

Consent for Treatment:

Medication Management / Psychotherapy / Counseling +/or Assessment

I understand and voluntarily agree to participate in the evaluation and/or counseling through the above-named providers, I understand that I will be provided with an explanation of assessment and/or counseling procedures and their purposes.

I also give consent for treatment of medications, if indicated. And I understand that a reasonable explanation regarding treatment and medications will be provided.

Patients on controlled substances such as stimulants (i.e. Adderall, Ritalin), benzodiazepines (Ativan, Xanax), hypnotics (Ambien) and other potentially addictive medications, need close monitoring along with frequent follow-up. **These prescriptions cannot be refilled without an appointment** in order to comply with State and Professional regulations for usage of these medications.

For the first six months of therapy on medications, patients will be seen every month. After six months, and once symptoms are stable, based on assessment of use, patient’s appointments may be extended to every 8-12 weeks. Practice standards require all patients to be seen in person, at minimum, every three months. The exception to this is **patients on Stimulants (Adderall, Vyvanse) will be seen every month.**

X 

Signature of patient, or legal guardian

_____ Date

MEDICATION REQUESTS

Prescriptions are written to take the patient from appointment to appointment. If refills are needed in-between appointments due to missed appointments – there could be a fee of \$20.

Any medication requests need to allow 24-48 hours to be processed.

Please be aware of policy change in 2015 regarding controlled substances.

These may not be refilled without an appointment.

Initial Here: 

Financial Arrangements

As a courtesy, we will file your insurance claim for you. However, the information you provide us is important in filing the claim correctly. We cannot be responsible for any misinformation provided. Actual coverage and payment provided by the insurance company cannot be determined accurately until your insurance company provides an *Explanation of Benefits* (EOB).

You are responsible for any fees not covered or paid by your insurance carrier. It is your responsibility to ensure all preauthorization is received prior to any visit. Co-payments, deductibles, or any out-of-pocket expenses are **due at the time of service**, unless previous arrangements have been made with the office.

I hereby authorize this office to file my insurance on my behalf and assign all benefits to which I am entitled to the provider. I authorize release of any information necessary to process my claim.

I have read the above information, and I understand that I am financially responsible for all charges not covered or paid by my insurance carrier.

Initial Here:

As stated above, we do offer to file your insurance when appropriate. However, there are certain requests and services that are not covered by insurance, and thus would then be patient responsibility. Examples of some of these services:

* **letters** and/or **forms** to employers, insurance, or disability carriers... * **etc.**

All of these services require the time of the provider for which they need compensation. The patient may also be asked to schedule an appointment, which would allow them to clearly communicate the needs of these services.

I hereby confirm that I understand that requesting some of these services listed above may result in charges that fall to patient responsibility – due at the time of service.

Initial Here:

Emergencies

When you call our office after regular office hours, a voicemail will receive your call. You may leave a message to be handled when the staff returns, or if **your call is an emergency**; the voicemail will provide you with a number to our answering service. The answering service, in turn, will contact the doctor and have him/her return your call. Please be sure that you will be at the number you have given. Should you be unable to wait for the provider to contact you, please go to the nearest emergency room or call 911.

Again, it is stressed that these after-hours calls are for extreme situations, and not to be substituted for an appointment. The provider may charge the patient in such cases where it is determined that these privileges are being abused.

Initial Here:

Cancellation Policy

Your appointment represents a valuable period of time that obligated the presence of you and us. Should you need to change an appointment, please notify us at least 24 hours in advance, and please call if there is an emergency or other problem that prevents you from being at your appointment on time.

If you fail to provide 24-hour notification to this office of your intent to cancel or reschedule your appointment or if you miss an appointment without notifying this office, you will be charged a fee – MINIMUM OF \$50 - that will not be covered by your insurance carrier.

Your credit card information is required for this purpose.

I have read and understand the above information. Initial Here:

Credit Card Information and Policy

We do not accept American Express.

Name on Credit Card: _____

Credit Card Number: _____

Exp. Date: _____ Zip Code: _____ Three Digit Security Number: _____

With your permission this credit card information may also be on-file to pay your copay, co-insurance or patient responsibility for telehealth, early, or late-hour appointments.

Initial Here:

ACKNOWLEDGEMENT OF HIPAA

This signature confirms that the patient and/or patient guardian is aware that a copy of the HIPAA laws may be found in our lobby, and the patient could be provided a copy of their own upon request.

Patient/Guardian: _____
Please Print

Signature: X

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 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	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	_____