Account#______________

Date______________

PATIENT INFORMATION SHEET

Name:______________________________

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

Cell:____________________

Home phone:____________________ Date of Birth:______________

Single ____ Married ____ Partner ____ Widowed ____ Divorced ____ Male ____ Female ____

Employer______________ Address______________ Phone:______________

Name of Significant Other/Spouse:______________ Phone:______________

IN CASE OF EMERGENCY NOTIFY:______________ Phone:______________

Relationship to patient______________ Referred by:______________

Pharmacy Name and phone number:______________________________

Primary Care Physician: Name and address:______________________________

Are you currently seeing another mental health professional? __________

If so, name and telephone number:______________________________

MEDICATIONS PATIENT MAY BE ALLERGIC TO:______________________________

MEDICAL INSURANCE INFORMATION

Primary______________ Insured's name______________ Policy #______________
Group #______________

Secondary______________ Insured's name______________ Policy #______________
Group #______________

PATIENT'S 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______________________________ Date______________

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

Name______________________________ Relationship to patient______________

Address______________________________ Phone______________
(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
Patient Information

Services Provided:

Neuropsychiatric Associates of Austin is a group of psychiatrists practicing together. 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 twenty four hours in advance, or on Friday in the case of a Monday appointment, to avoid being charged. 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 doctor is not available. When possible, call your doctor during regular working hours (9:00 am to 4:00 pm). Leave a brief message describing the nature of your call, and telephone numbers where you can be reached during the day and evening, either with a staff member or on your doctor's voice mail. Talk with a staff member in cases of emergency.

Calls after hours should be limited to emergencies and directed to the answering service at 406-3157. They will page the psychiatrist on call. If you have not heard from the doctor within fifteen minutes, call the answering service again. Routine refills are not considered an emergency and are subject to a charge.

Prescriptions:

Prescriptions with refills are written at scheduled appointments and should last until your next appointment. If not, ask the pharmacist to fax a refill request to our office at 454-6276. If you need a new prescription you must speak with your doctor. There will be a charge for prescriptions for controlled substances written between appointments.

Insurance:

Our billing staff will assist you with payment and insurance matters. If you are a Medicare patient or your doctor is an approved provider on your insurance plan, we will file the necessary 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 doctor is not an approved provider on 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 with regard to this process.

Be aware that you may be charged in full, for services not covered by Medicare or your insurance plan. (This will not occur in cases where the contract between your doctor and the insurance company forbids it.) In particular you may be billed for telephone calls, copies of your medical record, consultations with other care providers or attorneys, or for preparation of reports, letters or forms.

Office Visits:

The charge for your initial consultation with your doctor must be paid in full at the time of 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 doctor 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, discuss the matter with your doctor and the billing staff. Special payment schedules can be arranged, when appropriate. Delinquent accounts are turned over to a collection agency if payment is six 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 doctor or a member or 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

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 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. Pleas tell us about your PAST 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 PAST MEDICAL HISTORY

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

- ☐ Hypertension
- ☐ Kidney Disease/Injury
- ☐ Diabetes
- ☐ Pulmonary Problems
- ☐ Cancer
- ☐ Asthma
- ☐ Seizures
- ☐ Hepatitis/Liver Disease
- ☐ Head Injury
- ☐ HIV / AIDS
- ☐ Heart 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 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 medical and psychiatric illnesses.

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?

6. Please list all drug ALLERGIES

7. MEDICATIONS

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

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

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

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...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 much 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 into 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?	❍	❍

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem   Minor Problem   Moderate Problem   Serious Problem

	YES	NO
4. Have any of your blood relatives (i.e. 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?	❍	❍

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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	______

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A2663B 10-04-2005