New Patient Psychiatric Registration Forms

Today's Date:	**Date of Birth:**

Patient Information

Last Name: **First:** **Middle:** **Preferred Name:**

Sex: ☐ Male ☐ Female ☐ Non-Binary

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Separated ☐ Other

Race: ☐ Black/African American ☐ White ☐ Asian ☐ Hispanic ☐ Mixed ☐ American Indian/Alaskan Native ☐ Other ☐ Decline to answer

Ethnicity: ☐ Hispanic ☐ Non-Hispanic ☐ Decline to answer

Address:

Primary Phone Number:	**Secondary Phone Number:**

Email:

Insurance: ☐ **United Healthcare** ☐ **Oxford** ☐ **Oscar Health** ☐ **Aetna** ☐ **Florida Blue** ☐ **Cigna** ☐ **Uninsured (Self pay)**

Preferred method of contact:		
☐ Primary Phone ☐ Secondary Phone ☐ Email	☐ Ok to leave detailed message ☐ Leave call back message only ☐ Do not leave message	**Please note:** *In order for email communication to occur, please accept the disclosure below: I understand that if email is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email communication. ☐ **YES** ☐ **NO**

Emergency Contact Information

Emergency Contact: Phone: Relationship:

Can we speak to the above person regarding your personal, medical information? ☐ Yes ☐ No

Pharmacy Information

Pharmacy Name: Address: Phone Number:

How did you hear about us? ☐ **Family/Friend** ☐ **Google Search** ☐ **Psychology Today** ☐ **Social Media**

☐ **Headway** ☐ **Referred by** _____ ☐ **Other** _____

Please complete all information on this form and submit prior to your appointment. Failure to do so will result in your appointment being rescheduled. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Name_____Date of Birth_____

Do you give permission for ongoing regular updates to be provided to your Therapist? ☐ Yes ☐ No

Current Therapist/Counselor_____Therapist's Phone_____

What is the problem(s) for which you are seeking help?

1._____
2._____
3._____

What are your treatment goals?

_____

_____

_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

☐ **Depressed mood**
☐ **Unable to enjoy activities**
☐ **Sleep pattern disturbance**
☐ **Loss of interest**
☐ **Concentration/forgetfulness**
☐ **Change in appetite**
☐ **Excessive guilt**
☐ **Fatigue**
☐ **Decreased libido**
☐ **Racing thoughts**
☐ **Impulsivity**
☐ **Increase risky behavior**
☐ **Increased libido**
☐ **Decrease need for sleep**
☐ **Excessive energy**
☐ **Increased irritability**
☐ **Crying spells**
☐ **Excessive worry**
☐ **Anxiety attacks**
☐ **Avoidance**
☐ **Hallucinations**
☐ **Suspiciousness**
☐ _____
☐ _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ☐ Yes ☐ No
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? ☐ Yes ☐ No
How often do you have these thoughts? _____
When was the last time you had thoughts of dying? _____
Has anything happened recently to make you feel this way? _____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Would anything make it better? _____
Have you ever thought about how you would kill yourself? _____
Is the method you would use readily available? _____
Have you planned a time for this? _____
Is there anything that would stop you from killing yourself? _____
Do you feel hopeless and/or worthless? _____
Have you ever tried to kill or harm yourself before? _____
Do you have access to guns? If yes, please explain. _____

Past Medical History:

Allergies_____ Current Weight_____Height _____

List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name Dosage How Often?

_____

_____

_____

_____

_____

_____

_____

Current over-the-counter medications or supplements: _____

_____

Current medical problems: _____

_____

Past medical problems, nonpsychiatric hospitalization, or surgeries: _____

_____

Have you ever had an EKG? ☐ Yes ☐ No If yes, when _____

Was the EKG ☐ normal ☐ abnormal ☐ unknown

For women only: Date of last menstrual period_____

Are you currently pregnant or do you think you might be pregnant? ☐Yes ☐ No

Are you planning to get pregnant in the near future? ☐ Yes ☐ No

Birth control method _____

How many times have you been pregnant?_____How many live births? _____

Do you have any concerns about your physical health that you would like to discuss? ☐ Yes ☐ No

Date of last physical exam: _____

Personal and Family Medical History:

	You	**Family**	**Which Family Member?**
Thyroid Disease……	☐	☐	_____
Anemia……...	☐	☐	_____
Liver Disease ……	☐	☐	_____
Chronic Fatigue ……	☐	☐	_____
Kidney Disease ……	☐	☐	_____
Diabetes ……	☐	☐	_____
Asthma/COPD/emphysema……..	☐	☐	_____
Stomach or intestinal problems ……...	☐	☐	_____
Cancer (specify) ……	☐	☐	_____
Fibromyalgia ……	☐	☐	_____
Heart Disease ……	☐	☐	_____
Epilepsy or seizures ……..	☐	☐	_____

Chronic Pain …….☐ ☐ _____

High Cholesterol …….☐ ☐ _____

High blood pressure…….☐ ☐ _____

Head trauma…….☐ ☐ _____

Liver problems …….☐ ☐ _____

When your mother was pregnant with you, were there any complications during the pregnancy or birth?

_____

Past Psychiatric History:

Outpatient treatment ☐ Yes ☐ No If yes, Please describe when, by whom, and nature of treatment.

Reason Dates Treated By Whom

_____

_____

_____

Psychiatric Hospitalization ☐ Yes ☐ No If yes, describe for what reason, when and where.

Reason Date Hospitalized Where

_____

_____

_____

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write in what you do remember).

Antidepressants

Prozac (fluoxetine) _____

Zoloft (sertraline) _____

Luvox (fluvoxamine) _____

Paxil (paroxetine) _____

Celexa (citalopram) _____

Lexapro (escitalopram) _____

Effexor (venlafaxine) _____

Cymbalta (duloxetine) _____

Wellbutrin (bupropion) _____

Pamelor (nortriptyline) _____

Anafranil (clomipramine) _____

Tofranil (imipramine) _____

Elavil (amitriptyline) _____

Remeron (mirtazapine) _____

Other _____

Mood Stabilizers

Tegretol (carbamazepine) _____

Lithium _____

Depakote (valproate) _____

Lamictal (lamotrigine) _____

Topamax (topiramate) _____

Other _____

Antipsychotics/Mood Stabilizers

Seroquel (quetiapine) _____
Zyprexa (olanzepine) _____
Geodon (ziprasidone) _____
Abilify (aripiprazole) _____
Clozaril (clozapine) _____
Haldol (haloperidol) _____
Prolixin (fluphenazine) _____
Risperdal (risperidone) _____
Other _____

Sedative/Hypnotics

Ambien (zolpidem) _____
Sonata (zaleplon) _____
Rozerem (ramelton) _____
Restoril (temazepam) _____
Desyrel (trazodone) _____
Other _____

ADHD medications

Adderall (amphetamine) _____
Concerta/ Ritalin (methylphenidate) _____
Strattera (atomoxetine) _____
Vyvanse (lisdexamfetamine) _____
Other _____

Anti-anxiety medications

Xanax (alprazolam) _____
Ativan (lorazepam) _____
Klonopin (clonazepam) _____
Valium (diazepam) _____
Buspar (buspirone) _____
Other _____

Your Exercise Level:

Do you exercise regularly? ☐ Yes ☐ No What kind of exercise do you do? _____
How many days a week? How long? _____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	☐ Yes	☐ No	Schizophrenia	☐ Yes	☐ No
Depression	☐ Yes	☐ No	Post-traumatic stress	☐ Yes	☐ No
Anxiety	☐ Yes	☐ No	Alcohol abuse	☐ Yes	☐ No
Anger	☐ Yes	☐ No	Other substance abuse	☐ Yes	☐ No
Suicide	☐ Yes	☐ No	Violence	☐ Yes	☐ No

If yes, who had each problem? _____

Has any family member been treated with a psychiatric medication? ☐ Yes ☐ No If yes, who was treated, what medications did they take, and how effective was the treatment? _____

_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ☐ Yes ☐ No

If yes, for which substances? _____

If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the greatest number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No

Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No

Have you ever felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ☐ Yes ☐ No

Do you think you may have a problem with alcohol or drug use? ☐ Yes ☐ No

Have you used any street drugs in the past 3 months? ☐ Yes ☐ No

If yes, which ones? _____

Have you ever abused prescription medication? ☐ Yes ☐ No

If yes, which ones and for how long? _____

_____

Check if you have ever tried the following:

	Yes	No	If yes, how long and when did you last use?
Methamphetamine	☐	☐	_____
Cocaine	☐	☐	_____
Stimulants (pills)	☐	☐	_____
Heroin	☐	☐	_____
LSD or Hallucinogens	☐	☐	_____
Marijuana	☐	☐	_____
Pain killers (not as prescribed)	☐	☐	_____
Methadone	☐	☐	_____
Tranquilizer/sleeping pills	☐	☐	_____
Alcohol	☐	☐	_____
Ecstasy	☐	☐	_____
Other			_____

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

Tobacco History:

How you ever smoked cigarettes? ☐ Yes ☐ No

Currently? ☐ Yes ☐ No How many packs per day on average? _____ How many years? _____

In the past? ☐ Yes ☐ No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? ☐ Yes ☐ No In the past? ☐ Yes ☐ No
What kind?_____How often per day on average?_____How many years? _____

Family Background and Childhood History:
Were you adopted? ☐ Yes ☐ No Where did you grow up? _____
List your siblings and their ages: _____
_____

What was your father's occupation? _____
What was your mother's occupation? _____
Did your parents' divorce? ☐ Yes ☐ No If so, how old were you when they divorced? _____
If your parents divorced, who did you live with?_____
Describe your father and your relationship with him: _____
_____

Describe your mother and your relationship with her: _____
_____

How old were you when you left home? _____
Has anyone in your immediate family died? _____
Who and when? _____

Trauma History:
Do you have a history of being abused emotionally, sexually, physically or by neglect? ☐ Yes ☐ No
Please describe when, where and by whom: _____
_____

Educational History:
Highest Grade Completed? _____ Where? _____

Did you attend college?_____Where?_____Major?_____
What is your highest educational level or degree attained? _____

Occupational History:
Are you currently: ☐ Working Full-time ☐ Working Part-time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired
How long in present position? _____
What is/was your occupation? _____
Where do you work? _____
Have you ever served in the military?_____If so, what branch and when? _____
Honorable discharge ☐ Yes ☐ No Other type discharge _____

Relationship History and Current Family:
Are you currently: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed
Are you sexually active? ☐ Yes ☐ No
How would you identify your sexual orientation?
☐ straight/heterosexual ☐ lesbian/gay/homosexual ☐ bisexual ☐ transsexual
☐ unsure/questioning ☐ asexual ☐ other ☐ prefer not to answer
What is your spouse or significant other's occupation? _____
Describe your relationship with your spouse or significant other:
_____
Have you had any prior marriages? ☐ Yes ☐ No If so, how many? _____

Do you have children? ☐ Yes ☐ No If yes, list ages:

Describe your relationship with your children: _____
Who do you currently live with? _____

Do you currently feel safe at home? ☐ Yes ☐ No

Legal History:
Have you ever been arrested? _____
Do you have any pending legal problems? _____
If yes, please explain. _____

Spiritual Life:
Do you belong to a particular religion or spiritual group? ☐ Yes ☐ No
If yes, what is the level of your involvement? _____

Is there anything else that you would like us to know?

Signature _____ Date _____

Print Name _____ Date of Birth _____

Kind Hearted Integrative Health, LLC Policies and Disclosures

Cancellation and No Show Policy

At Kind Hearted Integrative Health, LLC your scheduled appointment time is reserved for you. There will be a $100.00 charge if you miss, do not cancel or reschedule your scheduled appointment with a minimum of 24 hours in advance. If you miss your appointment, it is your responsibility to reschedule that appointment.

Financial Policy

Kind Hearted Integrative Health, LLC has partnered with Headway to manage all insurance claims for Florida residents. Should you have any concerns regarding insurance claims, please reach out directly to Headway.

For Self-Pay Patients: You will be billed before services are rendered, using your card on file. In addition, any remaining balance on your account will be collected at the beginning of your next visit. Kind Hearted Integrative Health, LLC does not guarantee your insurance company will reimburse you for services rendered out of network. All unpaid patient balances will be sent to collections if there has been no attempt to repay debt within 90 days from bill origination. All accounts sent to collections will be charged a $25 collection fee in addition to the account balance.

Psychiatric/Medical Forms Fee Agreement

In any case where Kind Hearted Integrative Health, LLC is requested to complete paperwork or provide a letter, a $30 fee will be required per form or letter before it will be released. It is the responsibility of the patient to deliver/fax or mail the completed form or letter to the requesting agency or company. This fee is not covered by insurance and will be paid directly to Kind Hearted Integrative Health, LLC.

Follow Up Policy

Your healthcare provider may request a follow up visit. A message from the healthcare provider will be relayed to you via your preferred method of contact. If you have any questions regarding that message, a virtual visit (follow up visit) with the healthcare provider is recommended. During your visit, medications are prescribed in an amount equal to the amount needed for treatment or until your next follow up visit. If after an appointment, your symptoms worsen or don't improve, it's your responsibility to make a follow up appointment or go to the nearest Urgent Care or Emergency Room. Failure to follow instructions can result in injury or death.

Medication Refill Policy

You must give 5 days business notice for a medication refill to be approved and processed appropriately. Your healthcare provider may need to conduct a follow up with you before issuing a refill. If this is necessary, a refill will not be issued without a follow up visit.

Contact Policy

Your tests results will be relayed to you as soon as possible. Kind Hearted Integrative Health, LLC will make only 2 attempts to reach you, either by your preferred method of contact and/or secured message via patient portal. It is your responsibility to update all of your contact information for better communication.
With your permission, Kind Hearted Integrative Health, LLC will contact you through our HIPAA compliant patient portal. We may send messages to you regarding lab results, prescription refills, and/or diagnostic results.

By signing my initials, I acknowledge that I have read and agree to the above. _____ (initial)

_____ _____/_____/_____

Patient Signature (Parent or Guardian) **Date**

Patient Name: _____

Date of Birth: _____

Consent for Telehealth Services and Treatment

Telehealth is typically an electronic transmission of data, using video calling, using technologies provided by the electronic health record, for improved patient access and convenience, which can result in a better patient care experience. During the communication, correct patient identification and confirmation of your practitioner and their credentials will be ensured.

Telehealth does have some considerations:

The inability to have direct, physical contact with the patient is a primary difference between telehealth and direct in-person service delivery. The patient agrees that the practitioner determines whether the condition being diagnosed and/or treated is appropriate for a telemedicine encounter. The alternative to a telehealth consultation is to forgo evaluation and treatment, and to seek an in-person evaluation elsewhere.

The knowledge, experiences, and qualifications of the platform providing data and information to the provider of the telehealth services need not be completely known to and understood by the practice. Psychology Today does take active and layered security measures with the use of telemedicine technologies.

In addition, the quality of transmitted data may affect the quality of services provided by the provider. The patient agrees to hold the practitioner and Kind Hearted Integrative Health, LLC harmless for information lost due to technical failures.

The practice may, in some cases, be required to forward patient-identifiable information to a third party, for instance upon request by your insurance company. This is not different than the requirements for other non-telehealth medical records.

My Responsibilities:

I will not record any telehealth sessions without written consent from Kind Hearted Integrative Health, LLC. I understand that Kind Hearted Integrative Health, LLC will not record any of our telehealth sessions without my written consent.

I will inform Kind Hearted Integrative Health, LLC if any other person can hear or see any part of our session before the session begins. Kind Hearted Integrative Health, LLC will inform me if any other person can hear or see any part of our session before the session begins.

I understand that I, not Kind Hearted Integrative Health, LLC, am responsible for the configuration of any electronic equipment used on my computer for telehealth. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.

I understand that I must be a resident in the state the practitioner is licensed in to be eligible for telehealth services from Kind Hearted Integrative Health, LLC.

I understand and agree with the above, and consent to being treated and using telehealth with Kind Hearted Integrative Health, LLC. I am fully aware that my care will be provided by a board-certified Nurse Practitioner.

_____ _____/_____/_____

Patient Signature (Parent or Guardian) **Date**

Patient Name: _____

Date of Birth: _____

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 BEFORE SIGNING.

Federal law requires us to maintain the privacy of your health information. We are committed to protecting the privacy and confidentiality of patients Protected Health Information ("PHI") in compliance with applicable federal and state laws and regulations, including The Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the Health Information Technology for Economic and Clinical Health ("HITECH") Act. HIPAA is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper or orally, are kept confidential. HIPAA gives you, the client, new rights to understand and control how your health information is used. That law also requires us to give you this explanation of how we maintain the privacy of your health information. We reserve the right to change our privacy practices, provided the changes conform to applicable laws. Before we make a significant change in our privacy practices, we will change this notice and make the new notice available on request.

We may use and disclose your medical records only for each of the following purposes: treatment, payment, heath care operations, health care reminders, and for public benefit. Any other disclosure will require your written authorization.

- Treatment: means providing or managing health care and related services by one or more health providers. An example of this is the disclosure of information between your naturopathic consultant and other medically related professionals.
- Payment: means such activities as obtaining reimbursement for services, billing or collection activities and utilization review. An example of this is the disclosure from the naturopathic consultant to a billing person.
- Health care operations: include the business aspects of running the clinic and quality assessment.
- Reminders: means providing you with appointment reminders or to inform you of changes in the clinic services or hours by such means as postcards, emails, voicemail messages or letters.
- Public benefit: means the disclosure of information for the following types of reasons.: for public health activities including disease and vital statistic reporting; to report abuse, neglect or domestic violence; to health oversight agencies; to law enforcement officers pursuant to subpoenas and other lawful processing; to medical examiners and coroners; to avert a serious threat to health or safety; in connection with certain research activities; and as authorized by state and federal laws.

We may also create and distribute de-identified health information by removing all references to individually identifiable information. Any other uses and disclosures will be made only with **YOUR WRITTEN AUTHORIZATION**. You must give such authorization in writing to disclose it for any purpose, including but not limited to having a copy sent to a physician or receiving a copy for your own personal use. You may revoke such authorization in writing and we are required to honor that written request except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to Fairfield Family Health.

- The right to request restrictions on certain uses and disclosures of protected health information, including those related disclosures to family members, relatives, close personal friends or any other person identified by you. We are however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information. You must make a request in writing to obtain access to your health information. If you request copies, we will charge you a reasonable cost-based fee that may include labor, copying costs and postage. If you prefer, we may (but are not required to) prepare a summary or explanation of your health information for a fee.

Patient Name: _____

Date of Birth: _____

Notice of Privacy Practices

- The right to amend your protected health information. Your request must be in writing and must include an explanation why we should amend your records. We may deny your request under certain circumstances.
- The right to receive an accounting of disclosures of your protected health information.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

You have recourse if you feel your privacy protections have been violated. If you want more information about our privacy practices or have any questions or concerns, please contact us using the information listed at the end of this notice. You may also submit a written complaint to the US Department of Health and Human Services, Office of Civil Rights about violations of provisions of this notice or the policies and procedures of our clinic. We will not retaliate against you for filing a complaint.

I have read and understand the above-stated information.

_____ _____

Patient's Name Legal Guardian (under 18yo)

_____ _____

Patient's Signature Relationship to Patient

_____

Date

For more information about HIPAA or to file a complaint:

The US Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, SW
Washington, DC 2020
Phone: 202-619-0257
Toll Free: 877-696-677

Patient Name: _____

Date of Birth: _____

Credit Card Authorization Form

Please complete all fields and email or upload to your patient portal prior to your visit. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until cancelled.

Credit Card Information
Card Type: ☐ MasterCard ☐ VISA ☐ Discover ☐ AMEX ☐ Other _____
Cardholder Name (as shown on card): _____
Card Number: _____
Expiration Date (mm/yy): _____
Security Code (last 3 digits located on the back of the credit card): _____
Billing Address: _____

I,_____, authorize Kind Hearted Integrative Health, LLC to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account.

_____ _____

Patient Signature Date

_____

Print Name

Kind Hearted Integrative Health, LLC
Tel: (954) 406-1767 | kindheartedihllc@gmail.com | www.kindheartedintegrativehealth.com