Magnolia Psychiatry
www.magnoliapsychiatry.clinic
p. 281-724-7980
f. 281-547-7911

22325 Gosling Rd.
Spring, TX 77389

13145 Spring Cypress Rd.
Building #3 Ste. B
Cypress, TX 77429

PATIENT INFORMATION

Last Name:_____ First Name:_____ Middle Name: _____

Suffix (Circle): Jr. Sr. III IV Date of Birth:_____ Gender: □ Male □ Female □ other

Parent/Legal Guardian Name (If Applicable): _____

Marital Status: □Single □Married □Divorced □Separated □Widowed SSN:_____

Spouse Name:_____ Spouse Number: (__) _____ - _____

Home Address:_____City:_____State:_____Zip Code: _____

Home Phone: (___) _____ - _____ Mobile Phone: ( ) _____ - _____

*Email: _____

*An email address and social security number is required to access our patient portal.

EMERGENCY CONTACT

Full Name: _____ Relationship:_____

Home Phone: ( ) _____ - _____ Mobile Phone: ( ) _____ - _____

PATIENT EMPLOYMENT/SCHOOL DETAILS

Employment Status: □ Full-Time □ Part-Time □ Not Employed □ Self-Employed □ Military

Employer Name:_____ Work: (__) _____ - _____

Address:_____City:_____ State: _____ Zip: _____

Student Status: □ Full-Time □ Part-Time □ Not a Student School Name: _____

REFERRAL AND PHARMACY INFORMATION

Referring person: _____ Phone: ( ) _____ - _____

How did you hear about us? _____

Clinician Referral: ___ Google: ___ Social Media: ___ Friend/Family: ___ Other: _____

Please let us know which pharmacy you prefer:

□ Walgreens □ CVS □ HEB □ Kroger □ Target □ Sam's Club □ Walmart □Other:_____

Address: _____

Phone Number:_____

Mail Order Pharmacy: □ CVS Caremark □ Express Scripts □ Prime Mail □ Other:

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FINANCIAL RESPONSIBILITY

Primary Insurance Name: _____ Behavioral Health Phone Number: _____

Policy Number: _____ Group Number: _____

Insurance Claims Address (Back of Card): _____

Policy Holder Name: □ Self Full Name/Relationship: _____

Policy Holder DOB: _____/_____/_____

Secondary Insurance Name: _____ Behavioral Health Phone Number: _____

Policy Number: _____ Group Number: _____

INSURANCE ASSIGNMENT AND SELF PAY AGREEMENT

I certify that I have insurance coverage with the primary insurance company and the second insurance payer, if applicable, listed above. I assign directly to Magnolia Psychiatry all insurance payments, if any otherwise payable to me for services rendered. I understand I am financially responsible for any deductible, co-insurance, copayment, non-covered charges, and any balances not covered under a signature for all insurance submissions. I understand that it is my responsibility to pay for any services rendered at the time of visit.

FINANCIAL RESPONSIBILITY ACKNOWLEDGMENT

Payment for services rendered is the responsibility of the patient, parent, or guardian. This responsibility obligates you to ensure payment in full of your fees. As a courtesy, we will verify your coverage on your behalf. *However, you are ultimately responsible for the payment of your bill, regardless of insurance coverage.* Once insurance claims have processed, any remaining balance(s) will be billed to the patient. If the insurance company fails to process claims within 45 days from the date of service, the balance due may be collected from the patient. If insurance issues arise, it is the responsibility of the patient to contact the insurance company, group plan, administrator, or employer representative for resolution. A patient's insurance policy is a contract between the patient and the insurance carrier. Magnolia Psychiatry and its associates are not parties to that contract and cannot act as a mediator with the carrier or employer. The patient will become responsible for complete payment to the provider if coverage has terminated due to lack of premium payment. As required by insurance mandates, it is the responsibility of the patient to obtain any necessary authorization for medical treatments. If a referral is required for treatment, it is the responsibility of the patient to obtain the referral and present it at the time of treatment. If the patient is treated without the proper referral or authorization as required by the insurance carrier, the patient assumes responsibility for payment of all fees at the time of service.

Patient's Name: _____ DOB: _____

_____ **Date: _____**

Signature of adult patient OR the parent/legal guardian of a minor patient (under 18 years old)

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CONSENT FOR RELEASE OF INFORMATION/HEALTH CARE COORDINATION FORM

Patient's Name: _____ Date of Birth: ___/___/___ Social Security Number: ___ - ___ - ___

Home Address: _____ City: _____ State: _____ Zip Code: _____

Home Phone: (___) _____ - _____ Mobile Phone: (___) _____ - _____ Email: _____

I hereby authorize Magnolia Psychiatry to release/receive the following health information:

_____ Initial Evaluation/Assessment
_____ Medical History and Information
_____ Psychotherapy Notes
_____ Office Visit/Progress Notes
_____ Complete Medical Record
_____ Psychological Reports & Testing Results
_____ Laboratory Results/Reports
_____ Billing Records/Information
_____ Transfer/Discharge Summary
_____ Other: _____

Please release the requested information for these treatment dates: _____

[ ] Records to be released to: [ ] Records to be requested/received from:

Name: _____ Relationship: _____

Health Care Provider Name: _____ Address: _____

Telephone Number: (___) _____ - _____ Fax: (___) _____ - _____

I acknowledge that I have the right to revoke this authorization in writing at any time by sending such written notification to the releasing person/agency. I understand that my revocation will not be effective to the extent that Magnolia Psychiatry has already taken action in reliance of this authorization or if this authorization was obtained as a condition of, obtaining insurance coverage and the insurer has the legal right to contest the claim. I further acknowledge that even if I revoke this authorization, the use and disclosure of my protected health information could possibly still be required as indicated in the copy of the Notice of Privacy Practices of Magnolia Psychaitry, that I have received and reviewed. I acknowledge that the authorized recipient may accomplish the re-disclosure of my protected health information and that Federal Privacy Rule will no longer protect it. I acknowledge and understand that I am waiving my right to confidentiality with respect to the information or records released pursuant to this consent and I hereby release Magnolia Psychiatry and its staff from any and all liability arising from the release and disclosure of the information or records. A photocopy or fax of this authorization is as valid as the original. Please note: This authorization will automatically expire one year from signing unless other date of expiration is specified here: _____
I acknowledge that I have read this authorization for release of information in its entirety and I fully understand its terms and implications. I freely, voluntarily and without and coercion, agree with the terms and conditions contained in this authorization.

Patient's Name: _____ DOB: _____

_____ _____

Signature of adult patient OR the parent/legal guardian of a minor patient (under 18 years old) **Date**

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PATIENT HEALTH SCREENING INFORMATION AND MEDICAL/SURGICAL HISTORY:

EVENT	DATE

ALL CURRENT MEDICATIONS (MEDICAL AND PSYCHIATRIC):

NAME	DOSAGE

ALLERGIES/INTOLERANCES:

FAMILY HISTORY: Have you or any family members been treated for any of the following? Check all that apply.

ILLNESS	SELF	MOTHER	FATHER	AUNT	UNCLE	SISTER	BROTHER	CHILDREN	OTHER
ADHD/ADD									
ALZHEIMER'S									
ANXIETY									
BIPOLAR									
DEPRESSION									
HEART DISEASE									
SCHIZOPHRENIA									
SEIZURES									
STROKE									
SUBSTANCE ABUSE									
SUICIDE ATTEMPTS									

Care Team for patient_____ Date_____

Specialty	Clinician Name	Clinic Name	Phone number	Address	Reason being seen
Primary Care Provider					
		`			

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PRE-AUTHORIZED USE OF CREDIT CARD

DATE:_____

I authorize Magnolia Psychiatry to keep my signature on file and to charge my credit card during my course of treatment at Magnolia Psychiatry.

Charges include any payments that are patient responsibility including but not limited to: deductibles, copay, co-insurance and any non-covered or denied insurance payments.

Patient's Name:_____

Patient or Parent/Guardian
signature: _____

I authorize Magnolia Psychiatry to charge my credit card for any amount/fee owed to my credit card below.

Credit Card # _____

( ) Visa ( ) Mastercard ( ) Discover ( ) AMEX ( )Other

Expiration Date: _____ CVV (3-digit security code): _____
Billing zip code _____

Name on card: _____

Authorized Signature: _____

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 figety 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 _____

A2663B 10-04-2005

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	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?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		**Today's Date**				
Instructions *Please answer the questions below, rating yourself on a scale of 1 through 5 on each of the criteria as shown to the right. As you answer each question in a way that best describes how you have felt and conducted yourself in the past 6 months. Please give this completed checklist to your healthcare professional to discuss during your appointment.*		1 Never	2 Rarely	3 Sometime	4 Often	5 Always
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?						
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?						
3. How often do you have problems remembering appointments or obligations?						
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?						
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?						
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?						
7. How often do you make careless mistakes when you have to work on a boring or difficult project?						
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?						
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?						
10. How often do you misplace or have difficulty finding things at home or at work?						
11. How often are you distracted by activity or noise around you?						
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?						
13. How often do you feel restless or fidgety?						
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?						
15. How often do you find yourself talking to much when you are in social situations?						
16. When you are in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?						
17. How often do you have difficulty waiting your turn in situations when turn taking is required?						
18. How often do you interrupt others when they are busy?						
Total Score: Inattention, Subscale A						
Total Score: Hyperactivity, Subscale B						

The Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist was developed in conjunction with the World Health Organization (WHO), and the Workgroup on Adult ADHD that included the following team of psychiatrists and researchers: Lenard Adler, MD, Associate Professor of Psychiatry and Neurology, New York University Medical School; Ronald C. Kessler, PhD, Professor, Department of Health Care Policy, Harvard Medical School; and Thomas Spencer, MD, Associate Professor of Psychiatry, Harvard Medical School.

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

	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 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 in 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? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, 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?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

Severity of Posttraumatic Stress Symptoms—Adult*

*National Stressful Events Survey PTSD Short Scale (NSESSS)

Name:_____ **Age:** _____ **Sex: Male** ❑ **Female** ❑ **Date:**_____

Please list the traumatic event that you experienced: _____

Date of the traumatic event: _____

Instructions: People sometimes have problems after extremely stressful events or experiences. How much have you been bothered during the PAST SEVEN (7) DAYS by each of the following problems that occurred or became worse after an extremely stressful event/experience? **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
		Not at all	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**	**Item score**
1.	Having "flashbacks," that is, you suddenly acted or felt as if a stressful experience from the past was happening all over again (for example, you reexperienced parts of a stressful experience by seeing, hearing, smelling, or physically feeling parts of the experience)?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
2.	Feeling very emotionally upset when something reminded you of a stressful experience?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
3.	Trying to avoid thoughts, feelings, or physical sensations that reminded you of a stressful experience?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
4.	Thinking that a stressful event happened because you or someone else (who didn't directly harm you) did something wrong or didn't do everything possible to prevent it, or because of something about you?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
5.	Having a very negative emotional state (for example, you were experiencing lots of fear, anger, guilt, shame, or horror) after a stressful experience?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
6.	Losing interest in activities you used to enjoy before having a stressful experience?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
7.	Being "super alert," on guard, or constantly on the lookout for danger?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
8.	Feeling jumpy or easily startled when you hear an unexpected noise?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
9.	Being extremely irritable or angry to the point where you yelled at other people, got into fights, or destroyed things?	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
						Total/Partial Raw Score:	
						Prorated Total Raw Score: (if 1-2 items left unanswered)	
						Average Total Score:	

Name:_____ DOB:_____ Date:_____

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***		
2) ***Have you actually had any thoughts of killing yourself?***		
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"		
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"		
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***		

	YES	**NO**
6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past three months?***		

- Low Risk
- Moderate Risk
- High Risk

For inquiries and training information contact: Kelly Posner, Ph.D.
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