Ade Adeyemo APN, PMHNP-BC
Psych & Behavioral Healthcare LLC
555 High Street
Mount Holly
NJ 08060
Phone: 732-986-1971
Website:psychiatricandbehavioralhealth.com
email:pbhctreatment@gmail.com

Please fill out the following information as complete and as neat as possible. Thank You.

PERSONAL INFORMATION:

Name: ______________________ D.O.B. _________ Sex: M or F

Marital Status: _______ If married, Spouse Name: ______________________

Address: ______________________ City/State: ____________ Zip: __________

Phone#: ____________ SS#: ____________ Referred by: __________

Employer: ______________________ Work Phone: __________

Emergency Contact: ______________________ Phone: __________

INSURANCE INFORMATION:

Medicare# (if applicable): ______________________

Secondary Ins. (if applicable): ______________ Member ID: __________

Grp#: _________ Is this insurance under your name? If not please provide the following:

Name of Insured: ____________ D.O.B.: _______ SS#: __________

MEDICAL INFORMATION:

Have you ever lived outside of the U.S.? y or n If yes Where: __________
Do you use tobacco? y or n Do you drink Coffee? y or n If yes, how much _______
Highest level of Education ______________ Place of Birth: __________
Occupation: ______________ Religion: __________
Children: y or no How many? _________ # of pregnancies: __________
# of miscarriages: _________ Onset date of last menstrual period: __________
Periods: ______ regular ______ irregular

AdeolawaAdeyemo

PMHNP-BC

Patient Consent to the Use and Disclosure of Health Information
For Treatment, Payment, or Healthcare Operations

I____________________________, understand that as part of my health care, ■ Adeyemo originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care of treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among the many health professionals who contribute to my care,
- A source of information for applying my diagnosis and surgical information to my bill
- A means by which a third-party payer can verify that services billed were actually provided, and
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with a Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

I understand **the office** not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that **the office** reserves the right to change their notice and practices and prior to implementation, in accordance with Section 164.520 of the Code of Federal Regulations. Should ■ Adeyemo's office change their notice, they will send a copy of any revised notice to the address I've provided (whether U.S. mail or, if I agree, email).

I wish to have the following restrictions to the use or disclosure of my health information:

____

____

____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax, messages on answering machines or with family members. I fully understand and **accept or decline** the terms of this consent.

Patient's Signature____ Date______________

FOR OFFICE USE ONLY

[ ] Consent received by___________________________on__________

[ ] Consent refused by patient, and treatment refused as permitted.

[ ] Consent added to patient's medical record on __________________

Contract for Medical and or Psychiatric Appointments via Telemedicine (Video/Audio Conferencing)

I, ______________________________, hereby consent to having my Psychiatric
(Print)

Appointment(s) via Telemedicine (Video/Audio Conferencing). I am aware and agree that Skype/Doxy.Me/Telephone will be the electronic medium used during these appointments. I absolve Adeoluwa Adeyemo PMHNP-BC and its Affiliates of any liability or responsibilities related to the use of electronic media or confidentiality related issues.

Please note: Skype/Doxy.me will only be used during your scheduled Telemedicine face to face appointment. Do NOT send any messages or questions outside of this scheduled time to Skype/Doxy.me, THEY WILL NOT BE RESPONDED TO. You are to call the office number at all times for any concerns

______________________________ ______________________________

Signature Date

AUTHORIZATION FOR USE AND/ OR DISCLOSURE OF MEDICAL INFORMATION

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide this authorization. Please release copies of my medical records to:

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Release records and information regarding:

______________________ ______________________ ______________________

Name of Patient (List other names used) Medical Record # Date of Birth

______________________ ______________________

Address Telephone Number

Previous Physician: ______________________

Name of Receiving Party

____

Address

____

City, State, Zip Code

Duration: This authorization shall become effective immediately and shall remain in effect until _________ (enter date) or for one year from the date of signature if no date entered.

Revocation: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective up receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this authorization.

Redisclosure: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is Specifically required or permitted by law.

Specify Records: Check the box and initial which type of information is to be disclosed:

○ Medical Information ○ Psychiatric Information

______________________ ______________________

Signature Date

○ Drug/Alcohol ○ HIV Test Results

__________ __________ __________ __________

Signature Date Signature Date

OTHER (Specify): Recent Labs, Physical, Last Clinical Note(s), Medication Log

____

I request that the health information released pursuant to this authorization be used for the following purpose only:

____

____

A Copy of this authorization is valid as an original.

______________________ ______________________

Date Signature of Patient or Patient's Representative

CONSENT FOR USE OF PSYCHIATRIC MEDICATIONS

PATIENT NAME ______________________________ CASE # ______________

PART I: INFORMATION

As the physician for the above-named patient, I certify that I have provided the following information to this patient regarding the psychiatric medication(s) I have recommended:

- The nature of the patient's mental condition
- The type of medication, the name (s) of the specific medication(s), the dosage range, the route of administration (by mouth or injection), and the length of time taking the medication(s)
- The reasons for taking this medication, including the likelihood of improving or not improving without it
- The reasonable alternative treatments, if any
- The side effects of the medication known to commonly occur
- The information that when certain antipsychotic (neuroleptic)medications are taken for more than 3 months, a side effect known as *tardive dyskinesia* may occur; that this may result in persistent involuntary movements of the mouth, tongue or jaw (most commonly) or other body parts; that these movements may or may not be reversible and mig.. even appear shortly after the medication has been discontinued
- The right to accept or refuse medication and the right to .. ter withdraw this consent at any time

Printed information about the edication(s) was given to the patient: Ye.. __N ___

If answer is no, the r... **Adeoluwa Adeyemo**

PMHNP-BC

______ ______________________ ______________________

Date Printed na... of Physician Signature of Physician

PART II: CONSENT

With his/her signature below, the above-named patient hereby acknowledges that:

- All of the information above regarding the administration of psychiatric medications has been explained to me
- I understand this information, and I have no further questions at this time
- I understand that I can withdraw this consent at any time

I CONSENT TO THE USE OF

Class of Medication	Specific Medication	[illegible] Range	Route	Duration

(Classes-antidepressant, antipsychotic, mood stabilizer, anxiolytic/hypnotic, stimulant, antiparkinsonian, other)

______ ______________________________

Date Signature of Patient / Legal Guardian

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1) **Have you ever been depressed? If yes which of these symptoms have you experienced? (please circle all that apply)**

Depressed Mood Weight Loss Suicide AttemptLow Self Esteem
Self Neglect Helplessness Anhedonia Decreased Libido
Suicidal Ideation Poor Energy

2) **Have you ever experience anxiety? If yes which of these symptoms have you experienced? (please circle all that apply)**

High level of Anxiety Palpitations Diaphoresis Tremulousness Intrusive Thoughts
Compulsive Behavior Fear of Enclosed Places Heightened level of Arousal Irritability
Nightmares Flashbacks Avoidance

3) **Have you ever had Mania? If yes which of these symptoms have you experienced? (please circle all that apply)**

Elevated Energy Grandiosity Impulsivity Decreased Need for Sleep Racing Thoughts Pressured Speech Increased in Goal directed activities

4) **Have you ever experienced Hallucinations or Delusions? If yes which of these symptoms have you experienced? (please circle all that apply)**

Thought Insertion Auditory Hallucinations Visual Hallucinations Paranoid Delusions Bizarre Behaviors Thought Broadcasting Hypervigilance

Past Psychiatric History

1) **When was the first time you saw any clinician in Mental Health and for how long?**
____
____
____
____

2) **How many providers have you seen since then?** ____________________

3) **Who was the last provider you saw and for how long?** ________________

Education History

1) **Highest level of Education completed?**
____
____

Vocational History

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Notice of Discharge

This memo is to inform _________________________ that patient will be discharged from facility after 3 consecutive No Shows or 3 consecutive Cancellations.

______________________________ ______________________________

Patient Signature Date

Thank You

Office Management