Rittenhouse
PSYCHIATRIC ASSOCIATES

Office Fees

Subject to Change with 90-day Advanced Notice

Adult Patients - Age 18 and over

Nurse Practitioners (CRNP, PMHNP-BC)
-$135 20-Min Med Management -$200 45-Min Therapy or Family Meeting
-$285 60-Min Initial Consultation -$425 90-Min Initial Consultation

Pain Reprocessing Therapy (PRT) with Helen Rice CRNP, PMHNP-BC
-$425 90-Min Initial Consultation -$250 50-Min Therapy Sessions

Psychiatrists (MD, DO)
-$225 20-Min Med Management -$375 45-Min Therapy or Family Meeting
-$450 60-Min Initial Consultation -$675 90-Min Initial Consultation

Chris Pagnani, MD
-$250 20-Min Med Management -$400 45-Min Therapy
-$500 60-Min Initial Consultation -$750 90-Min Initial Consultation

Psychotherapists
-$135 45-Min Therapy -$200 60-Min Initial Consultation -$180 60-Min Couples/Family Therapy

Licensed Professional Counselors (LPC)
-$200 60-Min Initial Consultation (Individual) -$160 45-Min Individual Therapy
-$220 60-Min Initial Consultation (Couples/Family) -$180 60-Min Couples/Family Therapy

Licensed Clinical Psychologists (Ph.D./Psy.D.)
-$175 45-Min Therapy -$250 60-Min Initial Consultation

Kristine Spano, Psy.D.
-$190 45-Min Therapy -$265 60-Min Initial Consultation

Children & Adolescent Patients- Age 17 and under

Nurse Practitioners (CRNP, PMHNP-BC)
-$200 Med Management -$300 45-Minute Therapy or Family Meeting
-$550 90-Min Initial Consultation (a follow-up visit is often necessary before prescribing)

Fellowship Trained Psychiatrists (MD, DO)
-$225 Med Management -$375 45-Min Therapy or Family Meeting
-$450 60-Min Initial Consultation (a follow-up visit is often necessary before prescribing)
-$675 90-Min Initial Consultation

ALL PROVIDERS - Administrative Requests, Letters & Family Phone Discussions: $100/hour

Includes any letter or form to a third party, summary of care, medical record requests and discussions about care with individuals besides the patient (with patient permission).
The patient's credit card on file is used for pre-payment. Please allow 14 days for administrative requests.

By signing here you acknowledge you have read, understand, and agree to fees on this page

Office Policies

Appointments

Initial consultations are scheduled following a brief conversation by phone. A credit card is used to reserve your time. Evaluations are 60 or 90-Minutes in length (Child Psychiatry evaluations excluded, please discuss when scheduling) and consist of an extensive medical and psychiatric history. Laboratory studies and a brief neurological examination may be part of your workup. With permission, your provider may request collateral information from medical providers, family or significant others, to aid in case formulation and diagnosis. The initial evaluation is considered a consultation, as it is an opportunity for both the patient and provider to decide whether they are a good fit for ongoing care (individuals are responsible for the consultation fee regardless). Should both agree to work together after this consultation, follow-up appointments are either "Medication Checks" (20-minutes in length) or 45-minute therapy/ family appointments. We will collaborate to develop a treatment plan that fits your individual needs, which may include therapy, medication management or both. If you have a therapist that you would like to continue working with, we will be happy to collaborate with that individual, provided that you sign a release of information. At a minimum, on-going patients are seen every three months.

Payment of Fees

All fees are due at the time of service and payable by cash, check or credit card (Visa, MC, Amex, Discover). Checks should be made payable to "Rittenhouse Psychiatric Associates" or "RPA." There will be a 25 dollar fee for any returned / "bounced" checks. Accounts that are delinquent may be sent to collections. All patients are required to keep an active credit card on file (used for missed appointments, phone appointments, late cancellations, administrative work, letters & family conferences). If a patient misses two appointments, they will be required to prepay via credit card when scheduling. There are no changes to these policies when someone other than the patient is paying for visits. Additionally, paying for visits does not change confidentiality; a patient's progress, medical record and any privileged information can still only be given with direct consent from the patient.

Missed Appointments/Weather Policy/Cancellations

If you are unable to keep an appointment, please give 48 business hours advanced notice (excluding weekends and holidays), otherwise you will be charged in full for the time that was reserved for you (for example, if your appointment is on a Tuesday at noon, you must cancel by the previous Friday at noon or you will be responsible for the full appointment fee). Insurance companies do not reimburse for missed appointment charges. You may cancel your appointment by calling the office and leaving a message. If you are late for an appointment, you will be seen for the remainder of your reserved time. You will be responsible for the full session fee (this includes initial visits). We do not close due to weather, unless it is a State of Emergency. If you miss a visit and we are unable to reach you by phone, your provider will run your credit card on file. Signing this form gives permission to do so.

Additional Policies for Telehealth Appointments

Patients being seen for telehealth appointments (HIPAA Compliant Zoom visits for example) must review and sign an additional consent form. This form may be downloaded in the forms section of our website and is attached here.

By signing here you acknowledge you have read, understand, and agree to policies on this page

Medical Insurance

Rittenhouse Psychiatric Associates providers are out-of-network for all medical insurance companies. If you have out-of-network mental health benefits, we will be happy to assist you by supplying bills, diagnosis and other information that is requested by your carrier for reimbursement. Patients are responsible for submitting their own claims if they choose to do so. Reimbursement is not guaranteed. Insurance companies do not always reimburse for virtual appointments (even if a patient has out-of-network benefits), and it is the patient's responsibility to discuss this with their insurance company directly, prior to making an appointment.

Rittenhouse Psychiatric Associates and its providers do not accept or participate in Medicare, Medicaid, any Medical Assistance Program or Medicaid Managed Care Plans. Patients with these plans will be provided a separate waiver to sign. It is important for patients with these plans to understand that they may be able to receive psychiatric care at a significantly reduced (or free) cost outside of our practice. These federal and state programs may prevent patients from using their insurance to fill prescriptions, or prevent our providers from making referrals or handling prior authorizations. Patients also must agree to not submit any receipts for our services to Medicare, Medicaid or any state assistance programs. Patients are advised to directly contact Medicare, the relevant state Medicaid program, relevant Medicare Advantage plan, and/or relevant state Medicaid Managed care plan for more information.

Medical Records

Our providers generally do not release patient evaluations, progress notes or therapy notes. A summary of care will be provided to patients and/or third parties when medical records are requested. The above administrative rates apply to such requests and the card on file will be used for this service.

Office Coverage

If your provider is out of the office, they will leave the covering provider's information on their outgoing voicemail and in an automatic e-mail reply. For non-emergent issues, you may call the covering provider or leave a message for your provider's return. Prescription refills will be called in Monday through Friday 9AM-5PM. He/she will be able to respond to calls within 48 business hours. Covering providers do not refill controlled substances. Patients are responsible for keeping their appointments and re-scheduling (if they cancel or miss an appointment) several weeks prior to running out of controlled substances. We are not responsible for adverse events due to failure to do so.

Medication Requests and Prescription Refills

Patients may call the office and leave a message for prescription refills. Refills are called in Monday through Friday only, during normal business hours. Please allow 48 business hours for all requests. If you have not had an appointment within the last 3 months, there will be an associated 25-dollar fee (charged to your credit card on file). Our office takes the prescription of controlled medications very seriously. An initial face-to-face appointment AND an in-office visit every 90 days at a minimum may be required by your provider, the DEA and/or the state where you reside. We will not make exceptions to local or federal regulations. If you are prescribed a controlled substance, appointments will be required for refills. Lost or stolen controlled substance prescriptions will not be replaced under any circumstances. If patients are having withdrawal symptoms due to lost or stolen controlled prescriptions, they are responsible for going immediately to the ER or calling 911 to seek immediate medical attention (i.e. we will not break our controlled medication policies because a patient states that they are having withdrawal).

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Contacting Your Provider

Patients have access to their provider's business phone and e-mail address. E-mail is used for scheduling and cancelling appointments, prescription requests and administrative requests only. E-mails are added to the official medical record at Rittenhouse Psychiatric Associates' discretion. We can typically return calls and e-mails within 48 business hours Monday through Friday. When patients call with questions that can be answered quickly, a fee will not be charged. If questions require a lengthy discussion (for example, any medication change), patients will be asked if they would like to schedule an office or phone appointment (above rates apply). You will never be charged for a phone call, without your provider discussing it first. If a patient is abusing access to their provider's phone or e-mail address, this may result in termination of care, at the provider's discretion. Social media is not an acceptable form of communication for current or former patients (no exceptions). Texting is never an appropriate form of communication and business lines may not accept texts. Furthermore, your provider is not responsible for responding to any information sent via text.

Discharge/Closing Charts

Our providers may "close" or inactivate a patient's chart for a number of reasons including but not limited to: a patient terminating care voluntarily (as when moving or finding a new provider), a patient violating a controlled substance agreement, a patient not following a provider's treatment recommendations, a patient's condition requiring a higher level of care than we are able to provide (as assessed by the provider), a provider assessing that they do not have the skill-set required to adequately treat a patient or their condition, or a patient not following up at intervals specified by the provider.

If a patient is not seen for 3+ months, providers will mail or e-mail a letter stating that their chart will be closed unless the patient contacts their provider within a specified period of time. When a chart is "closed," we are no longer able to prescribe you medications, schedule you for appointments, or assist if you are in crisis. You are responsible for ensuring that you have office visits every 3 months or less (exact timing determined by your provider, exceptions made on a case-by-case basis) and for keeping your address/e-mail updated with our office. We are not responsible for letters not reaching their intended destination if you move/get a new e-mail and do not notify us. If a patient's chart is closed, and they would like additional information on resources in the community or finding a new provider, we will be happy to assist (call our office staff at 267-358-6155 x 1 or email Scheduling@RittenhousePA.com to receive our referral list). Additional information on finding a new provider is listed on our website: www.RittenhousePA.com/resources. Your provider will also be happy to assist you directly. If your chart is closed, and you would like to restart care, we cannot guarantee availability or that we can see you back as a patient. It will be based on provider availability and discretion, and you may be required to have an initial 60-minute visit (above fees apply).

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Emergencies

If you have an emergency (such as an allergic reaction to medicine, suicidal thoughts with plan to act, or a suicide attempt) you must call 911 or go to your nearest emergency room. This is a requirement, as we are not available at all times and emergencies require immediate attention. After doing you may call your provider's emergency number and share it with any providers caring for you. Your provider will return the call as soon as is possible.

Emergency numbers for all providers are found here:
https://rittenhousepa.com/office-policies-and-fees/
and
Emergency numbers are recorded on all providers' outgoing voicemails on their regular office lines. Please call 267-358-6155 and press your provider's extension as indicated in the directory to hear their outgoing message.

We are not always immediately available even if you call these numbers (this is why you MUST call 911 or go to your nearest emergency room first). If you have any concerns about this policy, you are required to discuss with your provider (at the initial evaluation or if you develop concerns during your course of treatment). Our providers do not have admitting privileges at local hospitals, a 24/7 dedicated emergency line, or support staff answering phones during evenings, holidays and weekends. We have the resources to see patients with moderate levels of mental illness, and to be available within 48 business hours for patient needs. If a patient requires an inpatient psychiatric admission, has a suicide attempt, or an act of self-harm, this is typically an indication that they would benefit from a provider with additional emergency resources. If this occurs, patients will need to work with their treatment team (if inpatient) or utilize resources that their provider at RPA offers them, to find a new provider that is more appropriate for their care. Safety is extremely important to us, and it is incredibly important that we are transparent about our capabilities, resources and competencies, and only practice within them.

Automatic (Robotic) Text Message Appointment Reminders

Many of our providers use an automatic (robotic) text message appointment reminder system.
Please indicate below if you would like to opt-in for this service (standard text charges through your carrier will apply). If you decide to opt-out, your provider will exclude you from this service. **If you send a return text to the robotic message <u>WE WILL NOT RECEIVE IT.</u>**

You can also cancel this service by replying [STOP] to any automatic message from our office.

CHOOSE TO OPT IN OR OUT OF TEXT REMINDERS: Yes - send texts

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TELEHEALTH INFORMED CONSENT

Telehealth is healthcare provided by any means other than a face-to-face visit. In telehealth services, medical and mental health information is used for diagnosis, consultation, treatment, therapy, follow-up and education. Health information is exchanged interactively from one site to another through electronic communications. Telephone consultation, videoconferencing, transmission of still images, e-health technologies, email, patient portals and remote patient monitoring are all considered telehealth services.

1. I understand that telehealth involves the communication of my medical and mental health information in an electronic or technology assisted format (phone, videoconferencing and others).
2. I understand that I may opt out of telehealth visits at any time. This will not change my ability to receive future care at Rittenhouse Psychiatric Associates, but may affect my ability to see my current provider.
3. I understand that telehealth services can only be provided to patients, including myself, who are physically located in the state of Pennsylvania, at the time of their visits. If my provider is also licensed in New Jersey (or another state), then I may also have telehealth visits, when I am physically located in that state as well (it is my responsibility to discuss with Rittenhouse Psychiatric Associate's staff, where my provider is licensed, and it is my responsibility to notify them, should I no longer be able to have appointments from a state where my provider is licensed).
4. I understand that telehealth billing information is collected in the same manner as regular office visits, and visit fees are the same for face-to-face visits and telehealth visits at Rittenhouse Psychiatric Associates.
   a. I understand that if technology fails for a videoconferencing session, the visit will be moved to a phone appointment, and I will still be responsible for the full visit fee.

5. If I have out-of-network health insurance benefits for mental health services, it is my responsibility to discuss with my insurance company, whether they reimburse for telehealth appointments. Our fees do not change whether a patient's insurance company accepts telehealth as a reimbursable expense, and it is my responsibility to research before making appointments with this office.
6. I understand that all electronic medical communications carry some level of risk. While the likelihood of risks associated with the use of telehealth in a secure environment is reduced, the risks are nonetheless real and important to understand. These risks include, but are not limited to:
   a. It is easier for electronic communication to be forwarded, intercepted, or even changed without my knowledge and despite taking reasonable measures.
   b. Electronic systems that are accessed by employers, friends or others are not secure and should be avoided. It is important for me to use a secure network.
   c. Despite reasonable efforts on the part of my healthcare provider, the transmission of medical information could be disrupted or distorted by technical failures.
   d. Telehealth visits could be "hacked," despite reasonable efforts being made to prevent this from occurring.
   e. Providers will not be able to perform a true physical examination, check vital signs or take other actions, that may be part of the standard of care, for the prescription of certain medications or when assessing patients with certain presentations or conditions. If my provider recommends that I purchase a blood pressure cuff and record data, see my primary care physician for vitals or take other actions to mitigate the risk of an adverse outcome because of this, it is my responsibility to do so, and I acknowledge that not doing so, may result in physical harm to me or an adverse outcome.

7. I agree that information exchanged during my telehealth visit will be maintained by doctors, nurse practitioners, therapists, administrators, and other providers involved in my care.
8. I understand that medical information, is governed by federal and state laws that apply to telehealth.
9. I understand that Skype, FaceTime or similar services may not provide a secure HIPAA-compliant platform, but I willingly and knowingly wish to proceed. If I have questions pertaining to the platform that my provider is using, it is my responsibility to discuss with my provider and/or Rittenhouse Psychiatric Associate's staff, before any telehealth appointments.
10. I understand that I must take reasonable steps to protect myself from unauthorized use of my electronic communications with others.
11. The healthcare provider is not responsible for breaches in confidentiality caused by an independent or third party or by me.
12. I agree that I have verified to my healthcare provider my identity and current location in connection with the telehealth services. I acknowledge that failure to comply with these procedures may result in the termination of my telehealth visit.
13. I understand that I have the responsibility to verify the identity and credentials of the healthcare provider rendering my care via telehealth and to confirm that he or she is my healthcare provider.
14. I understand that electronic communication cannot be used for emergencies or time-sensitive matters.
15. I understand and agree that a medical evaluation via telehealth may limit my healthcare provider's ability to fully diagnose a condition or disease. As a patient, I agree to accept responsibility for following my healthcare provider's recommendations- including further diagnostic testing, such as lab testing or an in-office visit.
16. I understand that electronic communication may be used to communicate highly sensitive medical information, such as treatment for or information related to HIV/AIDS, sexually transmitted diseases, mental health information and addiction treatment (alcohol and drug use, abuse and dependence for example).

What state will you be in for any visits that may occur via Telehealth?

By signing here I certify that I have read and understand the Telehealth Informed Consent agreement and that all of my questions have been answered to my satisfaction. I also agree to electronic communication between all staff at Rittenhouse Psychiatric Associates / Chris Pagnani MD PC and myself.

Patient Information

Legal Name (first, MI, last):

Preferred name: **Birthdate:** **Sex/Gender:**

Preferred Pronouns: **E-Mail:**

Mailing Address: **Apt/Unit:**

City/State/Zip:

Cell #: **Other Phone:**

How May We Contact You?: ☐ **E-Mail** ☐ **Cell #** ☐ **Other #**

Emergency Contact: **Their Phone:** **Relationship:**

Pharmacy Name/Address:

Insurance Company: **ID #:**

Prescription Benefits Company and ID # (if different):

***PCN:** ***RxBin:** ***RxGroup:**

(This information can be found either on the medical insurance card or separate Rx benefits card)

How Did You Hear About Us? (If a provider, please include their name):

Do you have Medicare? No

Our providers have either opted out of Medicare or cannot see patients who bill Medicare at this office. Thus, if you submit a bill to Medicare, you are committing medical fraud and are subject to penalties, fines, and other repercussions

By signing here I acknowledge and agree to the following:

-I have read the entire Office Policies section

-I am responsible for full payment at time of service

-I cannot submit claims to Medicare

-My provider does not participate with insurance companies

-I will be charged for phone appointments and any appointments broken without 48+ business hours of notice

-Business hours include M-F 9 am-5pm. Ex: If my appt is Tuesday at 12 pm, I must cancel by the previous Friday at 12 pm

-My provider has permission to charge my credit card on file for balances at their discretion in congruence with these policies

Medical and Psychosocial Information

In one sentence, what brought you to make your appointment?

Previously DIAGNOSED (by a professional) psychiatric conditions (examples: ADHD, depression, PTSD, generalized anxiety, bipolar disorder, eating disorder, borderline personality disorder, etc, or NONE).

Medical Conditions (include ALL from past and present. Ex: acid reflus, ulcerative colitis, asthma, ecezema, diabetes, high blood presssure, IBS, cancer, high cholesterol, stroke, heart attack, seizure, sleep apnea or write NONE):

Surgeries/Year Performed (or write NONE):

Allergies or Sensitivities to Medication (or write NONE):

Significant Injuries (Include year. Ex: major car accident, gunshot wound, head trauma, broken bones, concussions or NONE)

Current Medications, Dose, and Frequency (Include ALL medications you take [not just psychiatric]).
Include medications taken as needed, over the counter, birth control, IUDs, birth control implants, herbal supplements/ vitamins)
Write NONE if none:

List past psychiatric medications ever taken and max dose used (meds for depression, anxiety, mood, attention, sleep, or NONE)

Primary Care Provider name and phone #: **Last visit:**
Therapist name and phone #:
Do you own or rent? Who do you live with?:
Occupation or student status?:
Race and ethnicity: **Sexual Orientation:**
Highest Level of Education: **Religion:**
Have you served in the military:

FAMILY MENTAL HEALTH & SUBSTACE USE ASSESSMENT

Please check off any BIOLOGICAL family members who have had the following issues acknowledged by a mental health professional.

1) MAJOR DEPRESSIVE DISORDER (depression, including seasonal & post-partum)

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

2) BIPOLAR DISORDER (aka manic depression)

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

3) GENERALIZED ANXIETY DISORDER

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

4) OBSESSIVE COMPULSIVE DISORDER OR HOARDING

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

5) PANIC DISORDER/ PANIC ATTACKS

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

6) POST-TRAUMATIC STRESS DISORDER

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

7) PSYCHOSIS/ SCHIZOPHRENIA

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

8) SCHIZOAFFECTIVE DISORDER

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

9) ADHD/ADD (attention deficit)

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

10) BORDERLINE PERSONALITY

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

12) EATING DISORDER

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

13) DRUG USE DISORDER

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

14) SUICIDE ATTEMPT

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

15) COMPLETED SUICIDE

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

16) ALCOHOL USE DISORDER

- ☐ Mother
- ☐ Father
- ☐ Sibling
- ☐ Mother's Parent
- ☐ Father's Parent
- ☐ Cousin
- ☐ Child
- ☐ Mother's Sibling
- ☐ Father's Sibling

17) OTHERS (autism spectrum, body dysmorphic disorder, personality disorders, any others not listed)

SUBSTANCE USE ASSESSMENT

A good understanding of your current/past substance use is important for diagnosis and treatment.

ONLY INCLUDE SUBSTANCES NOT USED AS DIRECTED BY A MEDICAL PROFESSIONAL

Alcohol - I drink alcohol [0] times per week

I usually have [0] standard drinks per occasion

1 standard drink = 12 oz beer = 5 oz wine = 1.5 oz spirits)

☐ I have felt guilty about my drinking

☐ Others have annoyed me by criticizing my drinking

☐ I feel I need to cut back my drinking

☐ I have needed a drink in the morning to calm my nerves or ease a hangover

☐ I have been charged with DUI(s)

☐ I used to drink too much or too often

What age did you first drink alcohol? [ ]

WHEN USED		TYPE/HOW USED	AGE 1ST USE	AGE LAST USE
Present	Tobacco/Nicotine			
Present	Benzodiazepines/ Barbiturates (Xanax, Klonopin, Valium, etc)			
Present	Stimulants (Adderall, cocaine, crack, etc)			
Present	Cannabis			
Present	Steroids			
Present	Opioids (Oxy, morphine, Dilaudid, Percs, heroin, etc)			
Present	OTC meds			
Present	Synthetic Drugs (K2, PCP, etc)			
Present	Hallucinogens (acid, mushrooms, DMT, etc)			
Present	Gases/Inhalents			

BIOLOGICAL FAMILY HEALTH ASSESSMENT

Please check all boxes that apply to the specified family member.

Mother	Father	Maternal Grandparents	Paternal Grandparents	Siblings
☐ Heart attack	☐ Heart attack	☐ Heart attack	☐ Heart attack	☐ Heart attack
☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke	☐ Stroke
☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer	☐ Cancer
☐ Type I Diabetes	☐ Type I Diabetes	☐ Type I Diabetes	☐ Type I Diabetes	☐ Type I Diabetes
☐ Type II Diabetes	☐ Type II Diabetes	☐ Type II Diabetes	☐ Type II Diabetes	☐ Type II Diabetes
☐ Sudden Cardiac Death	☐ Sudden Cardiac Death	☐ Sudden Cardiac Death	☐ Sudden Cardiac Death	☐ Sudden Cardiac Death
☐ Obesity	☐ Obesity	☐ Obesity	☐ Obesity	☐ Obesity
☐ Overactive thyroid	☐ Overactive thyroid	☐ Overactive thyroid	☐ Overactive thyroid	☐ Overactive thyroid
☐ Under-active thyroid	☐ Under-active thyroid	☐ Under-active thyroid	☐ Under-active thyroid	☐ Under-active thyroid
☐ Prolonged QT Syndrome	☐ Prolonged QT Syndrome	☐ Prolonged QT Syndrome	☐ Prolonged QT Syndrome	☐ Prolonged QT Syndrome
☐ Congenital heart defects	☐ Congenital heart defects	☐ Congenital heart defects	☐ Congenital heart defects	☐ Congenital heart defects
☐ Alzheimer's/ Dementia	☐ Alzheimer's/ Dementia	☐ Alzheimer's/ Dementia	☐ Alzheimer's/ Dementia	☐ Alzheimer's/ Dementia
☐ Glaucoma	☐ Glaucoma	☐ Glaucoma	☐ Glaucoma	☐ Glaucoma

ADVERSE CHILDHOOD EVENTS ASSESSMENT

An understanding of the safety and security you experienced during your upbringing is extremely helpful to our treatment of your mental health concerns.

In the first 18 years of your life....

1) Did an adult in your household **often** swear at you, insult you, put you down, humiliate you OR act in a way that made you afraid you might be physically hurt? ◯ Y ◯ N

2) Did an adult in your household **often** push, grab, slap, or throw something at you OR **ever** hit you so hard you had marks or were injured? ◯ Y ◯ N

3) Did an adult or person at least 5 years older than you **ever** touch or fondle you, or have you touch their body in a sexual way OR try to or actually have oral, anal, or vaginal sex with you? ◯ Y ◯ N

4) Did you **often** feel that no one in your family loved you or thought you were important or special OR your family didn't look out for each other, feel close to each other, or support each other? ◯ Y ◯ N

5) Did you **often** feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect you OR that your caretakers were too drunk or high to take care of you or take you to the doctor if you needed it? ◯ Y ◯ N

6) Were your parents ever separated or divorced? ◯ Y ◯ N

7) Was your mother, stepmother, father, or stepfather **often** pushed/grabbed/slapped/had objects thrown at them? OR **Sometimes** kicked, bitten, punched, or hit with something hard? OR **ever** repeatedly hit over several minutes or threatened with a gun or knife? ◯ Y ◯ N

8) Did you live with anyone who was a problem drinker/alcoholic/used street drugs? ◯ Y ◯ N

9) Was a household member depressed, mentally ill, or did a household member attempt suicide? ◯ Y ◯ N

10) Did a household member go to prison? ◯ Y ◯ N

Is there any additional information you would like your provider to be aware of prior to your evaluation?

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	☐	☐	☐	☐	☐
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?	☐	☐	☐	☐	☐
3. How often do you have problems remembering appointments or obligations?	☐	☐	☐	☐	☐
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	☐	☐	☐	☐	☐
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	☐	☐	☐	☐	☐
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?	☐	☐	☐	☐	☐

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?	☐	☐	☐	☐	☐
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	☐	☐	☐	☐	☐
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	☐	☐	☐	☐	☐
10. How often do you misplace or have difficulty finding things at home or at work?	☐	☐	☐	☐	☐
11. How often are you distracted by activity or noise around you?	☐	☐	☐	☐	☐
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	☐	☐	☐	☐	☐
13. How often do you feel restless or fidgety?	☐	☐	☐	☐	☐
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?	☐	☐	☐	☐	☐
15. How often do you find yourself talking too much when you are in social situations?	☐	☐	☐	☐	☐
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	☐	☐	☐	☐	☐
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	☐	☐	☐	☐	☐
18. How often do you interrupt others when they are busy?	☐	☐	☐	☐	☐

Part B

How old were you when these problems first began to occur?_____

Patient Health Questionnaire (PHQ-9)

		Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks,* how often have you been bothered by any of the following problems?					
a. Little interest or pleasure in doing things	a	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	b	☐	☐	☐	☐
c. Trouble falling/staying asleep, sleeping too much	c	☐	☐	☐	☐
d. Feeling tired or having little energy	d	☐	☐	☐	☐
e. Poor appetite or overeating	e	☐	☐	☐	☐
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	f	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television.	g	☐	☐	☐	☐
h. 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.	h	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way.	i	☐	☐	☐	☐
2. If you checked off any problem on this questionnaire so far, 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 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
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. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid, as if something awful might happen	☐	☐	☐	☐

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc.

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?	☐	☐