Biltmore Psychiatric Group
6245 N. 24th Parkway, Suite 203, Phoenix, AZ 85016
Phone (602) 843-0035 • Fax (602) 843-8963

Patient Information
Patient Name: _____
Social Security Number: _____
Date of Birth: _____
Address: _____
Home Phone: _____
Work Phone: _____
Cell Phone: _____
Email Address: _____

Emergency Contact
Name: _____
Phone Number: _____

Financial Agreement
If we are contracted with your insurance plan, BPG will bill your insurance company as a courtesy to you. Patient is responsible for supplying all insurance information, including any secondary insurance coverage, at the first appointment. Patient agrees to notify the office of any changes in insurance coverage within 10 days. Patient is responsible for all charges not covered by insurance or if insurance cannot be verified, including any charges denied by insurance.

Signature (Patient or Guardian): _____
Date: _____

Contact Consent and Authorization
I, _____, hereby consent to and authorize Biltmore Psychiatric Group or any of its automated systems to contact me via phone call, text message, or email regarding any services received or any services scheduled, including but not limited to appointment reminders.

Phone Number: _____
Email: _____

Phone Call Reminders: Yes ☐ No ☐
Text Message Reminders: Yes ☐ No ☐
Email Reminders: Yes ☐ No ☐

Signature: _____
Date: _____

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Patient Information

Name: _____
Age: _____ Date of Birth: _____ Place of Birth: _____
Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed ☐
Who lives with you at home? _____
Nature of work: _____
Who referred you to us? _____
Is this your first visit to a psychiatrist's office? Yes ☐ No ☐
Why did you come to see us at this particular time? _____
Are you currently seeing a therapist or counselor? Yes ☐ No ☐
If yes, whom? _____
May we contact them? Yes ☐ No ☐

Current Medications (including over the counter medications)

Name of Medication	Strength	How Often	Physician	Reason for Use

Do you have allergies to medications? Yes ☐ No ☐

Medication	Reaction

Past Psychiatric History

Have you ever attempted suicide? Yes ☐ No ☐
Have you ever intentionally injured yourself? Yes ☐ No ☐
Have you ever been psychiatrically hospitalized? Yes ☐ No ☐

Date	Hospital	Reason

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Have you previously received psychiatric care elsewhere? Yes ☐ No ☐

Year	Doctor	City	Reason for Leaving

Past Psychiatric Medications. Please indicate your response to any of the following:

Medication	Results	Medication	Results
Prozac (fluoxetine)		Parnate (Tranylcypromine)	
Zoloft (sertraline)		Nardil (phenelzine)	
Paxil (paroxetine)		EMSAM	
Celexa (citalopram)		Lithium	
Lexapro (escitalopram)		Depakote (valproate)	
Luvox (fluvoxamine)		Tegretol (carbamazepine)	
Trintellix (vortioxetine)		Trileptal (oxcarbazepine)	
Viibryd (vilazodone)		Lamictal (lamotrigine)	
Effexor (venlafaxine)		Risperdal (risperidone)	
Pristiq (desvenlafaxine)		Zyprexa (olanzapine)	
Cymbalta (duloxetine)		Seroquel (quetiapine)	
Fetzima (levomilnacipran)		Geodon (ziprasidone)	
Wellbutrin (bupropion)		Abilify (Aripiprazole)	
Remeron (mirtazapine)		Latuda (lurasidone)	
Serzone (nefazodone)		Vraylar (cariprazine)	
Auvelity		Rexulti (brexpiprazole)	
Pamelor (nortriptyline)		Caplyta (lumateperone)	
Desipramine		Xanax (alprazolam)	
Imipramine		Klonopin (clonazepam)	
Ativan (lorazepam)		Buspar (buspirone)	
Valium (diazepam)		Ambien (zolpidem)	
Vistaril (hydroxyzine)		Lunesta (eszopiclone)	
Trazodone		Sonata (zaleplon)	
Adderall (amphetamine)		Ritalin (methylphenidate)	
Concerta		Vyvanse	
Strattera (atomoxetine)			

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PHQ-9

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling or staying asleep, or sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down				
7. Trouble concentrating on things, such as reading the news- paper or watching television				
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				
9. Thoughts that you would be better off dead or of hurting yourself in some way				

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 ☐

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all (0)	Several days (1)	More than half the days (2)	Nearly every day (3)
1. Feeling nervous, anxious or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it is hard to sit still				

6. Being easily annoyed or irritable				
7. Feeling afraid as if something awful might happen				

BSDS

1. Please read through the entire passage below before filling in any blanks.

Some individuals notice that their mood and or energy levels shift drastically from time to time. ☐
These individuals notice that, at times, their mood and/or energy level is very low, and at other times, very high. ☐
During their low phases, these individuals often feel a lack of energy; a need to stay in bed or get extra sleep, and little or no motivation to do things they need to do. ☐
They often put on weight during these periods. ☐
During their low phases, these individuals often feel "blue," sad all the time, or depressed. ☐
Sometimes, during these low phases, they feel hopeless or even suicidal. ☐
Their ability to function at work or socially is impaired. ☐
Typically, these low phases last for a few weeks, but sometimes they last only a few days. ☐
Individuals with this type of pattern may experience a period of "normal" mood in between mood swings, during which their mood and energy levels feel "right" and their ability to function is not disturbed. ☐
They may then notice a marked shift or "witch" in the way they feel. ☐
Their energy increases above what is normal for them, and they often get many things done they would not ordinarily be able to do. ☐
Sometimes, during these "high" periods these individuals feel as if they have too much energy or feel "hyper". ☐
Some individuals, during these high periods, may feel irritable, "on edge", or aggressive. ☐
Some individuals, during these high periods, take on too many activities at once. ☐
During these periods, some individuals may spend money in ways that cause them trouble. ☐
They may be more talkative, outgoing, or sexual during these periods. ☐
Sometimes, their behavior during these high periods seems strange or annoying to others. ☐
Sometimes, these individuals get into difficulty with coworkers or the police during these high periods. ☐
Sometimes, they increase their alcohol or non-prescription drug use during these high periods. ☐

2. Now that you have read this passage, please check one of the following four boxes:

☐ This story fits me very well, or almost perfectly
☐ This story fits me fairly well
☐ This story fits me to some degree, but not in most respects
☐ This story does not really describe me at all

3. Now please go back and put a check after each sentence that definitely describes you.

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PC-PTSD-5

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example: a serious accident or fire, a physical or sexual assault or abuse, an earthquake or flood, a war, seeing someone be killed or seriously injured, having a loved one die through homicide or suicide.

Have you ever experienced this kind of event? Yes ☐ No ☐

If no, screen total = 0. Please stop here. If yes, please answer the questions below.

In the past month, have you...	**Yes**	**No**
Had nightmares about the event(s) or thought about the event(s) when you did not want to?	☐	☐
Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?	☐	☐
Been constantly on guard, watchful, or easily startled?	☐	☐
Felt numb or detached from people, activities, or your surroundings?	☐	☐
Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?	☐	☐

ACE

From the list below, please place a checkmark next to each ACE category that you experience prior to your 18th birthday.	**Yes**	**No**
1. Did you feel you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?	☐	☐
2. Did you lose a parent through divorce, abandonment, death, or other reason?	☐	☐
3. Did you live with anyone who was depressed, mentally ill, or attempted suicide?	☐	☐
4. Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?	☐	☐
5. Did your parents or adults in your home hit, punch, beat, or threaten to harm each other?	☐	☐
6. Did you live with anyone who went to jail or prison?	☐	☐
7. Did a parent or adult in your home ever swear at you, insult you, or put you down?	☐	☐
8. Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?	☐	☐
9. Did you feel that no one in your family loved you or thought you were special?	☐	☐
10. Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?	☐	☐

Substance Use

Do you drink alcohol? Yes ☐ No ☐ How many drinks per week? _____

How much caffeine do you consume? _____

Do you smoke or vape? Yes ☐ No ☐ Do you use marijuana? Yes ☐ No ☐

Do you use street drugs? Yes ☐ No ☐ What and how often? _____

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Past Medical History
Do you have any medical conditions?

Condition	Yes	No	Comments
Thyroid Disease			
Headache			
Chronic Pain			
Orthopedic Issues			
Arthritis			
Heart Disease			
Hypertension			
Stroke			
Diabetes			
Kidney Disease			
Liver Disease			
Lung Disease			
Cancer			
Other			

Have you had any surgeries?

Age/Year	Surgery

Family History
Does anyone in your family have any of the following?

Condition	Who (e.g., grandmother)	Outcome
Depression		
Bipolar Disorder		
Schizophrenia		
Alcoholism		
Drug Abuse		
Psych Hospitalization		
Suicides		

Psychosocial Background
Father: Age: _____ Occupation: _____
Mother: Age: _____ Occupation: _____
How did you parents get along with each other? _____
Are you parents? Married ☐ Divorced/Separated ☐ Deceased ☐
Were you raised by your parents? Yes ☐ No ☐ If not, by whom? _____
Brothers _____ Ages _____
Sisters _____ Ages _____
How far did you go in school? _____

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Military Service
Did you serve in the military? Yes ☐ No ☐ Which branch? _____
What was your discharge rank and type? _____

Adult
How many children do you have? _____ Ages: _____
What was the worst difficulty you were ever in with the law? _____
Do you own any weapons? _____
How many and what type? _____
What was the most traumatic event in your life? _____
What one word would you use to describe your personality? _____
What one word you use to communicate how you feel? _____
Is there anything else that you think the doctor should know? Yes ☐ No ☐
If yes, please describe briefly: _____
_____
_____

Signature: _____ Date: _____

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Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. You have the right to obtain a paper copy of this notice upon request.

Patient Health Information

Under federal law, your patient health information is protected and confidential. Patient health information includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your health information also includes payment, billing, and insurance information.

How We Use Your Patient Health Information

We use health information about you for treatment, to obtain payment, and for health care operations, including administrative purposes and evaluation of the quality of care that you receive. Under some circumstances, we may be required to use or disclose the information without your permission.

Examples of Treatment, Payment, and Health Care Operations

Treatment: We will use and disclose your health information to provide you with medical treatment or services. For example, nurses, physicians, and other members of your medical team will record information in your record and use it to determine the most appropriate course of care. We may also disclose the information to other health care providers who are participating in your treatment, and to pharmacists who are filling your prescriptions.
Payment: We will use and disclose your health information for payment purposes. For example, we may need to obtain authorization from your insurance company before providing certain types of treatment. We will submit bills and maintain records of payments from your health plan.
Health Care Operations: We will use and disclose your health information to conduct our standard internal operations, including proper administration of records, evaluation of the quality of treatment, and to assess the care and outcomes of your case and others like it.

Special Uses

We may use your information to contact you with appointment reminders. We may also contact you to provide information about treatment alternatives or other health related benefits and services that may be of interest to you.

Other Uses and Disclosures

We may use or disclose identifiable health information about you for other reasons, even without your consent. Subject to certain requirements, we are permitted to give out health information without your permission for the following purposes:

Required by Law: We may be required by law to report gunshot wounds, suspected abuse or neglect, or similar injuries or events.

Research: We may use or disclose information for approved medical research.

Public Health Activities: As required by law, we may disclose vital statistics, diseases, information related to recalls of dangerous products, and similar information to public health authorities.

Health Oversight: We may be required to disclose information to assist in investigations and audits, eligibility for government programs, and similar activities.

Judicial and Administrative Proceedings: We may disclose information in response to an appropriate subpoena or court order.

Law Enforcement Purposes: Subject to certain restrictions, we may disclose information required by law enforcement officials.

Deaths: We may report information regarding deaths to coroners, medical examiners, funeral directors, and organ donation agencies.

Serious Threat to Health or Safety: We may use and disclose information when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Military and Special Government Functions: If you are a member of the armed forces, we may release information as required by military command authorities. We may also disclose information to correctional institutions or for national security purposes.

Workers Compensation: We may release information about you for workers compensation or similar programs providing benefits for work related injuries or illness.

In any other situation, we will ask for your written authorization before using or disclosing any identifiable health information about you. If you choose to sign an authorization to disclose information, you can later revoke that authorization to stop any future uses and disclosures.

Individual Rights
You have the following rights regarding your health information. Please contact the office to obtain the appropriate form for exercising these rights.

Request Restrictions: You may request restrictions on certain uses and disclosures of your health information. We are not required to agree to such restrictions, but if we do agree, we must abide by those restrictions.

Confidential Communications: You may ask us to communicate with you confidentially by, for example, sending notices to a special address or not using postcards to remind you of your appointments.

Inspect and Obtain Copies: In most cases, at the discretion of your physician, you have the right to look at or get a copy of your health information. There may be a charge for the copies.

Amend Information: If you believe that information in your record is incorrect, or if important information is missing, you have the right to request that we correct the existing information or add the missing information. Accounting of Disclosures: You may request a list of instances where we have disclosed health information about you for reasons other than treatment, payment, or health care operations.

Our Legal Duty
We are required by law to protect and maintain the privacy of your health information, to provide this notice about our legal duties and privacy practices regarding protected health information, and to abide by the terms of the notice currently in effect.

Changes in Privacy Practices
We may change our policies at any time. Before we make a significant change in our policies, we will change our notice and post the new notice in the waiting area. You can also request a copy of our notice at any time.

Complaint
If you are concerned that we have violated your privacy rights, or if you disagree with a decision we made about your records, you may discuss it with your attending physician. You may also send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

Contact Person
If you have any questions, requests, or complaints, please contact our office at:
6245 N 24th Parkway, Suite 203
Phoenix, AZ 85016
(602) 843-0035

I, _____, hereby acknowledge receipt of the Notice of Privacy Practices given to me.

Signed: _____
Date: _____

If not signed, reason why acknowledgment was not obtained: _____
Staff Witness seeking acknowledgment: _____ Date: _____

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Office Policies and Conditions of Treatment

I hereby authorize BPG to conduct an evaluation and perform treatment for myself and/or my dependents with regard to psychiatric or behavioral health problems.
My signature below indicates I have read and understood the following office policies and conditions of care:

Release of Information: The professional staff at BPG may disclose all or any part of the patient's medical and/or financial records to the following third parties:

1.Any party liable for payment of all or part of the patient's financial obligation such as insurance companies, workman's compensation payers, government agencies, etc.
2.Any concurrent treating professional, including psychiatrists, psychologists, social workers, and/or the therapist at the discretion of the responsible clinician.
3.Primary care, referring and other treating healthcare professionals to provide continuity of treatment or demonstrate medical necessity of continuing care.

Financial Agreement: If we are contracted with your plan, BPG will bill your insurance as a courtesy to you. Patient is responsible for supplying all insurance information, including any secondary insurance coverage, at the first appointment. Patient agrees to notify the office of any changes in insurance coverage within 10 days. **Patient is responsible for all charges not covered by insurance or if insurance cannot be verified, including any charges denied by insurance.**

Collection Fees: In the event that you fail to fulfill your financial obligations to the practice, BPG reserves the right to forward your account to an outside collection agency for resolution. Patient and/or guarantor will be responsible for any and all Collection Agency Fees, Attorney Fees, and any other Legal Fees associated with the debt incurred.

***Initial here to acknowledge understanding (____)**

Co-payments and deductibles are due at the time of service; a **$15.00 billing fee** will be assessed if these payments are not made at that time. Checks returned for lack of funds (NSF) will be subject to a **$25.00 processing fee**.

***Initial here to acknowledge understanding (____)**

Appointments: Professional services are by appointment only. There will be a fee charged (50% to 100% of appointment charge) for all appointments missed that were not canceled with 24-hour advance notice. **NO EXCEPTIONS.**

***Initial here to acknowledge understanding (____)**

Office Hours: Our office hours are Monday through Thursday from 7:00 a.m. to 5:00 p.m. The nurse is available on Fridays for urgent calls from 8:00 a.m. until 12:00 p.m. From 12 p.m. to 5 p.m. on Fridays, after hours and on weekends, our on-call physician is available for urgent

matters through the answering service. Non urgent messages left on Friday will not be returned until the following Monday.

Phone Calls: Excessive calls from patients to Professionals between office visits are subject to a charge according to time.

Paperwork: There will be an additional charge for written reports, letters, correspondence, and disability forms not completed during a visit.
Minimum fee $35.00.

Prescriptions: Contact your pharmacy directly for refills on prescriptions. The pharmacy will contact our office for approval. Please allow at least 48 hours for approval on all prescriptions as refills are processed Monday through Thursday 8:00 am to 5:00 pm and Friday 8:00 am to12:00 pm only. **Absolutely no routine refills will be approved during evenings or on weekends.**

Signature (Patient or Guardian) _____ Date: _____