GHALY
HEALING & WELLNESS CENTER

Dear _____,

Thank you for choosing the Ghaly Healing & Wellness Center.
Our providers and staff look forward to assisting you with your healthcare needs.

Your appointment is scheduled at our Downtown office:
614 South Salina St. 3rd Floor Syracuse, NY 13202

Date:_____

Time: _____

Provider: _____

*****PLEASE ARRIVE 15 MINUTES PRIOR TO YOUR SCHEDULED APPOINTMENT, and bring the following completed forms as well as your insurance card(s) and photo identification*****

As part of our ongoing efforts to provide timely and efficient care, it is very important that we have 24 hour notice if your appointment needs to be cancelled or changed. We reserve the right to charge the following fees for no-show and late cancellation of appointments:

- $100 No-show/ Late cancellation fee for Initial Appointment
- $50 No-Show/ Late cancellation fee for follow up appointments

Your appointment is for an evaluation only. You will be evaluated to determine your treatment plan going forward. This appointment does NOT guarantee prescriptions or future appointments.

Patient Signature:_____ Date:_____

614 S. Salina St. Syracuse, NY 13202 P:315.425.0599 F: 315.471.6760
www.ghalyhwc.com

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NEW PATIENTS PLEASE TAKE NOTE

YOU MUST COMPLETE THIS PACKET IN ITS ENTIRETY AND BRING IT TO YOUR APPOINTMENT.

DUE TO TIMING CONSTRAINTS, IF IT IS NOT COMPLETED PRIOR TO YOUR SCHEDULED APPOINTMENT TIME, WE WILL HAVE TO RESCHEDULE YOUR EVALUATION.

FOR YOUR SAFETY AS WELL AS OURS, **MASKS ARE REQUIRED IN OUR OFFICE.** YOU MUST BRING YOUR OWN MASK. WE DO NOT PROVIDE MASKS. IF YOU DO NOT HAVE A MASK, WE WILL NOT BE ABLE TO SEE YOU FOR YOUR APPOINTMENT.

PLEASE BE AWARE, NEW PATIENT EVALUATIONS TAKE APPROXIMATELY 1 HOUR.

IF YOU HAVE ANY QUESTIONS REGARDING THIS PAPERWORK PLEASE CONTACT OUR OFFICE AT (315) 425-0599

THANK YOU FOR YOUR UNDERSTANDING IN THIS MATTER.

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Patient Name:_____ DOB:_____

SS#_____ Sex:____M____F

Street Address:_____

City:_____ State:_____ Zip:_____

Primary Phone:_____ Secondary Phone:_____

Therapist Name:_____ Location:_____

***PLEASE PROVIDE US WITH YOUR HEALTH INSURANCE CARD AND PERSCRIPTION CARD TO BE SCANNED INTO OUR FILES.**

SUBSCRIBER INFORMATION:

Name:_____ DOB:_____ Sex____M____F

Relationship to Patient:_____

Address:_____

Employer:_____ Work Phone:_____

Employers Address:_____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____

Policy Number: _____

Group # (If applicable):_____Insurance Phone: _____

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____

Policy Number: _____

Group # (If applicable):_____Insurance Phone: _____

PRESCRIPTION COVEREAGE INFORMATION:

Insurance Company: _____

Policy Number: _____

Group # (If applicable):_____Insurance Phone: _____

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ADULT PATIENT MEDICAL HISTORY

Patient Name: _____ **Sex:** M F **Date of Birth:** ___/___/___ SS#_____

Medical History:
Please list any current medical conditions (example: High blood pressure, Asthma, Stroke, etc):

Medication Allergies (Include reaction):

Medications (Includes birth control, over the counter, vitamins, supplements, and herbal remedies):

Name:	Dose	Frequency	Reason for use

Pharmacy Name & Address: _____ **Phone:** _____

Surgeries:	Year	Procedure	Facility

Psychiatric Hospitalizations:	Year	Reason	Facility

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FAMILY PSYCHIATRIC HISTORY

Please list below any psychiatric medical illnesses in your family.

Father _____ Mother _____

Brother(s) _____ Sister(s) _____

Additional family members (not listed above) _____

PERSONAL BACKGROUND

Education level completed (please circle 1): Grade School High School College Graduate Degree

Marital status (please circle 1): Single Married Divorced Widowed Separated

Living situation (please circle all that apply): Alone Spouse/Partner Child(ren) Nursing Home

Assisted Living Facility Homeless College housing Other:_____

Occupation: _____ Employer: _____
Or circle one below:
Unemployed Retired Disabled/ Cause of disability _____

Tobacco/Vape Use: Yes____ No____ Former____ #Years_____ #Packs/day____ #Years quit_____
Alcohol Use: Yes_____ No_____ Former_____ Frequency_____ Abuse Y/N
Drug Use: Yes_____ No_____ Former_____ Type_____ IV Drugs Y/N
Have you ever been to rehab? Yes, if so where_____No_____

Are you now or have you ever been in the US military or armed forces? Yes_____ No_____
Have you ever been convicted of a felony or served jail time? Yes_____ No_____

I have completed this intake form to the best of my ability. I agree to allow the Ghaly Healing & Wellness Center to send a bill for treatment(s) to my insurance carrier and bill me for any balances that may incur.

Patient Name (Please print)_____

Patient Signature _____**Date** _____

PATIENT NAME:_____ DATE:_____

BECK DEPRESSION SCALE- ON THIS QUESTIONNAIRE ARE GROUPS OF STATEMENTS. PLEASE READ EACH ONE CAREFULLY, AND CIRCLE THE ANSWER(S) THAT BEST DESCRIBE THE WAY YOU HAVE BEEN FEELING THE PAST WEEK, INCLUDING TODAY. IF SEVERAL IN THE GROUP SEEM TO APPLY EQUALLY, CIRCLE EACH ONE.

0 I DO NOT FEEL SAD	0 I DON'T HAVE ANY THOUGHTS OF KILLING MYSELF.	0 I CAN WORK ABOUT AS WELL AS BEFORE.
1 I FEEL SAD	1 I HAVE THOUGHTS OF KILLING BUT WOULD NOT CARRY THEM OUT	1 IT TAKES EXTRA EFFORT TO GET STARTED AT SOMETHING.
2 I AM SAD ALL THE TIME. I CAN'T SNAP OUT OF IT.	2 I WOULD LIKE TO KILL MYSELF.	2 I HAVE TO PUSH MYSELF VERY HARD TO DO ANYTHING.
3 I AM SO SAD OR UNHAPPY, I CAN'T STAND IT.	3 I WOULD KILL MYSELF IF I HAD THE CHANCE.	3 I CAN'T DO ANY WORK AT ALL.
0 I AM NOT PARTICULARLY DISCOURAGED ABOUT THE FUTURE	0 I DON'T CRY ANY MORE THAN USUAL.	0 I CAN SLEEP AS WELL AS USUAL.
1 I FEEL DISCOURAGED ABOUT THE FUTURE.	1 I CRY MORE THAN I USED TO.	1 I DON'T SLEEP AS WELL AS I USED TO.
2 I FEEL I HAVE NOTHING TO LOOK FORWARD TO.	2 I CRY ALL THE TIME NOW.	2 I WAKE UP 1-2 HOURS EARLIER THAN USUAL AND FIND IT HARD TO GET BACK TO SLEEP.
3 I FEEL THAT THE FUTURE IS HOPELESS AND THAT THINGS CANNOT IMPROVE.	3 I USED TO BE ABLE TO CRY, BUT NOW I CAN'T, EVEN THOUGH I WANT TO.	3 I WAKE UP SEVERAL HOURS EARLIER THAN I USED TO AND CANNOT GET BACK TO SLEEP.
0 I DO NOT FEEL LIKE A FAILURE	0 I AM NO MORE IRRITATED NOW THAN I EVER AM.	0 I DON'T GET MORE TIRED THAN USUAL.
1 I FEEL I HAVE FAILED MORE THAN THE AVERAGE PERSON.	1 I GET ANNOYED OR IRRITATE MORE EASILY THAN I USED TO.	1 I GET TIRED MORE EASILY THAN I USED TO.
2 AS I LOOK BACK ON MY LIFE, ALL I CAN SEE IS A LOT OF FAILURES.	2 I FEEL IRRITATED ALL THE TIME NOW.	2 I GET TIRED FROM DOING ALMOST ANYTHING.
3 I FEEL I AM A COMPLETE FAILURE AS A PERSON.	3 I DON'T GET IRRITATED AT ALL BY THE THINGS THAT USED TO IRRITATE ME.	3 I AM TOO TIRED TO DO ANYTHING.
0 I GET AS MUCH SATISFACTION OUT OF THINGS AS I USED TO	0 I HAVE NOT LOST INTEREST IN OTHER PEOPLE.	0 MY APPETITE IS NO WORSE THAN USUAL.
1 I DON'T ENJOY THINGS THE WAY I USED TO.	1 I AM LESS INTERESTED IN OTHER PEOPLE THAN I USED TO BE.	1 MY APPETITE IS NOT AS GOOD AS IT USED TO BE
2 I DON'T GET REAL SATISFACTION OUT OF ANYTHING ANYMORE.	2 I HAVE LOST MOST OF MY INTEREST IN OTHER PEOPLE.	2 MY APPETITE IS MUCH WORSE NOW.
3 I AM DISSATISFIED OR BORED WITH EVERYTHING.	3 I HAVE LOST ALL OF MY INTEREST IN OTHER PEOPLE.	3 I HAVE NO APPETITE AT ALL ANYMORE.
0 I DON'T FEEL PARTICULARLY GUILTY.	0 I MAKE DECISIONS ABOUT AS WELL AS I EVER COULD.	0 I HAVEN'T LOST MUCH WEIGHT IF ANY LATELY.
1 I FEEL GUILTY A GOOD PART OF THE TIME.	1 I PUT OFF MAKING DECISIONS MORE THAN I USED TO.	1 I HAVE LOST MORE THAN 5 POUNDS.
2 I FEEL QUITE GUILTY MOST OF THE TIME.	2 I HAVE GREATER DIFFICULTY IN MAKING DECISIONS THAN BEFORE.	2 I HAVE LOST MORE THAN 10 POUNDS.
3 I FEEL GUILTY ALL OF THE TIME.	3 I CAN'T MAKE DECISIONS AT ALL ANYMORE.	3 I HAVE LOST MORE THAN 15 POUNDS.
0 I DON'T FEEL I AM BEING PUNISHED	0 I DON'T FEEL I LOOK ANY WORSE THAN I USED TO.	0 I AM NO MORE WORRIED ABOUT MY HEALTH THAN USUAL.
1 I FEEL I MAY BE PUNISHED.	1 I AM WORRIED THAT I AM LOOKING OLD AND UNATTRACTIVE.	1 I AM WORRIED ABOUT PHYSICAL PROBLEMS, SUCH AS ACHES AND PAINS, UPSET STOMACH ETC.
2 I EXPECT TO BE PUNISHED.	2 I FEEL THAT THERE ARE PERMANENT CHANGES IN MY APPEARANCE THAT MAKE ME LOOK UNATTRACTIVE.	2 I AM VERY WORRIED, IT'S HARD TO THINK OF MUCH ELSE.
3 I FEEL I AM BEING PUNISHED.	3 I BELIEVE THAT I LOOK UGLY.	3 I AM SO WORRIED THAT I CANNOT THINK OF ANYTHING ELSE.
0 I DON'T FEEL DISAPPOINTED IN MYSELF.	0 I DON'T FEEL I AM ANY WORSE THAN ANYBODY ELSE	0 I HAVE NOT NOTICED ANY CHANGES IN MY INTEREST IN SEX.
1 I AM DISAPPOINTED IN MYSELF.	1 I AM CRITICAL OF MY WEAKNESSES OR MISTAKES	1 I AM LESS INTERESTED IN SEX THAN I USED TO BE.
2 I AM DISGUSTED WITH MYSELF.	2 I BLAME MYSELF ALL THE TIME FOR MY FAULTS.	2 I AM MUCH LESS INTERESTED IN SEX NOW.
3 I HATE MYSELF.	3 I BLAME MYSELF FOR EVERYTHING BAD THAT HAPPENS	3 I HAVE LOST INTEREST IN SEX COMPLETELY.

Total Score:_____

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Hamilton Rating Scale for Depression

Name:_____ **Date:**_____

Please circle ONE number that best describes you:

Depressed Mood
(sadness, hopeless, helpless, worthless)
0 None
1 Yes but I will only admit it if you ask me directly
2 Yes, I specifically feel depressed
3 Yes but also communicated through facial expression, posture, voice and tendency to weep (people notice you look depressed)
4 Yes, I have VIRTUALLY ONLY these feelings

Feelings of Guilt
0 None
1 Self-blame, feels like you have let people down
2 Ideas of guilt or obsessing over past errors or sinful deeds
3 Present illness is a punishment. Delusions of guilt
4 Hears abusive or criticizing voices and/or experiences threatening visual hallucinations

Suicide
0 None
1 Feels life is not worth living
2 Wishing you were dead or any thoughts of possible death to self
3 Suicide ideas or gestures
4 Attempts at suicide (any serious attempt rates 4)

Insomnia - Early
0 No difficulty falling asleep
1 Complains of occasional difficulty falling asleep
2 Complains of nightly difficulty falling asleep

Insomnia - Middle
0 No difficulty
1 Complains of being restless and disturbed during the night
2 Waking during the night – any getting out of bed rates 2 (except for purposes of voiding)

Insomnia - Late
0 No difficulty
1 Waking in early hours of the morning but goes back to sleep
2 Unable to fall asleep again if gets out of bed

Work and Activities
0 No difficulty
1 Thoughts and feelings of incapacity, fatigue or weakness related to activities; work or hobbies
2 Loss of interest in activity; hobbies or work – (feels like you have to push self to work or do activities)
3 Decrease in actual time spent in activities or decrease in productivity.
4 Stopped working because of present illness.

Psychomotor Retardation:
(slowness of thought and speech; impaired ability to concentrate; decreased motor activity)
0 Normal speech and thought
1 Slight slowness of thought, movement
2 Obvious slowness of thought, movement
3 Difficulty communicating at all
4 Complete stupor

Agitation
0 None
1 Fidgetiness
2 Playing with hands, hair etc
3 Moving about – can't sit still
4 Hand Wringing, nail biting, hair pulling, biting of lips

Anxiety - Psychological
0 No difficulty
1 Tension and irritability
2 Worrying about minor matters
3 Apprehensive attitude, apparent to those around you
4 Fears expressed openly

Anxiety - Somatic
0 None *Physiological symptoms of anxiety such as:*
1 Mild *dry mouth, indigestion, diarrhea, cramps*
2 Moderate *belching, palpitations, headaches, sighing*
3 Severe *hyperventilation, urinary frequency, sweating*
4 Incapacitating

Somatic Symptoms - Gastrointestinal
0 None
1 Loss of appetite but eating without encouragement.
2 Difficulty eating without urging. Takes laxatives or medications for bowels or for GI symptoms

Somatic Symptoms - General
0 None
1 Heaviness in limbs, back or head, backaches, headache, muscle aches, loss of energy and fatigability
2 Any clear-cut symptoms

Genital Symptoms
0 None
1 Mild Symptoms such as: loss of libido,
2 Severe menstrual disturbances

Hypochondriasis (Health phobias)
0 None
1 Self-absorbed about specific bodily parts
2 Preoccupation with over-all health
3 Frequent complaints, requests for help, etc.
4 Delusions regarding being sick

Loss of Weight
0 No weight loss
1 Probable weight loss associated with present illness
2 Definite weight loss

Insight
0 Acknowledges being depressed and ill
1 Acknowledges illness but attributes cause to bad food, climate, overwork, virus, need for rest, etc.
2 Denies being ill at all

Daily Variation
A. Are symptoms worse in the morning or evening.
0 No difference
1 Worse in the AM
2 Worse in the P
B: If symptoms are present, note how severe:
0 None
1 Mild
2 Severe

Depersonalization and Derealization (Feelings of unreality)
0 None
1 Mild
2 Moderate
3 Severe
4 Incapacitating

Paranoid Symptoms
0 None
1 Suspicious
2 Ideas of reference (I <u>think</u> people are after me, people are talking about me, ect)
3 Delusions of reference or of persecution (I <u>know</u> people are after me, etc)

Obsessional & Compulsive Symptoms
0 None
1 Mild
2 Severe

TOTAL SCORE:_____

PATIENT NAME: _____ **DATE:** _____

Epworth Sleepiness Scale (ESS)

The following questionnaire will help you measure your general level of daytime sleepiness. You are to rate the chance that you would doze off or fall asleep during different routine daytime situations. Answers to the questions are rated on a reliable scale called the Epworth Sleepiness Scale (ESS). Each item is rated from 0 to 3, with 0 meaning you would never doze or fall asleep in a given situation, and 3 meaning that there is a very high chance that you would doze off or fall asleep in that situation. Even if you haven't done some of these activities recently, thing about how they would affect you.

Use this scale to choose the most appropriate number for each situation
0 = would never doze 2 = moderate chance of dozing
1 = slight chance of dozing 3 = high chance of dozing
It is important that you circle a number (0-3) on each of the questions.

Situation	**Chance of dozing (0-3)**
Sitting and reading	0 1 2 3
Watching television	0 1 2 3
Sitting inactive in a public place- for example, a theater or meeting	0 1 2 3
As a passenger in a car for an hour without a break	0 1 2 3
Lying down to rest in the afternoon	0 1 2 3
Sitting and talking to someone	0 1 2 3
Sitting quietly after lunch (when you've had no alcohol)	0 1 2 3
In a car, while stopped in traffic	0 1 2 3
	Total Score:

Fatigue Severity Scale (FSS)

The Fatigue Severity Scale (FSS) is a method of evaluating the impact of fatigue on you. The FSS is a short questionnaire that requires you to rate your level of fatigue. The FSS questionnaire contains nine statements that rate the severity of your fatigue symptoms. Read each statement and circle a number from 1 to 7, based on how accurately it reflects your condition during the past week and the extent to which you agree or disagree that the statement applies to you.

- A low value (e.g., 1) indicates strong disagreement with the statement, whereas a high value (e.g., 7) indicates strong agreement.
- It is important that you circle a number 1 to 7 for every question.

During the past week, I have found that:	**Disagree - Agree**
1. My motivation is lower when I am fatigued.	1 2 3 4 5 6 7
2. Exercise brings on more fatigue.	1 2 3 4 5 6 7
3. I am easily fatigued.	1 2 3 4 5 6 7
4. Fatigue interferes with my physical functioning.	1 2 3 4 5 6 7
5. Fatigue causes frequent problems for me.	1 2 3 4 5 6 7
6. My fatigue prevents sustained physical functioning.	1 2 3 4 5 6 7
7. Fatigue interferes with marrying out certain duties and responsibilities.	1 2 3 4 5 6 7
8. Fatigue is among my three most disabling symptoms.	1 2 3 4 5 6 7
9. Fatigue interferes with my work, family, or social life.	1 2 3 4 5 6 7
	Total Score:

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Patient Treatment Contract
All Patients must sign this contract to receive prescriptions from our office.

As a patient of Ghaly Healing I freely and voluntarily agree to accept this treatment contract as follows:

- I agree to keep and be on time to all my scheduled appointments and acknowledge that if I am late for my appointment I may be asked to reschedule.
- I agree to pay all copays and balances at the time of my appointment and agree to adhere to the payment policies outlined by this office.
- I agree that a missed appointment may result in me not being able to get medications/prescriptions until my next scheduled appointment.
- I understand that it is my responsibility to update the office of any changes to my address, phone number and insurance information.
- I agree to conduct myself in a courteous and respectful manner to both providers and staff of Ghaly Healing & Wellness Center. Disruptive, belligerent, abusive or discourteous behavior is grounds for discharge from our office.
- I understand that any illegal or disruptive activities observed by any provider may result in immediate discharge from the practice without any recourse for appeal.
- I understand I may be required to do a drug screen via urine or oral fluid at every appointment or randomly as seen fit by my provider. If I refuse to do a drug screen, I understand that my controlled medications may be discontinued by my provider and I may be subject to discharge from the office dependent upon the circumstances.
- I agree that my medications/prescriptions can only be given to me at my regular office visits unless otherwise approved by my provider at their discretion.
- I acknowledge that I must allow up to (3) business days for all medication prior- authorizations.
- I understand that samples of medications are given as a courtesy and cannot be consistently relied upon.
- I understand any lost medication and/or written prescriptions will not be replaced and will be reported to the DEA.
- I agree not to obtain psychiatric or controlled medications from any providers, pharmacies, or other sources without my treating provider at the Ghaly Healing & Wellness Center having knowledge of it.
- I agree not to sell, share or give any of my medications to another person.
- I understand I may be asked to bring my medications in for a pill count upon request.
- I agree to take my medication as prescribed by my treating provider at Ghaly Healing & Wellness Center.
- I understand that any mishandling of my medication is a serious violation of this agreement and will result in the immediate discharge from the Ghaly Healing & Wellness Center without recourse for appeal.
- I agree to abstain from all illicit drugs and/or mood altering substances.
- I acknowledge that it is medically advised by all providers of Ghaly Healing & Wellness Center to abstain from alcohol consumption.
- I agree that any unusual behavior witnessed by the employees of my pharmacy or by staff of our office will be reported to my provider at the Ghaly Healing & Wellness Center.

By signing this contract I agree that any violation to the above may be grounds for immediate termination of treatment.

Print Name:_____

Patient Signature_____ **Date:**_____

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Name _____ MR # _____ Date _____ Updated _____ _____ _____ _____

Start in the "ever taken" column by marking the treatments you have received in your lifetime. Complete the rest of the questions for each marked treatment. ***This information is important as it will help us determine the course of action in treating your symptoms.***

	Medication	Ever taken?	Last taken? (month/year)	Taken as directed for >6 weeks?	Highest dose/level	Did it help? Yes	Did it help? No	Side effects? What?
SSRI	Fluoxetine (Prozac)							
	Paroxetine (Paxil)							
	Sertraline (Zoloft)							
	Citalopram (Celexa)							
	Escitalopram (Lexapro)							
	Fluvoxamine (Luvox)							
SNRI	Duloxetine (Cymbalta)							
	Venlafaxine (Effexor)							
	Desvenlafaxine (Pristiq)							
	Milnacipram (Savella)							
	Levomilnacipram (Fetzima)							
Other	Vilazodone (Viibryd)							
	Vortcoxetine (Brintellix)							
	Bupropion (Wellbutrin)							
	Mirtazapine (Remeron)							
	Nefazodone (Serzone)							
	Trazodone (Desyrel)							
	Agomelatine (Valdoxan)							
TCA	Clomipramine (Anafranil)							
	Imipramine (Tofranil)							
	Amitriptyline (Elavil)							
	Desipramine (Noripramin)							
	Nortriptyline (Pamelor)							
	Trimipramine (Surmontil)							
	Amoxapine (Asendin)							
	Maprotiline (Ludiomil)							
	Doxepin (Sinequan)							
	Protriptyline (Vivactil)							
[illegible]	[illegible]							
	[illegible]							
	[illegible]							
	[illegible]							

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	Medication	Ever taken?	Last taken? (month/year)	Taken as directed for >6 weeks?	Highest dose/level	Did it help?		Side effects? What?
						Yes	No	
Antipsychotics	Aripiprazole (Abilify)							
	Quetiapine (Seroquel)							
	Olanzapine (Zyprexa)							
	Risperidone (Risperdal)							
	Paliperidone (Invega)							
	Ziprasidone (Geodon)							
	Clozapine (Clozaril)							
	Asanapine (Saphris)							
	Lurasidone (Latuda)							
	Haloperidol (Haldol)							
	Thioridazine (Mellaril)							
	Chlorpromazine-Thorazine							
	Perphenazine (Trilafon)							
	Trifluoperazine (Stelazine)							
Stabilizers	Lithium salts (Lithium)							
	Valproic acid / Depakote							
	Lamotrigine (Lamictal)							
	Carbamazepine (Tegretol)							
	Oxcarbazepine (Trileptal)							
Stimulants	Amphetamines (Adderall)							
	Dexamphetamine -Dexedrine							
	Dexmethylphenidate-Focalin							
	Lisdexamfetamine-Vyvanse							
	Ritalin/concerta							
	Modafinil (Provigil)							
	Armodafinil (Nuvigil)							
	Atomoxetine (Strattera)							
Other Agents	Buspirone (Buspar)							
	Liothyronine (Cytomel)							
	Gabapentin (Neurontin)							
	Pramipexole (Mirapex)							
	Omega 3 (Fish oil)							
	Methylfolate (Deplin)							
	Folate – Folic acid							

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Medication	Ever taken?	Last taken? (month/year)	Taken as directed for >6 weeks?	Highest dose/level	Did it help? Yes	Did it help? No	Side effects? What?
Testosterone/Androgel							
Estrogen							
Topiramate (Topomax)							
SAMe							
Roprinole (Requip)							
Inositol							
Varenicline (Chantix)							
[redacted]							

Treatment	Ever received?	Last received/used? (month/year)	Type of stimulation: 1 side	Type of stimulation: 2 sides	# of sessions: <6	# of sessions: 6-12	# of sessions: >12	Did it help? Yes	Did it help? No	Side effects? What??
ECT										
TMS										
t-DCS										
VNS			[redacted]							
DBS										
[redacted]										
Psychotherapy (CBT)										
Psychotherapy (DBT)										
Psychotherapy (Other)										

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ 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 _____

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Financial Responsibility Agreement:

Ghaly Healing & Wellness Center reserves the right to charge for services rendered by any practitioner or provider employed by Ghaly Healing & Wellness Center for all services rendered at our clinic. Please see the different sections below to indicate how payment will be collected and services will be billed. For any questions regarding this section, please be sure to ask one of our staff members.

Payments and Billing: Billing for services rendered is handled by our Billing Department. For privacy reasons, we do not fax or email statements unless specifically requested as a one-time courtesy. We expect co-pays and any co-insurance or deductibles to be paid at the time of service. To maintain a manageable client balance, the front office personnel will require payment of your co-insurance or deductible at the time of service. In some instances, clients may receive a statement due to insurance changes or other reasons.

Use of Insurance Plans: By signing this form, you acknowledge that your insurance coverage, notification of any pre-authorization requirement, and terms of coverage are ultimately your responsibility. You acknowledge that insurance verification checks may not always reflect recent insurance claims, coverage of benefits, or other information. We make every attempt to verify your benefits and obtain pre-authorization and will communicate this to you. If it is not provided or different from what is communicated to us by your insurance provider, you understand that benefits checks and re-authorization is not a guarantee of payment. If pre-authorization is obtained, but your insurance provider rejects services, you may still be responsible for payment of services provided. We make every effort to obtain pre-authorization for services prior to the start of care and will communicate coverage with you. However, insurance changes occur during the course of treatment and it is your responsibility to notify our office of any changes.

Billing Retractions: Some insurance companies may pre-authorize and/or pay for service and then retract payment at their own discretion at a later date. If this happens, the patient is responsible for the balance of their treatments. While our office will make every effort to work with you to arrange feasible billing options, significantly high balances after a reasonable amount of time to arrange payment are subject to termination of future treatments and the balance being transferred to a collections agency.

Past Due Balances: By signing this document, you acknowledge that unpaid balances of 30 days past due status may be subject to being submitted for collections. If balances are not paid, we reserve the right to utilize collection agency services. Payments are expected at the time of service; however, if a balance is due, it is due within 30 days and may be accepted in person or by mail via cash, credit/debit card or health savings account card. In some situations, a payment plan may be arranged with Ghaly Healing & Wellness Center.

Consent to Treatment: By signing this document, you agree to the following statements: *I agree to participate in treatment and understand that a positive outcome cannot by guaranteed. I understand that positive outcomes are also based on my compliance with treatments but compliance does not guarantee a positive outcome.*

I (print name)_____ have read and understood the above conditions of this document, and agree to them. I have asked any questions I am concerned with and understand the policies outlined above.

Patient Signature:_____ Date:_____

Patient Printed Name:_____

GHALY
HEALING & WELLNESS CENTER

INFORMED CONSENT FORM

PATIENT NAME:_____ DOB: _____

The behavioral services offered at Ghaly Healing & Wellness Center begin with an evaluation to determine the level of care you may need. This evaluation does not indicate that you are a patient of Ghaly Healing & Wellness Center until recommendations are made by the evaluating practitioner. Our out-patient services are not designed to address severe mental health needs or primary care issues, therefore every attempt will be made for you to receive the appropriate services.

The purpose of this document is to give authorization regarding services and treatments I receive by Dr. Nasri Ghaly and such providers, assistants, and associates employed by Ghaly Healing & Wellness Center. I understand that behavioral health services at the Ghaly Healing & Wellness Center are designed to complement my healthcare through development skills and strategies to help improve my lifestyle and habits.

I understand it may be recommended that I take medication for treatment of my illness. While medications may provide significant benefits, they may also pose risks. I have been informed of possible side effects. I acknowledge that I have received no warranties or guarantees, and I am aware of possible outcomes of the treatment or medication I am prescribed.

If I feel compelled to stop taking any prescribed medications, I agree to speak to my treating provider to discuss the appropriate protocol. I have informed the licensed health care provider of all known allergies to substances, drugs, and medications.

In all circumstances, consent to release information is given through written authorization. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

· When there is risk or imminent danger to myself or to another person, the clinician is ethically bound to take the necessary steps to prevent such danger.

· When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

· When there is suspicion that a child or elder is being abused or is at risk of such abuse, the clinician is legally required to inform the proper authorities.

We understand the importance of the completion of disability forms. Observations regarding mental health symptoms, diagnosis past and present prognosis and treatments cannot be summarized in an initial evaluation. Therefore, we require the patient to be seen a minimum of 6 months before we can fully analyze a patient in order to accurately submit disability paperwork.

The Ghaly Healing & Wellness Center ***DOES NOT*** provide emergency services. For non-emergency issues after normal office hours, please contact our answering service at: 1-877-551-4509. In a mental health emergency you should contact the Comprehensive Psychiatric Emergency Program at St. Joseph's Hospital: (315)448-6555. Located at 201 Prospect Ave. Syracuse, NY 13203. For immediate clinical care, call 911 or go to your nearest emergency room.

I have read and fully understand this document and have had to opportunity to have any questions I may have, answered by my healthcare provider.

PATIENT SIGNATURE:_____ DATE: _____

DIRECTIONS TO OUR DOWNTOWN LOCATION:
ALPHA MEDICAL BUILDING
614 S. Salina St.
3rd Floor
Syracuse, NY 13202
(315) 425-0599

We are located on the 3rd floor of the Alpha Medical building at the corner of S. Salina St. and E. Adams St. It is across the street from the old Central Tech building and adjacent to the Centro bus hub. There is a paid parking lot in the back of the building, accessible from Clinton St. The cost is $3.00 for all-day parking.