NEUROPSYCHIATRIC ASSOCIATES OF AUSTIN

PATIENT INFORMATION SHEET *Account # _____*

Name: _____ Date _____

Address: _____
(Street) (City) (State) (Zip)

Cell:_____ E-mail: _____

Home phone: _____ Date of Birth: _____

Single ___ Married ___ Partnered ___ Widowed ___ Divorced ___

Gender _____ Pronouns: _____ Sex assigned at birth: _____

Employer _____ Address _____ Phone _____

Name of Significant Other/Spouse: _____ _____ Phone _____

IN CASE OF EMERGENCY NOTFY: _____ _____ Phone _____

Relationship to patient: _____

Pharmacy Name and phone number: _____

Primary Care Physician Name and address: _____

Referred by: _____

Are you currently seeing another mental health professional? ___

If so, name and telephone number: _____

MEDICATIONS PATENT MAY BE ALLERGIC TO: _____

MEDICAL INSURANCE INFORMATION

Primary _____ Insured 's name _____

Policy # _____ Group # _____

Secondary _____ Insured 's name _____

Policy # _____ Group # _____

PATIENTS OR AUTHORIZED PERSON'S SIGNATURE: I authorize payment of medical benefits to the undersigned physician or supplier for services described below. I authorize the release of any medical or other information necessary to process this claim.

Signed _____

Responsible Party: Please complete the section below. (If different from information above)

Name _____ Relationship to patient _____

Address: _____
(Street) (City) (State) (Zip)

Employer_____ Address _____ Phone _____

Signature of patient, legal guardian or responsible party: I understand that I am responsible for payment of my bill including all charges not covered by insurance

Signature: _____

NEUROPSYCHIATRIC ASSOCIATES OF AUSTIN

Office Policy and Patient Attestation

Services Provided:

We provide a range of services including psychiatric evaluations, psychotherapy, medication management, and consultations.

Patient Responsibilities:

Patients are responsible for following their treatment plan which includes making and keeping appointments and taking medication as prescribed. If you cannot keep an appointment, you must cancel it at least forty-eight hours in advance or on Thursday in the case of a Monday appointment to avoid being charged the full fee for the appointment. Charges for late cancellations and missed appointments are not covered by insurance and are the responsibility of the patient. Be sure to reschedule any missed or cancelled appointments.

After Hours Emergencies:

We provide continuous psychiatric coverage, twenty-four hours a day, seven days a week. One member of the group is always on call to handle urgent matters when your provider is not available. When possible, contact your provider during regular working hours. Leave a brief message describing the nature of your call and telephone numbers where you can be reached either with a staff member or on your provider's voicemail or patient portal. Talk with a staff member in cases of emergency.

Calls after hours should be limited to emergencies and directed to the answering service at 512-404-9076. They will page the provider on call. If you have not heard from the provider within fifteen minutes, call the answering service again. Routine refills are not considered an emergency and are subject to a charge. Controlled substances are not prescribed by on call providers.

Prescriptions:

Prescriptions are written at scheduled appointments and should last until your next appointment, or a length deemed necessary by your provider. If you need a refill, contact your pharmacy to send a request to the office. If you need a new prescription, you must contact your provider. There will be a charge for controlled substance prescriptions written between appointments.

Insurance:

Our billing staff will assist you with payment and insurance matters. If your provider is in network with your insurance plan, we will file the claims for covered services. You must provide a copy of your insurance card and are responsible for your co-payment at the time of services.

If your provider is not in network with your insurance plan, we will not file an insurance claim for you however you may be able to file on your own for "out of network

benefits". Our billing staff can advise you regarding this process. It is your responsibility to verify your insurance and benefits coverage.

You may be charged in full for services not covered by your insurance plan (This will not occur in cases where the contract between your provider and the insurance company forbids it.). You may be billed for telephone calls, messaging, authorizations, copies of your medical record, consultations with other providers or attorneys, or for preparation of reports, letters, or forms.

Office Visits:

The charge for the initial consultation with your provider must be paid in full at the time of scheduling the appointment. Any payment subsequently received from a third party will be credited to your account or refunded. You are also responsible for payment in full at the time of follow up visits, except when the service has been preauthorized by your insurance plan. In this case you are responsible only for your co-payment.

Please schedule your appointments at least a month in advance so you will have a selection of times that are convenient for you. If you wait until the last minute to schedule an appointment, it may be several weeks before your provider has an opening. We make every effort to work patients in on short notice in cases of emergency.

Payments:

If you are unable to make payments as required by the above policy, please discuss the matter with your provider and the billing staff. Special payment schedules may be arranged, when appropriate, at the discretion of your provider. Delinquent accounts are turned over to a collection agency if payment is three months overdue and special arrangements have not been made.

We appreciate your cooperation with the office policies outlined above. Please discuss any questions or concerns with your provider or a member of the office staff. Our primary concern is the success of your treatment.

Notice Concerning Complaints: Complaints about physicians may be reported for investigation at the following address:

TMB
PO Box 2018
Austin, TX 78768-2018

PATIENT ATTESTATION: I have read and understand the above office procedures for the Neuropsychiatric Associates of Austin. I acknowledge that I have a responsibility to participate in my own care as outlined in the foregoing paragraphs.

Patient Signature *Date*

NEUROPSYCHIATRIC ASSOCIATES OF AUSTIN

Patient Clinical History

Patient Name _____ *Date of Birth* _____

Please help us to develop some of your history by answering the following questions. You may be brief in your answers but be as accurate as you can. We appreciate your cooperation.

1. *Please tell us why you have come today.*

2. *Please tell us about your PSYCHIATRIC HISTORY*

   A. *If you have had a psychiatric illness, please include here.*

   B. *Please list any psychiatric hospitalizations.*

   C. *Please list previous providers of care including psychotherapists and psychiatrists.*

   D. *Please list any history of treatment for alcohol or drug abuse*

3. *Please tell us about your MEDICAL HISTORY*

   A. *If you have any medical illness, please include here:*

☐ Hypertension	☐ Cancer	☐ Head Injury
☐ Kidney Disease/lnjury	☐ Asthma	☐ HIV/AIDS
☐ Diabetes	☐ Seizures	☐ Heart Disease
☐ Pulmonary Problems	☐ Hepatitis/Liver Disease	☐ Stroke / TIA
☐ Other (specify):		

B. *If you have had injuries of a serious nature please list them.*

C. *In the past year, how often have you used the following?*

	Never	*Once or Twice*	*Monthly*	*Weekly*	*Daily or Almost Daily*
Alcohol • *For men, 5 or more drinks a day* • *For women, 4 or more drinks a day*					
Tobacco and Nicotine Products					
Prescription Drugs *exceeding the recommended dosage*					
Recreational Drugs					
Caffeine *Coffee, energy drinks, sodas*					

4. *FAMILY HISTORY*

Please tell us about your family members as they are listed below. If they are not living, indicate the cause of death (if you know). Please list PSYCHIATRIC illnesses and any CARDIOVASCULAR diseases.

A. *Mother:*

B. *Father:*

C. *Brothers:*

D. *Sisters:*

E. *Children:*

F. *Others (Grandparents, Aunts and Uncles):*

5. *SOCIAL HISTORY*

   A. *Please list any important facts of your childhood and adolescence*

   B. *Please tell us about your educational attainment.*

   C. *With whom do you live?*

   D. *Occupation?*

6. *Please list all drug ALLERGIES*

7. *MEDICATIONS*

   A. *Please list all CURRENT PSYCHIATRIC MEDICATIONS including their doses, how long you have been taking them, side effects you have had to them, and response:*

   B. *Please list all CURRENT NON-PSYCHIATRIC MEDICATIONS you take including over the counter medications, when you take them and their doses.*

   C. *Please list all PAST PSYCHIATRIC MEDICATIONS, including their doses, how long you took them, the side effects you had to them, and your response:*

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than 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 is 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

(*For office coding: Total Score T*____ = ____ + ____ + ____)

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.