



# Rittenhouse

PSYCHIATRIC ASSOCIATES

## Office Fees

*\*Subject to Change with 90-day Advanced Notice\**

*\*\*There may be a slight variation amongst individual providers' rates\*\**

### ADULT PATIENTS - (18 and older)

#### **NURSE PRACTITIONERS (CRNP, PMHNP-BC)**

-\$150 20-Min Med Management    -\$225 45-Min Therapy or Family Meeting  
-\$300 60-Min Initial Consultation    -\$450 90-Min Initial Consultation

#### **Psychiatrists (MD, DO)**

-\$250 20-Min Med Management    -\$400 45-Min Therapy or Family Meeting  
-\$450 60-Min Initial Consultation    -\$675 90-Min Initial Consultation

\*Dr. Pagnani's one-time evaluations w/ report have a separate fee-schedule. Call to discuss.

#### **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.)**

-\$190 45-Min Therapy    -\$265 60-Min Initial Consultation

\*Additional fee for couples' therapy (\$25-50/session)\*

### CHILD AND ADOLESCENT PATIENTS (17 and younger)

#### **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)**

-\$250 Med Management    -\$400 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, 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 for the full fee of the scheduled appt.** Signing this form gives permission to do so. Two or more no shows or late cancellations within a calendar year may result in termination of the patient/provider relationship at the provider's discretion.

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

### ***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.

***Virtual / Telehealth Appointments to Patients in PA, NJ, NY, FL and others.*** Please view our provider search tool on our home page to see which providers are licensed in your area. \*Certain types of treatment may require an in-office evaluation and/or periodic in-office appointments. Call for information.

### ***Prescription of Controlled Medications***

- ❖ We take the prescription of controlled medications very seriously
- ❖ There should never be an expectation that a provider will write a patient for a controlled medication, even if the patient has previously taken a specific medication or previously been given a diagnosis (like ADHD, Anxiety or Insomnia) by another provider.
- ❖ If a patient has neuropsychological testing, medical records from another provider, or pharmacy records showing that they previously had a specific diagnosis or previously took a specific medication, we recommend that they bring that information to their first visit for their provider to review.
- ❖ Even when our providers deem that a controlled medication may be appropriate, they often will wait until a patient's second visit to write it, so that they have time to call the patient's previous pharmacies, review federal prescription databases, review records, and get additional information (like scales) completed by a patient or by family or significant others.
- ❖ **If a patient feels that they "need" a controlled medication urgently prescribed, we are not the right practice for them to schedule with.**
- ❖ A provider disagreeing about a patient's diagnosis or refusing to write for a controlled medication is NOT grounds for waiving the appointment fee.

### ***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.

### ***Release of Information and Collateral***

With a signed release providers may discuss patient data or provide records with other providers and/or third parties. The release can be obtained on our website. Additionally, providers within Rittenhouse Psychiatric Associates may collaborate on cases without a signed release (for example, if a patient is obtaining care from both a prescriber and a therapist both within our practice, it will be assumed that they can coordinate care, even without a signed release). Additionally, it is assumed that covering providers will also have full access to the patient's chart. Finally, there may be instances where a provider assesses that it is in the medical best interest of the patient to discuss their case with a third party without consent. Examples, include (but are not limited to) if a provider has concerns that a patient is at risk of harming themselves or others, is abusing a medication, is obtaining controlled medications from multiple providers, is having a severe side effect from a medication, or that a patient's medication may have a severe interaction with a medication being prescribed by another provider.

***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.

### ***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).

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

### ***Contacting Your Provider***

Patients have access to their provider's business phone and e-mail address. E-mail is used for scheduling and canceling 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). Patients CAN "follow" our business accounts, but they are not to use social media for communication with Rittenhouse Psychiatric Associates. **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, lack of follow up at intervals specified by the provider, or a patient missing or late canceling 2 appts within a year. 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](mailto:Scheduling@RittenhousePA.com) to receive our referral list). Additional information on finding a new provider is listed on our website: [www.RittenhousePA.com/resources](http://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).

### ***Transferring Between Providers in Our Practice***

If an active patient of one of our providers wishes to transfer to another provider within the practice, they are to discuss this directly with their active provider after filling out a transfer request form (see our "Intake Forms and PDFs" section of [www.RittenhousePA.com](http://www.RittenhousePA.com)). A transfer is dependent on BOTH the active provider confirming appropriateness to stay in the practice AND the new provider agreeing to accept the patient after reviewing the case with the active provider. A patient can transfer within the practice **ONE** time only. If a patient's chart was closed with the practice, or their care was terminated by their provider (for example, for breaching a controlled medication contract or if a provider deemed that they did not have the skill-set or resources to safely care for that patient), they may NOT re-open their chart with a new provider within the practice.

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

## ***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 WE WILL NOT RECEIVE IT.**

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

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

## **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.





# Rittenhouse

PSYCHIATRIC ASSOCIATES

## 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 cannot submit claims to Medicare
- I am responsible for full payment at time of service
- 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 reflux, ulcerative colitis, asthma, eczema, diabetes, high blood pressure, 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 & SUBSTANCE 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)

**Signing here indicates I have viewed and attempted to complete this page to the best of my ability**

# 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  times per week

I usually have  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 |
|-----------|--|---------------|-------------|--------------|
| CHOOSE    | Tobacco/Nicotine   |               |             |              |
| CHOOSE    | Benzodiazepines/<br>Barbiturates (Xanax,<br>Klonopin, Valium, etc) |               |             |              |
| CHOOSE    | Stimulants (Adderall,<br>cocaine, crack, etc)                      |               |             |              |
| CHOOSE    | Cannabis   |               |             |              |
| CHOOSE    | Steroids   |               |             |              |
| CHOOSE    | Opioids (Oxy,<br>morphine, Dilaudid,<br>Percs, heroin, etc)        |               |             |              |
| CHOOSE    | OTC meds   |               |             |              |
| CHOOSE    | Synthetic Drugs<br>(K2, PCP, etc)                                  |               |             |              |
| CHOOSE    | Hallucinogens (acid,<br>mushrooms, DMT,<br>etc)                    |               |             |              |
| CHOOSE    | Gases/Inhalents  |               |             |              |

## **BIOLOGICAL FAMILY HEALTH ASSESSMENT**

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

| <u>Mother</u>                                     | <u>Father</u>                                     | <u>Maternal Grandparents</u>                      | <u>Paternal Grandparents</u>                      | <u>Siblings</u>                                   |
|---|---|---|---|---|
| <input type="checkbox"/> Heart attack             | <input type="checkbox"/> Heart attack             | <input type="checkbox"/> Heart attack             | <input type="checkbox"/> Heart attack             | <input type="checkbox"/> Heart attack             |
| <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Stroke                   | <input type="checkbox"/> Stroke                   |
| <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Cancer                   | <input type="checkbox"/> Cancer                   |
| <input type="checkbox"/> Type I Diabetes          | <input type="checkbox"/> Type I Diabetes          | <input type="checkbox"/> Type I Diabetes          | <input type="checkbox"/> Type I Diabetes          | <input type="checkbox"/> Type I Diabetes          |
| <input type="checkbox"/> Type II Diabetes         | <input type="checkbox"/> Type II Diabetes         | <input type="checkbox"/> Type II Diabetes         | <input type="checkbox"/> Type II Diabetes         | <input type="checkbox"/> Type II Diabetes         |
| <input type="checkbox"/> Sudden Cardiac Death     | <input type="checkbox"/> Sudden Cardiac Death     | <input type="checkbox"/> Sudden Cardiac Death     | <input type="checkbox"/> Sudden Cardiac Death     | <input type="checkbox"/> Sudden Cardiac Death     |
| <input type="checkbox"/> Obesity                  | <input type="checkbox"/> Obesity                  | <input type="checkbox"/> Obesity                  | <input type="checkbox"/> Obesity                  | <input type="checkbox"/> Obesity                  |
| <input type="checkbox"/> Overactive thyroid       | <input type="checkbox"/> Overactive thyroid       | <input type="checkbox"/> Overactive thyroid       | <input type="checkbox"/> Overactive thyroid       | <input type="checkbox"/> Overactive thyroid       |
| <input type="checkbox"/> Under-active thyroid     | <input type="checkbox"/> Under-active thyroid     | <input type="checkbox"/> Under-active thyroid     | <input type="checkbox"/> Under-active thyroid     | <input type="checkbox"/> Under-active thyroid     |
| <input type="checkbox"/> Prolonged QT Syndrome    | <input type="checkbox"/> Prolonged QT Syndrome    | <input type="checkbox"/> Prolonged QT Syndrome    | <input type="checkbox"/> Prolonged QT Syndrome    | <input type="checkbox"/> Prolonged QT Syndrome    |
| <input type="checkbox"/> Congenital heart defects | <input type="checkbox"/> Congenital heart defects | <input type="checkbox"/> Congenital heart defects | <input type="checkbox"/> Congenital heart defects | <input type="checkbox"/> Congenital heart defects |
| <input type="checkbox"/> Alzheimer's/ Dementia    | <input type="checkbox"/> Alzheimer's/ Dementia    | <input type="checkbox"/> Alzheimer's/ Dementia    | <input type="checkbox"/> Alzheimer's/ Dementia    | <input type="checkbox"/> Alzheimer's/ Dementia    |
| <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Glaucoma                 | <input type="checkbox"/> Glaucoma                 |

Signing here indicates I have viewed and attempted to complete this page to the best of my ability

## 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?**

Signing here indicates I have viewed and attempted to complete this page to the best of my ability

### 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2.  | How often do you have difficulty getting things in order when you have to do a task that requires organization?      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3.  | How often do you have problems remembering appointments or obligations?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4.  | When you have a task that requires a lot of thought, how often do you avoid or delay getting started?                | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5.  | How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?                 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6.  | How often do you feel overly active and compelled to do things, like you were driven by a motor?                     | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Part A

|     |   |                          |                          |                          |                          |                          |
|-----|---|--------------------------|--------------------------|--------------------------|--------------------------|--------------------------|
| 7.  | How often do you make careless mistakes when you have to work on a boring or difficult project?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8.  | How often do you have difficulty keeping your attention when you are doing boring or repetitive work?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 9.  | How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 10. | How often do you misplace or have difficulty finding things at home or at work?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 11. | How often are you distracted by activity or noise around you?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 12. | How often do you leave your seat in meetings or other situations in which you are expected to remain seated?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 13. | How often do you feel restless or fidgety?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 14. | How often do you have difficulty unwinding and relaxing when you have time to yourself?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 15. | How often do you find yourself talking too much when you are in social situations?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 17. | How often do you have difficulty waiting your turn in situations when turn taking is required?  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. | How often do you interrupt others when they are busy?   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

Part B

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

Signing here indicates I have viewed  
and attempted to complete this page to  
the best of my ability

## Patient Health Questionnaire (PHQ-9)

|   |   | Not at all               | Several days             | More than<br>half the days | Nearly every<br>day      |
|---|---|--------------------------|--------------------------|----------------------------|--------------------------|
| 1. Over the <u>last 2 weeks</u> , how often have you been bothered by any of the following problems?  |   |                          |                          |                            |                          |
| a. Little interest or pleasure in doing things  | a | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| b. Feeling down, depressed, or hopeless   | b | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| c. Trouble falling/staying asleep, sleeping too much  | c | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| d. Feeling tired or having little energy  | d | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| e. Poor appetite or overeating  | e | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| f. Feeling bad about yourself or that you are a failure or have let yourself or your family down  | f | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| g. Trouble concentrating on things, such as reading the newspaper or watching television.   | g | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| 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 | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| i. Thoughts that you would be better off dead or of hurting yourself in some way.   | i | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |
| 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<br>at all  | Somewhat<br>difficult    | Very<br>difficult          | Extremely<br>difficult   |
|   |   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/>   | <input type="checkbox"/> |

Signing here indicates I have viewed and attempted to complete this page to the best of my ability



## GAD-7 Anxiety

| Over the <u>last two weeks</u> , 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  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Not being able to stop or control worrying  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Worrying too much about different things  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Trouble relaxing  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Being so restless that it is hard to sit still  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Becoming easily annoyed or irritable  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Feeling afraid, as if something awful might happen  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

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](mailto:ris8@columbia.edu). PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Signing here indicates I have viewed and attempted to complete this page to the best of my ability

# 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?   | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were so irritable that you shouted at people or started fights or arguments?   | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you felt much more self-confident than usual?  | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you got much less sleep than usual and found you didn't really miss it?  | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were much more talkative or spoke faster than usual?   | <input type="checkbox"/> | <input type="checkbox"/> |
| ...thoughts raced through your head or you couldn't slow your mind down?  | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were so easily distracted by things around you that you had trouble concentrating or staying on track?   | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you had much more energy than usual?   | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were much more active or did many more things than usual?  | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?  | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were much more interested in sex than usual?   | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?  | <input type="checkbox"/> | <input type="checkbox"/> |
| ...spending money got you or your family in trouble?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? <i>Please check 1 response only.</i>                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 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?<br><i>Please check 1 response only.</i> |                          |                          |
| <input type="checkbox"/> No problem <input type="checkbox"/> Minor problem <input type="checkbox"/> Moderate problem <input type="checkbox"/> Serious problem                                     |                          |                          |
| 4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?  | <input type="checkbox"/> | <input type="checkbox"/> |

Signing here indicates I have viewed and attempted to complete this page to the best of my ability