Care Psychiatry

Name: _____ DOB:_____/_____/_____

Name_____ □ Male □ Female **DOB:** ____/_____/___
Last First Middle

SSN:_____ □ Married □ Single □ Other _____

Home address: _____

City:_____**State:**_____**zip code:**_____

Phone:_____**preference:** ☐ **SMS** ☐ **Voice** **Email:**_____

Emergency contact:_____**Phone:**_____

Allergies: _____**Height:** _____**Weight**: _____

Race: ☐ Caucasian ☐ African American ☐ Asian ☐ American Indian ☐ Other

Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino

Smoking: ☐ **Yes** ☐ **No**

Primary physician:_____Referring physician:_____

Pharmacy: _____City:_____Phone: _____

Responsible Person /Guardian Information (Please skip if you are the responsible person)

Name:_____ □ Male □ Female DOB: ____/_____/___
Last First Middle

Primary Insurance:_____Policy #:_____Relationship:_____

Secondary Insurance:_____Policy #:_____Relationship:_____

Consent to Release claim information/Assignment of Benefits

- I hereby assign, transfer, and set over all rights, title, and interest to my medical reimbursement benefits under my insurance policy with the above insurance company (ies).
- I hereby consent for The Care Psychiatry Clinic or any of its employees or agents to release and disclose any information required about me (or the above named patient) to my insurance carrier, claims administrator, managed care company, or review agency and its employees or agents for the purpose of treatment, healthcare operations, and evaluating claims for payment.
- I understand insurance billing is a service provided as a courtesy, and that **I am at all times personally responsible for any fees not covered by insurance**. Should any insurance payment be made directly to me or to the issued for monies due on this account, I agree to immediately pay over these funds to The Care Psychiatry Clinic. I also acknowledge I am responsible for any deductible, co pay, or any other balance not covered by my insurance carrier.

_____ _____ _____ _____
Patient's Signature Date Parent/ Guardian Signature Date

Medication Informed Consent

I give my **Consent to** Sreedevi Vayalapalli, MD PC DBA: Care Psychiatry to prescribe medications.

THE FOLLOWING WAS EXPLAINED/PROVIDED TO ME:

1. Benefits of Treatment and Diagnosis information.
2. Administration of Treatment
3. Alternative to Treatment modes.
4. Consequences of not receiving proposed treatment
5. I have been advised of the name, mechanism of action, and potential side effects of the medications being prescribed to me.
6. I have been advised that if I am of **Child Bearing Age** to avoid becoming pregnant while taking psychotropic medication, and to notify my psychiatrist immediately upon becoming pregnant.

_____ _____ _____ _____

Patient's Signature Date Parent/ Guardian Signature Date

Authorization to Disclose Protected Health Information to Primary Physician

In order to assist you in your treatment response, Sreedevi Vayalapalli MD PC can contact your **Primary Care Physician** and provide them with information as to your treatment plan, medications prescribed, and condition.

I hereby authorize, **Care Psychiatry**, to release and exchange written, oral or electronically transmitted protected health information indicated below regarding:

Name: _____DOB: _____

TO:

Name/Facility/Organization: _____

Address: _____City/State/Zip Code: _____

For the PURPOSE of: Coordination of Services

- I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information.
- I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.
- I understand that Sreedevi Vayalapalli MD PC will not condition treatment or payment on this authorization.
- I understand that I have a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.
- I further understand that I retain the right to revoke this authorization. In order for the revocation of this authorization to be effective, Sreedevi Vayalapalli MD PC must receive the revocation in writing.

I fully understand and accept the terms of this authorization.

OR

☐ I **DO NOT** authorize, Care Psychiatry, to release and exchange written, oral or electronically transmitted protected health information

_____ _____ _____ _____

Patient's Signature Date Parent/ Guardian Signature Date

Care Psychiatry

Name: _____ DOB:_____/_____/_____

Reason for Consultation: _____

Significant losses\ traumas (marriage\ divorces\deaths\ traumatic events\ losses\ physical or sexual abuse etc.)

_____

Current Symptom Checklist (Please check that apply):

- ☐ ANXIETY ATTACKS
- ☐ AVOIDANCE
- ☐ CRYING SPELL
- ☐ CHANGE IN APPETITE
- ☐ CHECK THINGS OVER AND OVER
- ☐ CLEANING MYSELF ALL THE TIME
- ☐ DECREASED LIBIDO
- ☐ DEPRESSED MOOD
- ☐ DIFFICULTY LEAVING THE HOME
- ☐ DECREASED NEED FOR SLEEP
- ☐ DIFFICULTY GETTING ALONG
- ☐ DIFFICULTY BEING WITH PEOPLE
- ☐ DIFFICULTY WITH ANGER
- ☐ EXCESS ENERGY
- ☐ EXCESSIVE WORRY
- ☐ FATIGUE
- ☐ FEAR OF DEATH
- ☐ HEARING VOICES
- ☐ HOARDING
- ☐ IMPULSIVITY
- ☐ INCREASED RISKY BEHAVIOR
- ☐ INCREASED LIBIDO
- ☐ INCREASED IRRITABILITY
- ☐ LACK OF CONCENTRATION
- ☐ LACK OF ENERGY
- ☐ LOSS OF INTEREST
- ☐ MAKE MYSELF THROW UP
- ☐ NERVOUS AND SHAKY
- ☐ NIGHTMARES
- ☐ PROBLEMS AT WORK
- ☐ PEOPLE ARE OUT THERE TO GET ME
- ☐ RACING THOUGHTS
- ☐ SLEEP DISTURBANCE
- ☐ TAKING TOO MANY RISKS
- ☐ UNABLE TO ENJOY ACTIVITIES
- ☐ UNABLE TO LOOK FOR FUTURE
- ☐ WANTING TO CUT/HURT SELF
- ☐ WANTING TO HURT SOME ONE
- ☐ OTHER: _____

PRIOR PSYCHIATRIC HISTORY

Have you ever seen a psychiatrist? If yes, please list:_____

Are you currently seeing a therapist? _____

Have you ever been treated for any of the following (check all that apply):

- ☐ ADHD
- ☐ ANGER PROBLEMS
- ☐ ANOREXIA/ BULIMIA
- ☐ ALCOHOL PROBLEMS
- ☐ ANXIETY
- ☐ BIPOLAR DISORDER
- ☐ BINGE-EATING
- ☐ DEPRESSION
- ☐ DRUG USE
- ☐ GENERALIZED ANXIETY
- ☐ PANIC ATTACKS
- ☐ PTSD
- ☐ LOSSES
- ☐ OCD
- ☐ SCHIZOPHRENIA
- ☐ SEXUAL OR PHYSICAL ABUSE
- ☐ OTHER: _____

Prior Psychiatric Hospitalizations: Please list in chronological order ☐ **None**

Approximate date	Length of stay	Name of Hospital	Reason for admission

Have you ever attempted to harm/kill yourself? ☐ **Never**

Approximate date of attempt	How did you attempt?

Substance use history:

	Never used	Age 1st use	Last used	Peak use	Frequency
Alcohol					
Cocaine					
Amphetamines\Speed\Ecstasy					
Marijuana					
LSD\Mescaline\Mushrooms\PCP\ Angel dust\GHB					
Pain Pills\ Heroine					
Klonopin\Ativan\diazepam\Xanax					
Inhalants					
Laxatives\Diuretics\Diet Pills					
Nicotine use					
IV drug abuse					
Other: _____					

Care Psychiatry

Name: _____ DOB:_____/_____/_____

List all current medications (Please include birth control pills, over the counter and herbal medication)

Medication Name	Dosage	# times a day	How long?	Side effects	Physician name

Please let us know if you had used any of the below medications in the past?

- ☐ ABILIFY
- ☐ ADDERALL
- ☐ AMBIEN
- ☐ ANAFRANIL
- ☐ ANTABUSE
- ☐ ARICEPT
- ☐ BENZODIAZEPINES
- ☐ BUSPAR
- ☐ BUPRENORPHINE
- ☐ CAMPRALC
- ☐ CARBAMAZEPINE
- ☐ CELEXA
- ☐ CONCERTA
- ☐ CLOZARIL
- ☐ CYMBALTA
- ☐ DEPAKOTE
- ☐ DEXEDRINE
- ☐ DOXEPINE
- ☐ EFFEXOR
- ☐ ELVAIL
- ☐ FOCALIN
- ☐ GABAPENTIN
- ☐ GEODON
- ☐ HALDOL
- ☐ HYDROXYZINE
- ☐ INDERAL
- ☐ INTUNIV
- ☐ INVEGA
- ☐ KLONOPIN
- ☐ LAMICTAL
- ☐ LATUDA
- ☐ LEXAPRO
- ☐ LIBRIUM
- ☐ LITHIUM
- ☐ LOXAPINE
- ☐ LUNESTA
- ☐ LUVOX
- ☐ MELLARIL
- ☐ METADATE
- ☐ METHADONE
- ☐ MIRTAZEPINE
- ☐ NAMENDA
- ☐ NAVANE
- ☐ NEURONTIN
- ☐ PAXIL
- ☐ PHENELZINE
- ☐ PRAZOSIN
- ☐ PRISTIQ
- ☐ PROLIXIN
- ☐ PROZAC
- ☐ PROVIGIL
- ☐ QUETIAPINE
- ☐ REMERON
- ☐ RESTORIL
- ☐ RISPERIDONE
- ☐ RITALIN
- ☐ SAPHRIS
- ☐ SEROQUEL
- ☐ STRATTERA
- ☐ SINEQUAN
- ☐ TOPAMAX
- ☐ TEGRETOL
- ☐ TRILEPTAL
- ☐ THORAZINE
- ☐ TRAZODONE
- ☐ VALIUM
- ☐ VISTARIL
- ☐ VYVANSE
- ☐ XANAX
- ☐ ZOLOFT
- ☐ ZOLPIDEM
- ☐ ZYPREXA

OTHERS: _____

Do you have, or have you ever had any of the following (please check all that applies)

- ☐ASTHMA
- ☐ARTHRITIS
- ☐CANCER
- ☐CHRONIC PAIN
- ☐COPD
- ☐CROHN'S DISEASE
- ☐DIABETES
- ☐ENDOCRINE ISSUES
- ☐HEAD ACHES
- ☐HEAD INJURY
- ☐HEPATITIS
- ☐HYPOTHYROIDISM
- ☐HIV/AIDS
- ☐HIGH BLOOD PRESSURE
- ☐HEART DISEASE
- ☐HYSTERCTOMY
- ☐HIGH CHOLESTEROL
- ☐IRRITABLE BOWEL
- ☐KIDNEY DISEASE
- ☐LIVER DISEASE
- ☐LUNG DISEASE
- ☐LUPUS
- ☐ SEIZURES
- ☐ SLEEP APNEA
- ☐ STROKE
- ☐ THYROID PROBLEMS
- ☐ ULCERATIVE COLITIS
- ☐ UTI

List medical Hospitalizations | Surgeries: _____

Family History: Please check all that apply and when appropriate indicate paternal or maternal

	Father	Mother	Brother	Sister	Aunt	Uncle	Children	Grand parents	Medications used
Depression									
Anxiety									
Bipolar									
Schizophrenia									
Alcohol/Drugs									
Suicide attempts									

Only for female patients: Are you pregnant? ☐ Yes ☐ No. Last Menstrual Period: _____

Contraception: ☐ **Condoms** ☐ **Oral Contraceptives** ☐ **Abstinence** ☐ **Tubal Ligation** ☐ **Others-**_____

If you are planning to conceive, Please let the Physician know: _____

Childhood History:

Significant Birth History:_____

Mile Stones: □ Delayed □ Normal; Other information:_____
Primary Care Giver:_____

Highest degree obtained: (Check only one)
□ High school □ G.E.D. □ 4 year college degree □ M.B.A./M.A./M.S./M.P.H. □ M.D.
□ Technical school diploma □ J.D./LL.B. □ Ph.D □ Other_____
Any behavior problems in school? _____

EMPLOYMENT HISTORY: (summarize jobs you've had)
What is your occupation? _____
□ FULL-TIME □ PART-TIME □ SOCIAL SECURITY DISABILITY □ OTHER_____
Any work-related problems**?** □ Yes □ NO If Yes, Please explain -_____
_____

Current marital status:
□ SINGLE, NEVER MARRIED □ MARRIED, LIVING TOGETHER □ SEPARATED □ WIDOWED
□ COHABITING WITH PARTNER □ DIVORCED OTHER: _____

- If you are married or cohabitating with partner, how long has this been? _____Years _____Month
- Total number of marriages? _____How many children do you have? _____
- Spouse's/Partner's Name_____
- Who else lives with you? _____

Current Residence □ OWN MY HOUSE □ RENTING □ RETIREMENT /SENIOR HOUSING □ Other_____

Do you have access to Guns or Weapons?, if Yes, Please list _____

Legal Problems? □ Yes □ NO If Yes, Please explain -_____

Care Psychiatry

Name: _____ DOB:_____/_____/_____

Treatment Consent and Acknowledgement

Effective and efficient provision of treatment requires the following policies to enable these processes:

Financial Policy: We ask that you plan to pay **at time of service** your co-pay, co-insurance, and any deductible not met or any portion you are responsible for. You are responsible for any pre-authorization or referrals required by your insurance. If you do not have insurance or your insurance does not cover these services, you will be considered "Self-Pay" and payment is due **in-full** at time of service.

Appointment Policy: All appointments are to be kept to ensure consistency in the treatment process. A **fee** of $50 will be charged for cancellations without a 24 hour notice or non-appearance for a scheduled appointment.

Medication Policy: Medication renewal will occur during the medication follow-up session with the prescribing psychiatrist. No medications will be prescribed over the phone routinely**.** Any written script for a controlled substance which is lost will not be re-written. If the script or the medications are lost, then another prescription may be provided to the patient once if a Police Report is obtained. The patient must wait for the eligibility date of the next month for the doctor to prescribe (30 days after the original script). Any script for a controlled substance which has expired must be returned and exchanged at the office before a new script written.

Phone Policy: Phone calls to the office may be made at any time. Phone calls made for treatment purposes may be charged a fee. Phone calls for scheduling or matters of short duration will not be charged.

General Office Policy: As a service it is our policy to bill your insurance and to keep accurate and complete records. A fee will be charged for the copying and release of these records. Letters and other documents generated by your request may also be charged.

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:_____

I hereby authorize Sreedevi Vayalapalli, MD PC to release to my insurance company or its representative, any/all information requested to include my diagnosis and records of my mental health treatment by this practice. I also authorize and direct my insurance company to pay directly to Sreedevi Vayalapalli, MD PC, the amount due for treatment and/or services rendered. Patient/Insured agrees to pay for any/all services that are denied by the insurance company as not medically necessary, etc.

Furthermore, I hereby give consent to Sreedevi Vayalapalli, MD PC render mental health services deemed necessary for myself and/or minor child as designated in the treatment plan.

_____ _____ _____ _____

Patient's Signature Date Parent/ Guardian Signature Date

Patient Bill of Rights & Responsibilities:

1. The Patient has the right to considerate and respectful care and treatment, regardless of gender, race, sexual orientation, age, culture, disabilities, or religious beliefs.
2. The Patient has the right to have their care and treatment information kept private, and have the opportunity to have their records released only with their written permission, except required by law.
3. Patients have a right to make informed choices regarding their medications, behavioral heath services, and their providers.
4. The Patient has a right to expect reasonable continuity of care.
5. The Patient has the right to examine and receive an explanation of costs for treatment as applicable.
6. The Patient has the right to know what relationship Sreedevi Vayalapalli, MD PC has with other health care providers and facilities in regard to their health care.
7. The Patient has the right to inquire as to their provider's degree, licensure, and training.
8. The Patient has the right to inquire as to the role of the providers on the treatment team in the treatment process.
9. The Patient has the right to an explanation of their condition and the treatment options.
10. The Patient has the right to expect that Sreedevi Vayalapalli, MD PC will make reasonable effort in providing the identified services of the treatment plan.
11. The Patient has the right to be informed if Sreedevi Vayalapalli MD PC is engaging in research about behavioral health care and have the right to refuse participation in that research.
12. The Patient has the right to register complaints to their behavioral health care professional and/or an administrator.

Patient's Responsibilities

1. The Patient has the Responsibility to treat those providing care with dignity and respect.
2. The Patient has the Responsibility to ask questions regarding the diagnosis, treatment, medications, or any instructions.
3. The Patient has the Responsibility to follow instructions concerning medications, follow-up visits, and other essential components of their treatment and to notify their behavioral health care provider if the instructions cannot be followed or problems develop.
4. The Patient has the Responsibility to assist Sreedevi Vayalapalli MD PC in obtaining approvals for payments for treatment, referrals, and authorizations.
5. The Patient has the Responsibility to provide as much information as is possible to their provider to assist in the assessment and rendering of services.

_____ _____ _____ _____

Patient's Signature Date Parent/ Guardian Signature Date