Huntsville Neuropsychiatric Services
185 Whitesport Drive SW, Suite 5
Huntsville, AL 35801

NEW PATIENT PAPERWORK

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

-Please complete all sections to the best of your ability

Last name: _____ First name: _____ MI: _____ Preferred Name: _____

Date of Birth: _____ / _____ / _____ Sex at Birth: ☐ MALE ☐FEMALE Pronoun:_____

Phone #: _____ ALT Phone#: _____ SSN: _____ - _____ - _____

Email: _____ Do you allow us to send unencrypted emails? ☐ YES ☐NO

Address: _____ Apt _____ City: _____ State: ____ Zip Code: _____

Highest Level of Education? _____ Occupation: _____ Martial Status: _____

Race: ☐White, ☐African American, ☐ Native American, ☐Other: _____, ☐ Decline to Answer

Ethnicity: ☐Non-Hispanic, ☐Hispanic, ☐Other: _____, ☐ Decline to Answer

Emergency Contact:
Name: _____ ***WE MUST HAVE THIS FOR YOU TO BE A PATIENT***
Phone Number: _____ **Relationship to Patient:** _____
Emergency contacts are for urgent outreach. Permission to share clinical details is addressed separately on the information sharing page.

Care Team:

Primary care clinician / practice _____ Phone _____

Referring clinician (if any) _____ Phone _____

Therapist / Practice _____ Phone _____

Pharmacy & Location _____ Phone _____

Reason for Visit:

Main Concerns & Goals: _____
_____

When did you first notice these symptoms or concerns? _____

MENTAL HEALTH HISTORY:

List all current medications, vitamins, and/or supplements? (include dosages): _____
_____
_____

List all PAST medication trails for Psychiatric care? (list med and reason for failure): _____
_____

Allergies:

☐ No known allergies ☐ Unsure ☐ Allergies (Medication, Food, or Environmental & list reaction): _____
_____

Patient/Guardian Initials: _____ *(please make sure all pages are initialed before returning)*

Medical and Family History

Medical History:

☐ Heart disease / arrhythmia ☐ High blood pressure ☐ Fainting / POTS ☐ Seizures
☐ Head injury ☐ Thyroid disorder ☐ Diabetes ☐ Glaucoma ☐ Asthma ☐ Sleep apnea
☐ Migraines ☐ Anemia ☐ Autoimmune condition ☐ Other _____
Other medical conditions or nonpsychiatric hospitalizations with dates: _____
_____

Surgery History:

Have you had any surgeries? ☐ No ☐ Yes If Yes, Procedure and approximate date / year: _____
_____

Family History

Include the relative and condition if known (for example ADHD, anxiety, depression, bipolar disorder, psychosis, suicide, or substance use).
Family history: _____
_____

Mood, Attention, Sleep, and Perception:

☐ Low mood / loss of interest ☐ Worry / panic ☐ Irritability / anger ☐ Mood elevation / unusually high energy
☐ Difficulty focusing / organizing ☐ Restlessness ☐ Intrusive thoughts / repetitive behaviors
☐ Sleep difficulty / oversleeping ☐ Nightmares ☐ Appetite / weight change ☐ Hearing or seeing things others do not

REVIEW OF SYSTEMS:

Please mark ALL symptoms you may be experiencing right NOW:

GENERAL / CONSTITUTIONAL: ☐Chills, ☐Fever, ☐ Fatigue, ☐Weight Gain, ☐Weight Loss

OPHTHALMOLOGIC: ☐Eye Problems, ☐Eye Pain, ☐ Itching & Redness, ☐ Blurred Vision

ENT: ☐ Snoring, ☐ Nasal Congestion, ☐ Decreased Hearing, ☐ Ear Pain, ☐ Nosebleed, ☐ Ringing in Ears

ALLERGIES/IMMUNOLOGY: ☐ Hives, ☐ Itching, ☐ Rash, ☐ Seasonal, ☐ Watery Eyes

ENDOCRINE: ☐Excessive Sweating, ☐ Excessive Thirst, ☐ Heat Intolerance, ☐ Cold Intolerance

RESPIRATORY: ☐ Shortness of Breath, ☐ Cough, ☐Wheezing

CARDIOVASCULAR: ☐ Irregular Heartbeat, ☐ Palpitations, ☐ High Blood Pressure

GASTROINTESTINAL: ☐ Decreased Appetite, ☐Difficulty Swallowing, ☐ Heartburn, ☐ Nausea, ☐ Vomiting

GENITOURINARY: ☐ Painful Urination, ☐Blood in Urine, ☐ Frequent Urination, ☐ Difficulty Urinating

☐ **No current symptoms listed above**

☐Other symptoms or details: _____

Anything else you want your clinician to know? _____

_____

Patient/Guardian Initials: _____ *(please make sure all pages are initialed before returning)*

SOCIAL & HOUSEHOLD HISTORY:

Do you smoke cigarettes? ☐NO ☐YES Do you vape nicotine? ☐NO ☐YES

Do you use alcohol? ☐NO ☐YES If yes, how much/often? _____

Daily caffeine intake? ☐NO ☐YES If yes, how much/often? _____

Do you use recreational drugs? ☐NO ☐YES If yes, how much/often? _____

Have you ever been treated for substance abuse? ☐NO ☐YES If Yes, Last Treatment: _____

Who lives in the Home with you? _____ Any Children?: ☐NO ☐YES, Ages: _____

Do you feel Safe at Home? ☐NO ☐YES If No, reason: _____

Practice Information and Consent

Please read and initial at the bottom before signing the acknowledgment at the end.

Care and communication

I consent to psychiatric evaluation and clinically appropriate treatment, which may include medication management, testing, psychotherapy, and telehealth when offered. The clinician will discuss recommendations and alternatives with me. Evaluation does not guarantee a prescription, refill, or specific dose, including controlled medications. I may ask questions or decline a recommended treatment.

Students may observe or participate under supervision. I may decline student participation without affecting my care. Session recording requires my separate agreement; declining recording will not affect care.

IAM and HNS are outpatient practices and do not provide emergency services. For an immediate medical or psychiatric emergency, call 911 or go to an emergency department. Call or text 988 for crisis support. Portal, phone, email, and prescription messages are reviewed during business hours and are not appropriate for emergencies.

Privacy and coordination

I acknowledge that the Notice of Privacy Practices has been offered to me. The practice may use and disclose health information for treatment, payment, and health care operations as permitted by applicable law. Optional sharing with family members or others is addressed on page 8. I can request a copy of the Notice and discuss privacy questions with the office.

Appointments and conduct

At least 24 hours notice is requested for cancellations or rescheduling. Late cancellations and missed visits may result in a $25 to $75 fee depending on appointment type and provider. Repeated missed visits may affect ongoing care. Arriving late may require rescheduling. Telehealth check in and required payment must be completed before the visit.

Threats, harassment, violence, sexual misconduct, theft, property damage, or disruptive conduct may affect continued care, with appropriate transition arrangements. Staff and clinicians do not accept personal social media friend or follow requests from patients.

Patient/Guardian Initials: _____ *(please make sure all pages are initialed before returning)*

Payment and requests

Copayments, deductibles, coinsurance, self-pay balances, and other patient charges are due at or before service. I am responsible for keeping insurance information current and for noncovered services. The practice may require a valid payment method on file. Charges to a stored card should be explained in a separate payment authorization or checkout process.
Forms, letters, disability paperwork, prior authorizations, and record summaries may involve a $25 to $75 fee based on the work required. Disability, FMLA, and emotional support animal documentation generally require an established treatment relationship of at least six months and remain at the clinician's discretion. Fees and eligibility should be confirmed with the office before requesting a service.

Medication Monitoring

To promote safe prescribing and compliance with state and federal regulations, IAM and HNS may require random urine drug screens, pill counts, laboratory testing, vital sign monitoring, and review of Medications. In-office urine drug screens are a non-covered administrative service and are subject to a $10 fee due at the time of collection. Refusal or failure to comply with monitoring requirements, treatment recommendations, or financial obligations may affect prescription refills, treatment decisions, and continued care.

Medication and Controlled Substance Agreement

Applies when controlled medication is prescribed. Discuss any questions with your clinician.

Safe use and monitoring

I will take medication as prescribed, store it securely, and not share or sell it. I will tell my clinician about other medications, supplements, substance use, health changes, hospitalizations, and prescriptions from other clinicians. I will avoid alcohol, illicit substances, and non-prescribed controlled medications when their combination could be unsafe and discuss any concerns before changing treatment.
The practice may request vital signs, laboratory tests, prescription monitoring review, urine drug screens, or pill counts to support safe treatment. An in-office urine drug screen may carry a $10 noncovered administrative fee. A medical clearance letter or specialist assessment may be requested when a health condition raises prescribing concerns. Decisions about prescribing and monitoring are based on individual clinical judgment.

Pharmacy, visits, and refills

I will obtain controlled prescriptions through my IAM or HNS clinician unless another arrangement is approved and use one pharmacy when possible. I will notify the office before a pharmacy change; repeated transfers may not be possible. I will attend required follow ups and request refills through Healow at least four business days before medication is needed. Refill requests outside visits are not guaranteed. Early refills and replacement of lost, stolen, or damaged medicine are generally unavailable.

Changes to treatment

The clinician may modify, reduce, or stop controlled medication when clinically indicated. Misuse, concerning test results, refusal of needed monitoring, or withholding relevant health information may change the treatment plan. The clinician may recommend a substance use or specialty assessment. If the practice ends treatment, it will follow applicable professional obligations for notice and transition of care.

Patient/Guardian Initials: _____ *(please make sure all pages are initialed before returning)*

Acknowledgment and Signatures

I have reviewed the practice information and, if relevant to my treatment, the controlled substance agreement. I had an opportunity to ask questions. I understand that I may request a copy of these policies and the Notice of Privacy Practices. My signature confirms acknowledgment and consent to evaluation and treatment; it does not require me to accept any medication or service.

Patient signature: _____ Date: _____

If the patient is a minor or a legal representative is signing:

Parent / legal guardian printed name:_____ Relationship & Legal Authority: _____

Signature: _____ Date: _____

Office use: Notice of Privacy Practices provided / offered on _____

HIPAA/ Optional Information Sharing

Complete this page only if you want us to discuss your care with a person outside your treatment team.

Patient name _____ Date of birth _____

I authorize IAM and HNS to share information with the people or organizations listed below. This permission is optional and is separate from routine disclosures permitted for treatment, payment, or health care operations. An emergency contact is not automatically authorized to receive clinical information.

LIST PERSONAL NAMES, ORGANIZATIONS, OR FACILITIES:

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

If you need more room, please let the front staff know.

What may be shared?

☐ Appointment / scheduling information ☐ Medication information ☐ Treatment information

☐ Billing information ☐ Other (specify) _____

Purpose: _____

Expires on (date or event): _____ If blank, this authorization will not end unless written termination is provided.

I may revoke this permission in writing at any time, except for information already shared based on it. Information received by a person who is not a health care provider may not have the same privacy protections. My treatment and payment are not conditioned on signing this optional authorization, except where permitted by law. I may request a copy of this signed authorization.

Patient signature: _____ Date: _____

If the patient is a minor or a legal representative is signing:

Parent / legal guardian printed name:_____ Relationship & Legal Authority: _____

Signature: _____ Date: _____

Patient/Guardian Initials: _____ *(please make sure all pages are initialed before returning)*

CARD ON FILE AGREEMENT

This Card on File Agreement ("Agreement") authorizes **Huntsville Neuropsychiatric Services, LLC** ("Practice") to securely store and process payments using the credit card, debit card, or HSA/FSA card ("Card") provided by the patient or the patient's guarantor ("Patient") for all services rendered and outstanding balances.

Authorization to Store Card Information

The Patient hereby grants Practice permission to store Card information securely through a PCI-compliant payment processor. The stored Card details will be utilized exclusively for authorized payment transactions.

By signing this Agreement, the Patient consents to the Practice charging the Card for the following:

- Copayments due at the time of the appointment,
- Deductibles and coinsurance amounts as established by the Patient's insurance plan,
- Outstanding patient balances after insurance claim processing,
- Self-pay charges, payable at the time of service,
- Charges related to missed or cancelled appointments per Practice policy ($25 fee),
- Fees for non-covered services, such as paperwork ($50–$75 fee).

Upon request, the Practice will inform the Patient of any amounts owed and may provide email or text notifications before initiating charges, in accordance with Practice policy. Statements or notifications may be delivered electronically or by mail. The Patient has the right to request detailed information regarding any charge applied to the Card.

The Patient is responsible for informing the Practice of any changes to the Card, including expiration or cancellation. This Agreement shall remain valid until revoked in writing. The Patient may revoke this authorization at any time by submitting written notice to the Practice; however, revocation does not affect charges for services already rendered or balances due. The Practice will not disclose or use Card information for purposes other than authorized billing, and all Card data will be maintained in secure, PCI-compliant systems.

Patient Acknowledgment

By signing below, the Patient acknowledges and accepts the terms outlined in this Agreement and expressly authorizes the Practice to securely store and charge the Card as described above. If you do not wish to save a card on file, please initial here: _____

Effective Date: _____ *Please give a copy of the card to the front staff*

Name on Card:_____

Card Type:_____

Card Number: _____

Expiration Date: _____ (The agreement will expire on this date unless otherwise stated)

CVC Code: _____ Zip code (associated with the card): _____

Would you like to add a limit per daily transaction? YES _____ No____ If yes, do not exceed _____

Patient signature: _____ Date: _____

If the patient is a minor or a legal representative is signing:

Parent / legal guardian printed name:_____ Relationship & Legal Authority: _____

Signature: _____ Date: _____

Patient/Guardian Initials: _____ *(please make sure all pages are initialed before returning)*