understand my treatment plan may include mandatory therapy, per my prescriber's discretion, and my services with Sher Psychiatry may be terminated if I do not comply.

Name ______________________________ Organization ______________________

Address ____

Phone # ______________________ Fax # ______________________

Name ______________________________ Organization ______________________

Address ____

Phone # ______________________ Fax # ______________________

Patient Signature ______________________________ **Date** ______________________

(***Please sign even if you did not fill out anything above***)

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Controlled Substance Agreement

Controlled substance medication, i.e. stimulants, anxiolytics, sedatives, etc. can be helpful as part of your treatment plan, but they also come with a high potential for misuse, abuse, dependency and/or addition. Therefore, these medications are closely regulated and controlled by local, state, and federal government. These medications are intended to help with symptoms that result in distress and/or impairment of daily functioning and are only meant to be prescribed as part of your overall treatment plan. Sher Psychiatry providers often prescribe these controlled substances and therefore require patients agree to the following:

1. I am responsible for the controlled substance medication prescribed to me. If my prescription(s) are misplaced, stolen, or taken beyond the amount prescribed causing me to run out early, I understand that this medication **cannot be replaced** regardless of the circumstances.

2. Refills of controlled substance medication(s):
    a. Will be made only during regular office hours. Refills cannot be made after hours, during weekends, or holidays.
    b. I understand that I must schedule in advance accordingly prior to running out of my medication.

3. I agree to be evaluated for potential dependence at the discretion of my provider should they feel it necessary. I understand that if I do not attend such an appointment, my medication may be discontinued or may not be refilled beyond tapering dose completion.

4. I agree to comply with initial and subsequent toxicology testing (optional saliva or urine samples accepted) at the discretion of my provider. Sher Psychiatry utilizes Infiniti Lab for medication monitoring (covered by insurance) which allows providers to properly manage my medications and overall treatment plan effectiveness. Genetic testing is also available at Sher Psychiatry upon patients request (not typically covered by insurance) and can be discussed with your prescriber.

5. I understand that if I do not comply with any of the above conditions, my prescription(s) for controlled substance medication and/or my treatment with Sher Psychiatry may be terminated immediately. If the violation involves obtaining undisclosed medication or controlled substances from another provider/ individual or the combination of non-prescription/illicit drugs, I may also be reported to other providers, pharmacies, medical facilities, and/or the appropriate authorities.

6. I understand that the main treatment goal is to improve my ability to function and/or work. In consideration of this goal and the fact that I am being prescribed medication to reach my goal, I agree to help myself by following better health habits, exercise, weight control, and avoid the use of alcohol and excessive use of tobacco. I must also comply with the treatment plan as outlined and/or discussed by my provider(s), which may include mandatory therapy per my prescriber's discretion.

7. I understand that the advantages and disadvantages of long-term medication use may have yet to be scientifically determined and my treatment may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long-term use of controlled substances and that my prescriber will advise me of advances in the field and will make necessary treatment changes accordingly.

8. I understand that my failure to keep scheduled appointments with my therapist at Sher Psychiatry will be a violation of my treatment plan and my co-occurring appointments with my prescriber will be cancelled accordingly. Sher Psychiatry's model for treatment often involves counseling and medication management and therefore communication between those providers will be regular and ongoing.

9. I will inform Sher Psychiatry/my prescriber if I see another prescriber urgently (urgent care) or emergently (emergency room) or in any other medical office setting that dispenses controlled substances or medications in general. I will also notify Sher Psychiatry / my prescriber of the medication name, dosage, instructions, and quantity. I understand I must leave a message on the Sher Psychiatry voicemail if calling after office hours.

10. I will keep all appointments with my prescriber and/or therapist as scheduled. I understand if I continuously miss up to three appointments, my medication will be refilled for one month then my treatment at Sher Psychiatry will be discontinued/terminated.

11. I am not involved in the sale, illegal possession, diversion, and/or transport of controlled substances.

12. I will agree to participate in a program for chemical dependency should a problem be identified.

I am currently working with another specialist that provides me with controlled substances: **YES or NO**

Provider(s) Name ____________________

Organization ____________________ Phone # ____________________

Medication(s) Prescribed ____________________

I will sign a HIPPA release, so my specialist provider and Sher Psychiatry provider may exchange health information related to my treatment. I have been fully informed regarding psychological dependence (addiction) of controlled substance medication. I know that some individuals may develop a tolerance to the medication, necessitating a dose increase to achieve desired effect, and doing so increases the risk of becoming physically dependent on the medication. This may occur if I am on the medication for several weeks, months and/or years. Therefore, when I need to stop taking a medication, I must do so slowly and/or under the supervision of my prescriber or I may have withdrawal symptoms.

Patient Name ____________________ **Date** ____________________

Patient Signature ____________________ **Date** ____________________

Sher Psychiatry Employee Signature (witness) ____________________ **Date** ____________________

(Updated 11/1/17)

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