PATIENT REGISTRATION INFORMATION

Patient's Full Name: _____
Last First Middle/Maiden

DoB: _____ Age: _____ Sex: M / F Race: _____ Social Security No.: _____

Mailing Address: _____
Street City State Zip Code

Telephone Number: _____ Alternate Telephone Number: _____

Marital Status: _____ Spouse/Partner Name (if applicable): _____

Employment Status (Check what applies): __ Unemployed __ Disability __ Employed __ Retired __ Student __ Other

Pharmacy Name: _____ Phone: _____

Emergency Contact Information (or parent/guardian if patient is a minor):

Name: _____ Telephone Number: _____

Referred By: _____ Reason for Referral: _____

Insurance Information

Medicare Number: _____ Is Medicare your primary insurance? Y / N

Medicaid Number: _____

Primary Insurance Company: _____

Address/Phone Number: _____ / _____

Policy #: _____ Group #: _____

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Relationship to Patient: _____

Secondary Insurance Company: _____

Address/Phone Number: _____ / _____

Policy #: _____ Group #: _____

Insured's Name: _____ Insured's Date of Birth: _____

Insured's Relationship to Patient: _____

Psychiatric Services of Carolinas, PC

PAST MEDICAL HISTORY

Do you, now or have you ever had, any of the following:

Endocrine:	**Infectious/Inflammatory:**	**Neurological:**
☐ Hypo/Hyperthyroidism	☐ HIV/AIDS	☐ Epilepsy/Seizures
☐ Hypo/Hyperaldosteronism	☐ Systemic Lupus Erythematosus	☐ Huntington's Disease
☐ Hypo/Hyperparathyroidism	☐ Tuberculosis	☐ Wilson's Disease
☐ Diabetes	☐ Mononucleosis	☐ Head Trauma
☐ Vitamin B Deficiency	☐ Fibromyalgia	☐ Parkinson's Disease
☐ Hypoglycemia	☐ Temporal Arteritis	☐ Stroke/ TIAs
☐ Cushing's Disease	☐ Chronic Fatigue Syndrome	☐ Dementia
☐ Porphyria	☐ Cancer:	☐ Inner Ear Problems
☐ Folate Deficiency	☐ Group A Strep/Scarlet Fever	☐ Multiple Sclerosis
☐ Addison's Disease	☐ Syphilis	☐ Encephalitis
☐	☐	☐
Cardiovascular:	**Gastrointestinal:**	**Respiratory:**
☐ Heart Attack	☐ IBS	☐ Pulmonary Embolism
☐ Hypertension	☐ Crohn's Disease	☐ Asthma
☐ Mitral Valve Prolapse	☐ Ulcerative Colitis	☐ Pneumonia
☐ Coronary Artery Disease	☐ Ulcers	☐ COPD
☐ Congestive Heart Failure	☐ Pancreatitis	☐ Sleep Apnea
☐ Heart Arrhythmia	☐ Liver Disease	☐
☐ High Cholesterol	☐ Gallstones	**Eyes/Ears/Nose/Throat:**
☐ Heart Murmur	☐ Jaundice	☐ Seasonal Allergies
☐ Pacemaker/Defibrillator	☐ Hepatitis	☐ Glaucoma
☐	☐	☐ Vertigo
Reproductive:	**Kidney/Bladder:**	☐ Ear Infections
☐ Prostate Disease	☐ Uremia	☐
☐ Polycystic Ovaries	☐ Chronic Kidney Disease	**Other:**
☐ Problems with Menstruation	☐ Kidney Failure	☐ Electrolyte Imbalance
☐ Erectile Dysfunction	☐ Dialysis	☐ Pernicious Anemia
☐ **Last Menstrual Period:**	☐ Urinary Tract/Bladder Infections	☐ Pellagra
☐	☐	☐
☐	☐	☐
☐	☐	☐

Please check as appropriate. If other than what is listed, add to the bottom.

Drug Allergies: _____

_____

Surgeries: _____

_____

Chart # _____ Reviewed by Provider: _____

Psychiatric Services of Carolinas, PC

Social History			
Do you use tobacco products?	Past:	Current:	Never
Do you drink/use coffee/caffeine products?	Past:	Current:	Never
Do you drink alcohol?	Past:	Current:	Never
Do you abuse medications/street drugs?	Past:	Current:	Never
Do you exercise?	Yes: How often?		No
Do you use any form of birth control?	Yes:		No

Health Maintenance Screening Tests			
Test	Date	Office That Ordered Test	Result
Cholesterol/Lipids			
Fasting Blood Sugar			
Eye Exam			
Physical Exam			
Mammogram			
Colonoscopy			
Prostate Exam			
Bone Density Test			

Family Medical/Psychiatric History (grandparents, parents, siblings, children)			
	Family Member(s)		Family Member(s)
Heart Disease		Depression	
High Blood Pressure		Bipolar	
Sudden Cardiac Death		Anxiety/Panic Attacks	
Stroke/TIA		Schizophrenia/Psychosis	
Epilepsy		ADHD	
COPD/Emphysema		Obsessive-Compulsive	
Cancer		Dementia	
Parkinson's Disease		Mental Retardation	
Diabetes		Autism	
Thyroid Disease		Alcoholism	
Kidney Disease		Substance Abuse	
High Cholesterol		Fibromyalgia	
Anemia/Blood Disorders		Other:	

Current Doctors/Providers	Office Name	Last Appt.	Reason for Seeing

Chart # _____

Reviewed by Provider: _____

Psychiatric Services of Carolinas, PC

REVIEW OF SYSTEMS

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands/feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

Chart # _____

Reviewed by Provider: _____

Psychiatric Services of Carolinas, PC

MEDICATIONS

Current Medications

(Including prescribed, over the counter, and herbal medications, vitamins, and supplements)

Name	Dose/Frequency	Prescribed By

Past Psychiatric Medications

(Medications taken in the past for depression, bipolar, anxiety, etc.)

Name	Dose/Frequency	Response (Did it help? Did you have side effects? etc.)

Chart # _____

Reviewed by Provider: _____

Psychiatric Services of Carolinas, PC

CONSENT AND AUTHORIZATION FORMS AND POLICIES

I understand and agree that (regardless of my insurance status) I am ultimately responsible for the balance on my account for any professional services rendered. I certify this information to be true and correct to the best of my knowledge. I agree to notify the office of any changes in my health or health insurance status or any of the above information. I also grant permission to Psychiatric Services of Carolinas office to remind me of my scheduled appointments with the provider.

_____ _____

Patient/ Guardian Signature Date/Time

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

(To your insurance company for payment)

I authorize Psychiatric Services of Carolinas, PC to release my medical records and information needed for the purpose of insurance payments and authorizations.

_____ _____

Patient/ Guardian Signature Date/Time

AUTHORIZATION TO PAY

Patient's Full Name: _____

Last First Middle/Maiden

Relationship to Patient: _____ Responsible Party: _____

Insurance Company: _____

All professional services rendered are charged to the patient. As a courtesy, we will file with your insurance company regardless of whether or not we participate with your insurance plan to help expedite the payment. However, the patient (Guarantor) is responsible for all costs regardless of the insurance coverage. It is also expected that copayment be made at the time the services are rendered.

I hereby authorize Psychiatric Services of Carolinas, PC to furnish my information to my insurance carriers concerning my or my dependant's examinations and treatments and I hereby assign to the physician all payments for medical services rendered. I understand that I am ultimately responsible for all the charges as well as any and all amounts not covered by my insurance company.

_____ _____

Patient/ Guardian Signature Date/Time

_____ _____

Witness Signature Date/Time

Chart # _____ Reviewed by Provider: _____

Psychiatric Services of Carolinas, PC

ATTENDANCE POLICY

CANCELLATION OF AN APPOINTMENT:

In order to be respectful of the medical needs of our patients, please be courteous and call **Psychiatric Services of Carolinas, PC** promptly, if you are unable to attend an appointment. In order to best serve the needs of our patients, this time will be reallocated to someone who is in urgent need of treatment. If it is necessary to cancel your scheduled appointment, we require that you call **within 24 hours of your scheduled appointment time.** Appointments are in high demand, and your early cancellation will give another person the possibility to have access to timely medical care. Late cancellations will be considered as a "No Show". Failure to be present at the time of a scheduled appointment will be recorded in the patient's chart as a "No Show". After **3 "No Shows", you may be discharged from the practice** and referred to the local mental health facility. A copy of the letter to this effect will be placed in the patient's file.

LATE ARRIVALS TO APPOINTMENTS:

Due to the busy schedules of our providers in the office, for anyone who checks in late for his/her scheduled appointment, we will make every effort to accommodate you with the first available appointment. Be aware though, that you may not be seen by the provider that day and may be rescheduled. Late arrivals affect everyone involved, and are an inconvenience to the patients who arrive promptly and the providers who are delayed in seeing them.

_____ _____

Patient/ Guardian Signature Date/Time

MEDICATION(S) CONSENT FORM

By becoming a patient of a provider at Psychiatric Services of Carolinas, PC, I understand that medication(s) can be prescribed to me, myself, or _____ a person for whom I am the legal guardian and I consent to be prescribed medication.

It is recommended that women who are pregnant, who are breastfeeding, or who are trying to become pregnant discuss this with their doctor before taking any medications.

It is recommended that patients become educated on reporting all side effects they experience, including but not limited to which side effects to report immediately to a healthcare provider.

It is recommended that any provider prescribing medications obtain a thorough patient history that should include, but may not be limited to:

1. What medications (prescribed and over the counter) the patient is or has been taking.
2. What food/drug allergies the patient has.
3. What medical conditions the patient has.

Those patients who are prescribed controlled substances, including but not limited to benzodiazepines, stimulants, and/or Suboxone may be required to complete a drug screening on a routine or random basis. These patients may also be required to see the provider more frequently as these medications have a high potential for dependence and abuse and must be closely monitored.

_____ _____

Patient/ Guardian Signature Date/Time

_____ _____

Provider Signature Date/Time

Chart # _____ Reviewed by Provider: _____

Psychiatric Services of Carolinas, PC

CONSENT FOR TREATMENT

I hereby, voluntarily grant authorization for such treatment, procedures and other therapies that may be deemed necessary and recommended by my attending physician.

I consent for myself or on behalf of the patient named above the selection and assignment of a physician and/or clinician and agree to make arrangements with the physician and/or clinician for obtaining a complete diagnosis and continuation of treatment as needed.

I certify that I have read the above consent for patient treatment and fully understand it. I also certify that no guarantee or assurance has been made to me as to the results that may be obtained from this treatment.

Patient/Guardian signature_____ Date _____

PATIENT'S RIGHT TO REFUSE TREATMENT

Patients must be notified the right to refuse treatment per 10A NCAC 27D .0303 (INFORMED CONSENT). Each voluntary client or legally responsible person has the right to consent or refuse treatment/habilitation in accordance with General Statute 122C-57 (RIGHT TO TREATMENT AND CONSENT TO TREATMENT). A voluntary client's refusal of consent shall not be used as the sole grounds for termination or threat of termination of service unless the procedure is the only viable treatment/habilitation option available at the facility. Per G.S. 122C-57 each voluntarily admitted client or the client's legally responsible person (including a health care agent named pursuant to a valid health care power of attorney) has the right to consent to or refuse any treatment offered by the facility. Consent may be withdrawn at any time by the person who gave the consent. If treatment is refused, the qualified professional shall determine whether treatment in some other modality is possible. If all appropriate treatment modalities are refused, the voluntarily admitted client may be discharged.

Per G.S. 122C-51 (CLIENTS' RIGHTS AND ADVANCE INSTRUCTION), it is the policy of the State to assure basic human rights to each client of a facility. These rights include the right to dignity, privacy, humane care, and freedom from mental and physical abuse, neglect, and exploitation. Each facility shall assure to each client the right to live as normally as possible while receiving care and treatment.

It is further the policy of this State that each client who is admitted to and is receiving services from a facility has the right to treatment, including access to medical care and habilitation, regardless of age or degree of mental illness, developmental disabilities, or substance abuse. Each client has the right to an individualized written treatment or habilitation plan setting forth a program to maximize the development or restoration of his capabilities.

Patient/Guardian Signature:_____ Date:_____

Chart # _____

Reviewed by Provider: _____

Psychiatric Services of Carolinas, PC (*Psychiatric & Counseling Services*)

MEDICATION(S) CONSENT FORM

By becoming a patient of a provider at Psychiatric Services of Carolinas, PC, I understand that medication(s) can be prescribed to me, myself, or_____a person for whom I am the legal guardian and I consent to be prescribed medication.

It is recommended that women who are pregnant, who are breastfeeding, or who are trying to become pregnant discuss this with their doctor before taking any medications.

It is recommended that patients become educated on reporting all side effects they experience, including but not limited to which side effects to report immediately to a health care provider.

It is recommended that any provider prescribing medications obtain a thorough patient history that should include, but may not be limited to:

1. What medications (prescribed and over the counter) the patient is or has been taking.
2. What food/drug allergies the patient has.
3. What medical conditions the patient has.

Those patients who are prescribed controlled substances, including but not limited to benzodiazepines, stimulants, and/or Suboxone may be required to complete a drug screening on a routine or random basis. These patients may also be required to see the provider more frequently as these medications have a high potential for dependence and abuse and must be closely monitored.

_____ _____
Patient/ Guardian Signature Date/Time

_____ _____
Provider Signature Date/Time

CONSENT FOR TREATMENT INCLUDING EMERGENCY MEDICAL TREATMENT

I hereby, voluntarily grant authorization for such treatment, procedures and other therapies that may be deemed necessary and recommended by my attending physician. I also grant permission to seek emergency medical care from a hospital or physician as well as the Mobile Crisis Units which may be deemed necessary and appropriate by my attending physician.

I consent for myself or on behalf of the patient named above the selection and assignment of a physician and/or clinician and agree to make arrangements with the physician and/or clinician for obtaining a complete diagnosis and continuation of treatment as needed.

I certify that I have read the above consent for patient treatment and fully understand it. I also certify that no guarantee or assurance has been made to me as to the results that may be obtained from this treatment.

Patient/Guardian signature_____Date _____

Chart # _____ Reviewed by Provider: _____

Psychiatric Services of Carolinas, PC

AUTHORIZATION FOR RELEASE OF INFORMATION

Patient Name: _____ DoB: _____

Many of our patients allow family members such as spouse, parents, or others to call and request appointment dates/times, billing information, and/or medication information Under the Health Insurance Portability and Accountability Act (HIPAA) requirements, we are not allowed to give this information to anyone without the patient's consent. If you wish to have your appointment dates/times, billing information, and/or medication information released to family members you must sign this form. Your signing this form will only give information to family members indicated below.

Additionally, the HIV/AIDS related conditions statue for protection mandates that the information will only be released in accordance with G.S. 130A-143 (CONFIDENTIALITY OF RECORDS) and the statues for Substance Abuse include "Once information is disclosed pursuant to this signed authorization, I understand that the Federal Health Privacy Law 45 CFR Part 164 (PRIVACY OF INDIVIDUALLY IDENTIFIABLE HEALTH INFORMATION) may not apply to the recipient of the information and, therefore, may not prohibit the recipient of the information from re-disclosing it". Other laws, however, may prohibit re-disclosure. When information is released from this agency protected by state law (NC G.S. 122C) or substance abuse treatment information protected by federal law 42 CFR, Part 2 (CONFIDENTIALITY OF SUBSTANCE USE DISORDER PATIENT RECORDS), the recipient of the information is informed of that consent voluntarily. Re-disclosure is prohibited except as permitted or required by these two laws.

Please check what information you would like to release to each person you put on the list.
A = Appointment dates/times **B** = Billing Information **M** = Medication Information

I authorize Psychiatric Services of Carolinas to release my medical and/or billing information to the following individuals:

		A	B	M
1. _____	Relationship to Patient _____	___	___	___
2. _____	Relationship to Patient _____	___	___	___
3. _____	Relationship to Patient _____	___	___	___
4. _____	Relationship to Patient _____	___	___	___
5. _____	Relationship to Patient _____	___	___	___

This Authorization for Release of Information expires one year from the date of signature.

Expiration Date: _____

I understand that I have the right to revoke this authorization in writing at any time.

Signature: _____ Date: _____

I do not wish to release any of my information to anyone at any time

Signature: _____ **Date:** _____

Chart # _____ Reviewed by Provider: _____

Psychiatric Services of Carolinas, PC

PATIENT CODE OF CONDUCT

In an effort to provide a safe and healthy environment for all, Psychiatric Services of Carolinas expects **patients, family members, and visitors** to refrain from behaviors that are disruptive, threatening or violent to the rights and safety of **other patients and staff.**

Disruptive behavior is inappropriate behavior that interferes with the functioning and flow of the workplace. It hinders or prevents providers and staff members from carrying out their professional responsibilities. It is important that providers, managers, and supervisors address disruptive behavior promptly. If left unaddressed, disruptive behavior typically continues to escalate, resulting in negative consequences for the individual as well as others. Examples include yelling, using profanity, waving arms or fists, verbally abusing others, attempting to intimidate or harass other individuals by making offensive or intimidating statements, or threats of violence through phone calls, letters, voicemail, email, or other forms of written, verbal or electronic communication and refusing reasonable requests for identification. As well as Racial or cultural slurs or other derogatory remarks associated with, but not limited to, race, language or gender.

Threatening behavior includes physical actions short of actual contact/injury (e.g., moving closer aggressively), general oral or written threats to people or property ("You better watch your back" or "I'll get you") as well as implicit threats ("You'll be sorry" or "This isn't over"), possession of firearms or any weapons, making verbal threats to harm another individual or destroy property and using gestures or profane language.

Violent Behavior includes any physical assault, with or without weapons; behavior that a reasonable person would interpret as being potentially violent (e.g., throwing things, pounding on a desk or door, or destroying property), or specific threats to inflict physical harm (e.g., a threat to shoot a named individual), climbing on furniture or property, and inflicting bodily harm.

This is to include behaviors that are witnessed in the office as well as telephone calls placed either to or from the office, and email correspondence. This kind of behavior will not be tolerated and will result in immediate action up to and including discharge from the practice.

Print Name: _____

Signature: _____ **Date:** _____

Witness Signature: _____

CONTINUANCE OF CARE

In the event that your doctor leaves the practice, goes on medical leave, or cannot see you, one of the following will take place:

1. Your appointment will be rescheduled to see another provider at this office
2. You will be worked in to see another provider at this office
3. You will need to contact your primary care provider to have them refer you to another mental health care facility

Medications will still be managed by this office until we can get you in with another provider or until you get an appointment at a different office (within a reasonable time frame).

Signature: _____ **Date:** _____

Chart # _____ Reviewed by Provider: _____

Psychiatric Services of Carolinas, PC

NOTICE OF PRIVACY PRACTICES

This notice describes how medical of health information about you may be used and disclosed and how you can get access to this information. Please review it carefully

Protecting your privacy
Protecting your privacy and your medical and Health information at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the internet. At Foothills Consulting Services, LLC, privacy is one of our highest priorities.

Keeping your information
Keeping the medical and health information we have about you, secure, is one of our most important responsibilities. We value your trust and will handle your information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise to meet your needs. We may also access information about you when considering a request from you or when exercising your rights under the law or any agreement with you. We safeguard information during all business practices according to established security standards and procedures and we continually assess new technology for protecting information. Our employees are trained to understand and comply with these principles.

Working to meet your needs through information
In the course of doing business, we collect and use various types of information, like names and address and claims information. We use this information to provide service to you, to process your claims and to bring you health information that might be of interest to you.

Keeping your information accurate
Keeping your health information accurate and up to date is very important. If you believe the health we have about you is incomplete, inaccurate or not current, please call or write us at the telephone number or address listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How and why information is shared
We limit who receives information and what types of information is shared (Except as required by law or as described about. We do not share information with other parties, including government agencies. FCA does not share any consumer information with third party marketers who offer their products and services to our patients. As information is shared or disclosed, we will attempt to explain the disclosure to you as permitted by law as soon as possible).

- Sharing information within FCA, we share information within our company to deliver you the health care services and the related information and education programs specified in your plan.
- Sharing information with companies that work with us. To help us offer you our services, we may share information with companies that work with us, such as claims processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them, confidential.
- Patient specific personal identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data is released with the
- If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so).
- FCA may disclose that fact of your admission or discharge to your next of kin whenever it is determined that the disclosure is in your best interest.
- In addition, you may have access to confidential information in your patient record, except information that would be injurious to your physical or mental well being as determined by the attending physician or if there is none, the Clinical Director.
- We also may disclose information to certain consumer advocates, attorney and in certain court proceedings in accordance with applicable state statues.
- We are also required to share information when, in our opinion, there is imminent danger to your health or safety of another individual or there is a likelihood of the commission of a felony or violent misdemeanor.
- We may exchange confidential information with a physician or other health care provider who is providing emergency medical services to you to the extent necessary to meet the emergency need.
- We may share information for certain statistical reporting and research such as non-identifying, aggregated information.
- NC TOPPS (North Carolina Treatment Outcomes and Program Performance System) will now be the chief method for collecting information necessary for accountability, quality improvement and local outcomes management for the states substance abuse and mental health consumers.

PAYMENT AND FEE FOR SERVICES

You have the right to know the cost for services and billing practices. At the of admission, or as you request, FCA will discuss the fee for service and information related to the use of your insurance, Medicaid, State and other funding benefits. We will ask for information related to your insurance and benefits. At any time you may request information to your account.

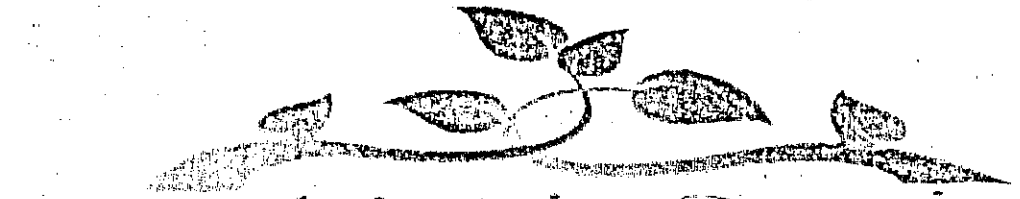
Patient/Guardian Signature Date

Medical Records #:

Insurance ID:

Chart # _____

Reviewed by Provider: _____



Psychiatric Services of Carolinas

Providing Harmony in Life

Psychiatric Services of Carolinas, PC
1530-A Union Road, Suite A
Gastonia, NC 28054-2201
Telephone: (704) 867-6188 Fax: (704) 866-4437

August 2019

Union Commons Office Park Smoking and Parking Policy

Please note that effective August 1, 2019, the Union Commons Office Park Association will start issuing fines to anyone caught smoking anywhere on the Union Commons property (this includes "Vaping"). Fines may also be levied on anyone who is not parked in a designated parking area/spot and to anyone loitering on the Union Commons property. This means that if someone brings you to your appointment, **YOU** are responsible to let them know not to smoke on the Union Commons Campus and let them know that they will either need to come inside the waiting room or to come back to pick you up. Fines can be up to $100 and will need to be paid at the time of receiving services at Psychiatric Services of Carolinas. Failure to comply with these policies may result in a discharge from the practice.

_____

Print Name

_____

Signature

_____

Date

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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
☐	☐	☐	☐

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	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 much 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 into 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?	○	○

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e. 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?	○	○

SCORING THE MOOD DISORDER QUESTIONNAIRE (MDQ)

The MDQ was developed by a team of psychiatrists, researchers and consumer advocates to address a critical need for timely and accurate diagnosis of bipolar disorder, which can be fatal if left untreated. The questionnaire takes about five minutes to complete, and can provide important insights into diagnosis and treatment. Clinical trials have indicated that the MDQ has a high rate of accuracy; it is able to identify seven out of ten people who have bipolar disorder and screen out nine out of ten people who do not.[1]

A recent National DMDA survey revealed that nearly 70% of people with bipolar disorder had received at least one misdiagnosis and many had waited more than 10 years from the onset of their symptoms before receiving a correct diagnosis. National DMDA hopes that the MDQ will shorten this delay and help more people to get the treatment they need, when they need it.

The MDQ screens for Bipolar Spectrum Disorder, (which includes Bipolar I, Bipolar II and Bipolar NOS).

If the patient answers:

1. **"Yes"** to seven or more of the 13 items in question number 1;

AND

2. **"Yes"** to question number 2;

AND

3. **"Moderate"** or **"Serious"** to question number 3;

you have a positive screen. All three of the criteria above should be met. A positive screen should be followed by a comprehensive medical evaluation for Bipolar Spectrum Disorder.

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[1] Hirschfeld, Robert M.A., M.D., Janet B.W. Williams, D.S.W., Robert L. Spitzer, M.D., Joseph R. Calabrese, M.D., Laurie Flynn, Paul E. Keck, Jr., M.D., Lydia Lewis, Susan L. McElroy, M.D., Robert M. Post, M.D., Daniel J. Rapport, M.D., James M. Russell, M.D., Gary S. Sachs, M.D., John Zajecka, M.D., "Development and Validation of a Screening Instrument for Bipolar Spectrum Disorder: The Mood Disorder Questionnaire." *American Journal of Psychiatry* 157:11 (November 2000) 1873-1875.