MATTHEW A PETRILLI MD, PLLC.

*Email: MatthewPetrilliMD@mpetrillimd.com*
*Tel: (919) 726-4600*
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# Psychiatric Intake Form

(All information on this form is strictly confidential)

*Please complete all information on this form and email it back prior to the first visit.*

Name:_____ Birthdate:_____ Today's Date: _____

Address: _____

Cell Phone: _____ Other Phone: _____ Email: _____

Primary Care Physician:_____ Phone: _____

Other Physicians (please list specialty):_____ Phone: _____

What are the problem(s) you are seeking help for?

What are your treatment goals?

Current Symptoms Checklist:

| | | | |
|---|---|---|---|
| ( ) Depressed mood | ( ) Racing thoughts | ( ) Excessive worry | ( ) Unable to enjoy activities |
| ( ) Impulsivity | ( ) Anxiety attacks | ( ) Sleep disturbance | ( ) Increase risky behavior |
| ( ) Avoidance | ( ) Loss of interest | ( ) Increased libido | ( ) Hallucinations |
| ( ) Poor concentration | ( ) Decrease need for sleep | ( ) Suspiciousness | ( ) Change in appetite |
| ( ) Excessive energy | ( ) Excessive guilt | ( ) Increased irritability | ( ) Fatigue |
| ( ) Crying spells | ( ) Decreased libido | ( ) Memory issues | ( ) _____ |

**Your Medical History:**

Allergies: _____ Weight:_____Height: _____

List ALL current **prescription** medications and how often you take them (if none, write none):

| *Name* | *Dose* | *Frequency* | *Name* | *Dose* | *Frequency* |
|---|---|---|---|---|---|
| *hydrochlorothiazide* | *25mg tablet* | *In the morning* | *Metformin* | *500mg table* | *Twice a day* |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |

Current **over-the-counter** medications or supplements:

_____

_____

Current medical problems:_____

_____

_____

Past medical problems, non-psychiatric hospitalization or surgeries:

_____

_____

_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when? _____

What was the EKG result? ( ) Normal ( ) Abnormal ( ) Unknown

Do you have any concerns about your physical health that you would like to discuss? ( ) Yes ( ) No

Date and place of last physical exam: _____

For women only:

Date of last menstrual period: _____ Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No

Are you planning to get pregnant in the near future? ( ) Yes ( ) No Birth control method: _____

How many times have you been pregnant? _____

How many live births? _____

**Personal and Family Medical History:**

| Condition | You | Family | Which Family Member |
|---|---|---|---|
| Thyroid Disease | ( ) | ( ) | |
| Anemia | ( ) | ( ) | |
| Liver Disease | ( ) | ( ) | |
| Chronic Fatigue | ( ) | ( ) | |
| Kidney Disease | ( ) | ( ) | |
| Diabetes | ( ) | ( ) | |
| Asthma | ( ) | ( ) | |
| Stomach or Intestinal Problems | ( ) | ( ) | |
| Cancer (list what type) | ( ) | ( ) | |
| Fibromyalgia | ( ) | ( ) | |
| Heart Disease | ( ) | ( ) | |
| Seizures | ( ) | ( ) | |
| Chronic Pain | ( ) | ( ) | |
| High Cholesterol | ( ) | ( ) | |
| High Blood Pressure | ( ) | ( ) | |
| Head Trauma | ( ) | ( ) | |
| Liver Problems | ( ) | ( ) | |
| Other | ( ) | ( ) | |

Is there any additional personal or family medical history? ( ) Yes ( ) No

If yes, please explain: _____

_____

_____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

**Your Past Psychiatric History:**

Previous outpatient treatment? ( ) Yes ( ) No

If yes, please describe:

| By whom? | Reason? | Dates treated? |
|---|---|---|
| | | |
| | | |
| | | |

Prior psychiatric Hospitalizations? ( ) Yes ( ) No

If yes, please describe:

| Where? | Reason? | Dates hospitalized? |
|---|---|---|
| | | |
| | | |
| | | |

Past Psychiatric Medications? ( ) Yes ( ) No

If yes, please describe:

| Name of medication? | Dosage? | Dates taken? | Response / Side-Effects? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Family Psychiatric History:**

Has anyone in your family been diagnosed with or treated for any of the following?

| Issue | Yes or No | | If yes, which Family Member |
|---|---|---|---|
| Depression | ( ) Yes | ( ) No | |
| Anxiety | ( ) Yes | ( ) No | |
| Bipolar Disorder | ( ) Yes | ( ) No | |
| Schizophrenia | ( ) Yes | ( ) No | |
| Suicide / Suicide Attempt | ( ) Yes | ( ) No | |
| PTSD | ( ) Yes | ( ) No | |
| Alcohol Abuse | ( ) Yes | ( ) No | |
| Other Substance Abuse | ( ) Yes | ( ) No | |
| Violence | ( ) Yes | ( ) No | |
| Other: _____ | ( ) Yes | ( ) No | |

**Your Substance Use History:**

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substances? _____

Where were you treated and when? _____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used any street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones? _____

Have you abused prescription medication? ( ) Yes ( ) No

If yes, which ones and for how long? _____

Have you ever tried any of the following substances?

| Substance | Yes | No | If yes, how long and when did you last use? |
|---|---|---|---|
| Methamphetamine | ( ) | ( ) | |
| Cocaine | ( ) | ( ) | |
| Stimulants | ( ) | ( ) | |
| Heroine | ( ) | ( ) | |
| LSD or Hallucinogens | ( ) | ( ) | |
| Marijuana | ( ) | ( ) | |
| Pain Killers (not prescribed) | ( ) | ( ) | |
| Methadone | ( ) | ( ) | |
| Tranquilizers / Sleeping Pills (not prescribed) | ( ) | ( ) | |
| Alcohol | ( ) | ( ) | |
| Ecstacy | ( ) | ( ) | |
| Other:_____ | ( ) | ( ) | |
| Other:_____ | ( ) | ( ) | |
| Other:_____ | ( ) | ( ) | |

How many caffeinated beverages do you drink a day? Coffee_____ Sodas_____ Tea _____

**Your Tobacco History:**

Do you currently smoke cigarettes? ( ) Yes ( ) No

How many packs per day on average? _____

And for how many years? _____

Have you smoked cigarettes in the past? ( ) Yes ( ) No

How many years did you smoke? _____

When did you quit?

**Your Family Background and Childhood History:**

Were you adopted? ( ) Yes ( ) No

Where did you grow up? _____

List your siblings and their ages:

_____ _____ _____ _____

_____ _____ _____ _____

What is/was your father's occupation? _____

What is/was your mother's occupation? _____

**Your Educational History:**

Highest educational level/degree attained? _____ Which school? _____ When did you graduate? _____

**Your Occupational History:**

Are you currently: ( ) Working ( ) Not working by choice ( ) Unemployed ( ) Disabled ( ) Retired

How long have you been in your present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you served in the military?_____If so, what branch and when?_____Type of discharge? _____

**Your Relationship History and Current Family:**

Are you currently: ( ) Married ( ) Divorced ( ) Partnered ( ) Single ( ) Widowed

If you are in a relationship, for how long? _____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender:

_____

_____

List everyone who currently lives with you?

_____

_____

Legal:

Have you ever been arrested? _____ Do you have any pending legal problems? _____

Trauma:

Have you ever been the victim of any violence or trauma? _____

Is there anything else that you would like Dr. Petrilli to know?

_____

_____

_____

_____

_____

_____

_____

**Emergency Contact:**

Name:_____ Relationship to You: _____

Emergency Contact's Tel Number:_____ Email Address: _____

**Preferred Pharmacy:**

Name:_____ Address:_____

Tel Number:_____ Fax Number: _____

Your Signature: _____

Today's Date: _____

MATTHEW A PETRILLI MD, PLLC

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# Financial Agreement

**Patient Name:**_____ **Birthdate:** _____

I am authorizing Dr. Matthew Petrilli to charge my credit card in the event that I fail to show for a scheduled appointment as recorded on my bill, or do not notify Dr. Petrilli of my inability to attend a scheduled appointment at least 24 business hours in advance.

Furthermore, for outstanding payments of services rendered, I authorize Dr. Petrilli to charge my credit card for the full amount due. I will not dispute charges for sessions I have received or that I have not cancelled less than 24 hours in advance. If I do not honor this financial agreement and develop an outstanding balance, I will pay the charges within 30 days. I agree to an interest charge of 1.5% per month (18% per year) if my balance is not paid within 30 days. I authorize Dr. Petrilli to disclose information about my attendance/cancellation to my credit card company if I dispute a charge. If payment is not made, I waive the right to confidentiality for purpose of collection of the said fee. Any reasonable attorney fees and costs incurred by Dr. Petrilli for the collection of the past due account shall be my obligation as well.

To ensure the solvency of Matthew A Petrilli MD, PLLC, the following credit card information will be on file. As is the case with most clients, fees are charged to the credit card at the time of appointments. I understand that the credit card will not be charged unless the following conditions apply: no show for a scheduled appointment, cancellation less than 24 business hours in advance, or participation in treatment (e.g. appointment session) without payment rendered.

Cardholder Name: _____

Card Type (please circle): VISA MASTERCARD DISCOVER AMERICAN EXPRESS

Number:_____ Expiration date: _____

V-code (3-digit code on back of card): _____

Billing Address: _____

_____ _____

**Signature of patient** **Date**

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## OUT-OF-NETWORK BENEFITS

Dr. Petrilli does not participate in any insurance plans. He is considered an out-of-network provider. Payment is due at the time of services unless other arrangements are made with the doctor. Many health insurance plans offer substantial out-of-network benefits which will reimburse a generous portion of your treatment costs. Dr. Petrilli cannot guarantee that you will be reimbursed by insurance and he may be unable to provide additional documentation that insurance may require.

Please use the following worksheet to learn more about your individual insurance plan's benefits as you assess your out-of-pocket expenses. Call the number on the back of your insurance card and ask your representative the questions below.

- Note the date and time of the call. Ask the representative for his/her name and direct contact number.

- "Does my insurance plan include out of network benefits for outpatient behavioral/mental health? If so, what are the benefits?"

- "Do I need to obtain prior authorization to have these services covered?"

- "Does my plan have an annual out-of-pocket maximum (which is usually the sum of my deductible and co-insurance) that I am expected to meet before my benefits kick in? If so, what is the amount?"

- "When my benefits do kick in, how much will be covered and how much will I be responsible for?
  (For example, a plan might have an annual out-of-pocket maximum of $2000. After I have spent this much, my plan will reimburse 70% of my bill.)"

- "Are there specific claim forms that I must submit and is there a time frame in which the claims must be sent in? Where do I submit the claims?"

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# Notice of Privacy Practices
# Acknowledgement of Receipt

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

I have been offered or provided a copy of the Notice of Privacy Practices which describes how medical information about me may be used and disclosed, and how I can access this information. I understand that Matthew A Petrilli MD, PLLChas the right to change its Notice of Privacy Practices from time to time and that I may request updates at the address above to obtain a current copy of the Notice of Private Practices.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I was unable to obtain written acknowledgement from patient. I made a good faith effort to obtain a written acknowledgment of receipt of the Notice of Privacy Practices from the above-named patient, but was unable to because:

☐ Patient declined to sign this Written Acknowledgment.

☐ Other: _____

Name: _____

Date: _____

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# Patient Request for Communications via Email, Text, or Telephone

Patient Name:_____Birthdate: _____

E-mail Address:_____Telephone: _____

I request to communicate with my provider via unencrypted email, telephone, or text. Completing this form is requested to document your request and permit a provider/program communicate with you via unencrypted email.

**I understand that communications over the Internet or use of an email system may not be secure. There is no assurance of confidentiality when communicating via email.**

**I am advised that:**

- **This request applies only to Matthew Petrilli, MD. If you would like to request to communicate via unencrypted email with another health care provider or program, a separate form is required.**
- An email address must be provided
- A test email is recommended before corresponding via email.

**I understand and agree to the following:**

- The email address provided is accurate and that I accept full responsibility for messages sent to or from this address.
- I understand and acknowledge that communications over the internet or using unencrypted email may not be secure and there is no assurance of confidentiality of information communicated via email.
- I understand that email communications may be forwarded to other providers for purposes of providing treatment to me.
- I agree to hold Matthew A Petrilli MD PLLC and individuals associated with it harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

_____ _____

**Signature of patient** **Date**

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# Request / Authorization to Release Confidential Records and Information

Patient Name:_____ Date of Birth: _____

Street Address:_____ Phone: _____

City: _____ State: _____ Zip Code:_____

I hereby authorize the release of my protected health information to and from the following doctors/entities:

1. Matthew A. Petrilli, MD
   Tel: (919) 726-4600 Fax: (919) 799-5312

2. Person or facility: _____ Fax: _____
   Address: _____
   Tel: _____ Fax:_____
3. Person or facility: _____ Fax: _____
   Address: _____
   Tel: _____ Fax:_____
4. Person or facility: _____ Fax: _____
   Address: _____
   Tel:_____Fax: _____

The purpose for this request to release medical information is:

□ Medical Care / Treatment □ Other _____

I have had explained to me and fully understand this request/authorization to release records and information, including the nature of the records, their contents, and the consequences and implications of their release. This request is entirely voluntary on my part. I understand that I may take back this consent at any time, except to the extent that action based on this consent has already been taken. This consent will expire automatically after one year from the date on which it is signed.

_____ _____

**Patient / Representative Signature** **Date**

If the patient listed above is a minor or is unable to sign and you are a parent, legal guardian, or personal representative signing on behalf of this patient, please sign above and complete the following:

_____ _____

**Print Name** **Relationship to Patient**

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# Telepsychiatry Consent Form

Telepsychiatry provides psychiatric services using interactive video conferencing tools, such as Zoom or Doximity, in which the psychiatrist and the patient are not at the same location. Telepsychiatry will allow the patient to receive medical care without the need to visit the office and travel long distance. Potential risks include, but may not be limited to: information transmitted may not be sufficient (poor resolution of video); delays in medical evaluation and treatment due to deficiencies or failures of the equipment; security protocols can fail, causing a breach of privacy; and a lack of access to all the information available in a face to face visit that may result in errors in medical judgment. Alternative to telepsychiatry include traditional face to face sessions which Dr. Petrilli is not offering at this time.

**Your Rights:**

- 1) I understand that the laws that protect the privacy and confidentiality of medical information also apply to telepsychiatry; 2) I understand that Zoom and/or Doximity is known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. 3) I understand that all rules and regulations which apply to the practice of medicine in the State of North Carolina also apply to telepsychiatry.

**Your Responsibilities:**

- 1) I will not record any telepsychiatry sessions without the prior written consent of Dr. Petrilli and I understand that Dr. Petrilli will not record telepsychiatry sessions without my consent; 2) I will inform Dr. Petrilli if any other person can hear or see any part of our session before the session begins. Likewise, Dr. Petrilli will inform me if any other person can hear or see any part of the session before the session begins. 3) I understand that I MUST be a resident of North Carolina and I MUST be physically located in North Carolina at the time of appointment to be eligible for telepsychiatry services from Dr. Petrilli.

Your signature below indicates that you have read and understand the information provided above regarding telepsychiatry, and that you authorize Dr. Matthew Petilli use telepsychiatry in the course of diagnosis and treatment.

X_____ X_____

**Patient or Parent/Legal Guardian Signature** **Date**

X_____. X_____.

**Print Name** **Relationship to Patient**