

# New Patient Paperwork

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*Please complete all sections to the best of your ability. If you have any questions or need assistance, ask a front staff member.*

Last name: \_\_\_\_\_ First name: \_\_\_\_\_ MI: \_\_\_\_\_

Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_ Male \_\_\_\_\_ Female \_\_\_\_\_ SSN: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Phone Number: \_\_\_\_\_ Email: \_\_\_\_\_

Marital Status: Single \_\_\_\_ Married \_\_\_\_ Divorced \_\_\_\_ Widowed \_\_\_\_ Grade level (if applicable): \_\_\_\_\_

Address: \_\_\_\_\_ Apt \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_ Who do you live with? \_\_\_\_\_

Current Employment Status: (Check one) Employed \_\_\_\_ Unemployed \_\_\_\_ Student \_\_\_\_ Retired \_\_\_\_

Occupation: \_\_\_\_\_

Emergency Contact Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

Emergency Contact Phone Number: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_ Can we send notes: YES \_\_\_\_ No \_\_\_\_

Primary Care Phone: \_\_\_\_\_ Location: \_\_\_\_\_

Was your referral given by your primary care provider? YES \_\_\_\_\_ NO \_\_\_\_\_

Referring provider: \_\_\_\_\_ Can we send notes: YES \_\_\_\_ No \_\_\_\_

Referring provider phone: \_\_\_\_\_ Location: \_\_\_\_\_

Current Pharmacy: \_\_\_\_\_ Phone/Address : \_\_\_\_\_

## Insurance Information (if applicable):

Primary Insurance Company: \_\_\_\_\_ Policyholder Name: \_\_\_\_\_

Policyholder Date of Birth: \_\_\_\_ / \_\_\_\_ / \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance (if applicable): \_\_\_\_\_

Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**Reason for Visit / Concerns**

Briefly describe the issue(s) you are seeking help for: \_\_\_\_\_  
\_\_\_\_\_

When did you first notice these symptoms or concerns? \_\_\_\_\_

How did you hear about us? (Check all that apply): \_\_\_\_\_

**Mental Health History:**

Have you previously received mental health treatment? (Check all that apply)

- Yes, therapy
- Yes, psychiatric medication
- Yes, hospitalization
- No

If yes, please provide details: \_\_\_\_\_

Do you have a history of any of the following? (Check all that apply)

- ADHD/ADD
- Depression
- Anxiety
- Bipolar Disorder
- Other: \_\_\_\_\_
- PTSD
- Eating Disorders
- Substance Use
- Self-Harm
- Suicidal Thoughts
- Psychosis

**Medical History**

Are you currently taking any medications and/or vitamins/supplements? (List medications and dosages)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have any allergies? (medications, foods, etc.): \_\_\_\_\_

Past Surgical History: \_\_\_\_\_  
\_\_\_\_\_

**Substance Use History**

Do you smoke cigarettes? YES \_\_\_\_ NO \_\_\_\_  
 Do you vape nicotine? YES \_\_\_\_ NO \_\_\_\_  
 Do you use alcohol? YES \_\_\_\_ NO \_\_\_\_  
 If yes, how often? \_\_\_\_\_  
 Do you use recreational drugs? YES \_\_\_\_ NO \_\_\_\_  
 If yes, what substances and how often?  
 \_\_\_\_\_  
 Have you ever been treated for substance abuse? YES  
 \_\_\_\_ NO \_\_\_\_ Last Treatment: \_\_\_\_\_

**Family History**

Does anyone in your family have a history of mental health issues? If yes, please specify:  
 (including anxiety disorders, depression, bipolar disorder, schizophrenia, ADHD, history of substance abuse): \_\_\_\_\_  
 \_\_\_\_\_

Do you have children? Yes \_\_\_\_ No \_\_\_\_ If yes, how many and ages: \_\_\_\_\_

Do you have any of the following conditions:

- Anemia
- Asthma
- Cardiac Arrhythmia
- COPD
- Diabetes
- Elevated cholesterol
- Fibromyalgia
- Gastric Ulcer
- GERD
- Glaucoma
- Herniated Disc
- Hypertension
- Hyperthyroidism
- Hypothyroidism
- Ischemic heart disease
- Lupus
- Chronic Migraines/Headaches
- Myocardial Infarction/Heart Attack
- Seasonal allergies
- Seizures
- History of Stroke or Transient Ischemic Attack
- Vitamin B12 deficiency
- Vitamin D deficiency
- Other: \_\_\_\_\_

**Legal History**

Are there any legal issues currently affecting you? (including FMLA/short term/long term disability)

If yes, please provide details: \_\_\_\_\_

**Consent for Treatment**

I consent to treatment and understand that my mental health provider may need to discuss my case with other healthcare providers when appropriate.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Privacy Policy and HIPAA Acknowledgment**

I acknowledge that I have received and reviewed the Notice of Privacy Practices (HIPAA) and understand my rights regarding confidentiality and privacy. This clause is also to give consent for IAM and HNS to send evaluation and progress notes to your primary care provider and/or referring provider office.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**Fee Acknowledgement**

I acknowledge that if I do not give a 24-hour notice when canceling or rescheduling an appointment, I will be charged a \$25 Late/No-Show fee. I also understand that my provider charges a separate fee for paperwork to be filled out or letter to be given. The charge for the paperwork is dependent on the length of time needed to complete the paperwork (varies anywhere from \$25-75).

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

# HIPAA AUTHORIZATION FORM

(PERMISSION FROM PATIENT/PATIENT'S LEGAL GUARDIAN TO SHARE PERSONAL MEDICAL INFORMATION)

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

STREET ADDRESS: \_\_\_\_\_

CITY, STATE, ZIP: \_\_\_\_\_

I, \_\_\_\_\_ hereby authorize Huntsville Neuropsychiatric Services (HNS) & the Institute of Attention and Mood (IAM) to release any and all medical information and test results that pertain to me, to the following individual(s):

Name: \_\_\_\_\_ Phone #: \_\_\_\_\_ Relationship: \_\_\_\_\_

Facility: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

Facility: \_\_\_\_\_ Address: \_\_\_\_\_ Phone: \_\_\_\_\_

I understand that I may revoke/cancel this authorization by notifying HNS or IAM, in writing, of my intent to revoke authorization or change the name(s) of the individuals or facilities to whom information is to be released.

Patient Printed Name: \_\_\_\_\_

Signature of Patient: \_\_\_\_\_ Date: \_\_\_\_\_

or, if applicable

Printed Name of Legal Guardian: \_\_\_\_\_

Signature of Legal Guardian: \_\_\_\_\_ Date: \_\_\_\_\_

Relationship to Patient: \_\_\_\_\_

# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?

(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING   0   +      +      +       
=Total Score:     

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult  
at all

Somewhat  
difficult

Very  
difficult

Extremely  
difficult

**REVIEW OF SYSTEMS:**

Please select any symptoms you may be experiencing:

**GENERAL:**

- Chills       Fatigue       Weight gain       Weight loss

**EYE:**

- Blurred vision       Itchy eyes       Eyesight problems

**ENDOCRINE:**

- Cold intolerance       Excessive sweating       Excessive thirst       Heat intolerance

**EAR, NOSE, AND THROAT (ENT):**

- Decreased hearing       Ear Pain       Ringing in the ears       Snoring

**GASTROINTESTINAL:**

- Decreased appetite       Diarrhea       Difficulty swallowing       Heartburn  
 Nausea       Vomiting

**GENITOURINARY:**

- Blood in Urine       Difficulty Urinating       Increased frequency of urination  
 Painful urination

**CARDIOVASCULAR:**

- High blood pressure       Irregular heartburn       Palpitations

**RESPIRATORY:**

- Cough       Shortness of breath       Wheezing

**MUSCULOSKELETAL:**

- Joint pain       Joint stiffness       Muscle aches       Muscle weakness

**ALLERGIES:**

- Hives       Itching       Rashes       Seasonal allergies       Watery eyes

**NEUROLOGICAL:**

- Dizziness       Fainting       Headaches       Vertigo

**HEMATOLOGY:**

- Easy bruising       Swollen glands       Weakness

I AM NOT EXPERIENCING ANY SYMPTOMS LISTED ABOVE

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Huntsville, AL 35801

Institute of Attention and Mood – IAM  
11743 County Line Road, Suite C  
Madison, AL 35758

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

This agreement is made between **IAM – Institute of Attention & Mood, Huntsville Neuropsychiatric Services, LLC**, and the above-named patient for the purpose of managing and monitoring the appropriate use of **controlled substance medications** prescribed for the treatment of a diagnosed medical condition.

Controlled substances include medications such as opioids (e.g., hydrocodone, oxycodone), benzodiazepines (e.g., lorazepam, clonazepam), stimulants (e.g., amphetamine, methylphenidate), and other drugs regulated by law due to their potential for **dependence, misuse, and abuse**.

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### Patient Responsibilities

#### 1. Medication Use

- I agree to take the medication exactly as prescribed.
- I will not increase the dose or frequency without approval from my provider.
- I will keep my medications in a secure location and out of the reach of others, especially children.
- I understand that giving or selling my medication to another person is illegal and may result in criminal prosecution and termination of care.
- I understand that combining controlled substances with alcohol, illicit drugs, or other sedatives (e.g., sleep aids) is dangerous and may result in serious harm or death.

#### 2. Disclosure of Other Medications or Conditions

- I agree to inform my provider of **all medications** (prescription, over-the-counter, herbal) and **all medical conditions**, including physical health, mental health, or substance use history.
- I understand that there are certain psychiatric medications, including controlled substances, that may carry increased risk when combined with underlying medical conditions such as high blood pressure, heart problems, or other physical health concerns. For my safety and to ensure the effectiveness of my treatment, I agree to inform my psychiatric provider of any current or new medical conditions, including visits to other medical specialists (e.g. cardiologist, etc.), hospitalizations, or changes in my overall physical health.

#### 3. Refills and Appointments

- I understand if I cancel or No-Show a scheduled appointment, refills will not be sent till I am seen again in-person or by telehealth (when applicable).
- I will **not** request early refills on medications. (If you plan to go out of town, please plan accordingly to ensure you have enough to travel).
- Lost, stolen, or misplaced medications may **not** be replaced. I'm aware a Police report may be required as well.
- I understand that failure to attend follow-up appointments with my doctor or nurse practitioner may result in discontinuation of medication.

- I understand that my doctor or nurse practitioner has the right to adjust, change, or stop my medication during any encounter.

**4. Monitoring and Compliance**

- I understand routine vitals may be taken or requested of me at every in-person or telehealth appointment. My provider may require me to come in-person between visits before refills are provided if deemed necessary.
- I agree to periodic **urine drug screens, blood lab work, pill counts, and review of prescription monitoring programs** (e.g., PMP, PDMP).
- I understand that non-compliance, including a positive drug screen for illicit drugs or unprescribed medications may result in tapering, discontinuation of medication, or referral to specialized care.

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**Acknowledgment and Consent**

I acknowledge that failing to disclose relevant medical information may put my health at risk and interfere with safe medication management. I understand that if I do not report medical issues, this may result in the discontinuation of controlled substances and or discharge from psychiatric care at this practice.

I have read this agreement (or had it read to me). I understand the information and agree to the terms.

**Patient/Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Provider Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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## Policy for Divorced or Separated Parents

Our highest priority is the care of our patients. We have many patients whose parents are either separated or divorced and we are happy to work with either or both parents to make sure the child's healthcare needs are met.

When a child is seen by our staff and accompanied by either parent, we will assume that parent has the authority to make medical decisions for the child, unless we are instructed otherwise by legal documentation.

It is essential that both parents reach an agreement regarding their child's healthcare needs prior to arriving at our office as we will not mediate disagreements. We will discuss our assessments and recommendations with the adult who accompanies the child to the office, televisit or portal communication. However, we are happy to answer any questions regarding your child's health from either parent at any time.

Copays will be collected at time of service by the accompanying adult, regardless of divorce decree. If legal documentation states otherwise, we will be happy to provide a receipt at the time of visit for medical reimbursement to be settled privately between the parents.

As a collaborating office, we will not become involved in disputes between family members. Should a dispute interfere with your child's healthcare, or should an issue become disruptive to our practice, we have reserved the right to discharge the patient from further treatment.

Parent Printed Name: \_\_\_\_\_

Parent Signature: \_\_\_\_\_ Date: \_\_\_\_\_