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

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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: _____- _____ - _____

Main Phone #: _____ Alt. Phone #: _____

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

Address: _____ Apt _____

City: _____ State: _____ Zip Code: _____

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 ***
Emergency Contact Phone Number: _____ Relationship to Patient: _____

Primary Care Provider: _____ Can we send notes: YES ___ NO___
Primary Care Phone:_____ Location: _____
Can we send records to your Primary Care Physician's office? YES ___ NO___
Can we send records to the referring physician that referred you to our office? YES ___ NO___

Current Pharmacy: _____ Phone: _____
City & State / 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: _____
When did you first notice these symptoms or concerns? _____

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

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): _____

_____

_____

Do you have any of the following conditions: (please CIRCLE ALL that apply):

Anemia	Fibromyalgia	Hypertension	Seasonal Allergies
Asthma	GERD	Hyperthyroidism	Seizures
Autoimmune Disorder	Glaucoma	Hyperthyroidism	Vitamin B12 DEF
Diabetes Type I or II	Heart Issues	Migraines/Headaches	Vitamin D DEF
Elevated Cholesterol	Head Trama	POTS	OTHER (tell your provider)

Any Developmental issues or Delays growing up? _____

Do you have any of the following psychiatric conditions: (please CIRCLE ALL that apply):

ADHD/ADD	Bipolar Disorder	Self-Harm	Suicidal Thoughts
Anxiety	Eating Disorder	Substance Use	Psychosis
Depression / MDD	OTHER: _____		

Any medication, food, or environmental allergies? _____

Past Surgical History (include year): _____

_____

Ever been hospitalized for Psychiatric/Mental Health Needs? (include date and what for): _____

_____

Any other Hospitalizations? _____

SOCIAL & HOUSEHOLD HISTORY :

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

Do you use alcohol? YES ____ NO ____ If yes, how often? _____

Daily caffeine intake? YES ____ NO ____ If yes, how often? _____

Do you use recreational drugs? YES ____ NO ____ If yes, how often? _____

Have you ever been treated for substance abuse? YES ____ NO ____ Last Treatment: _____

Highest Level of Education? _____ Occupation: _____

Current Marital Status: _____ Who lives in the Home with you? _____

Any Children? YES ____ NO ____ If yes, how many and what ages? _____

Do you feel Safe at Home? YES ____ NO ____ If No, why? _____

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

FAMILY HISTORY -

Does anyone in your family have a history of mental health issues? If yes, please specify who in relation to you and issue (including anxiety disorders, depression, bipolar disorder, schizophrenia, ADHD, history of substance abuse)

EXAMPLE: Mother – diagnosed with anxiety and depression

_____

_____

_____

REVIEW OF SYSTEMS:

Please **CIRCLE ALL** symptoms you may be experiencing:

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

MUSCULOSKELETAL:
Painful Joints Lower Back Pain Joint Stiffness Muscle Weakness Muscle Aches Leg Cramps

NEUROLOGICAL:
Dizziness Vertigo Headaches Fainting

HEMATOLOGY:
Easy Bruising Swollen Glands Weakness

I AM NOT EXPERIENCING ANY SYMPTOMS LISTED ABOVE ☐

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

OFFICE POLICIES, CONSENT FOR TREATMENT, & CONTROLLED SUBSTANCE AGREEMENT

HIPAA & Care Coordination

I acknowledge receipt of the Notice of Privacy Practices and understand my rights regarding the confidentiality of my health information. I authorize Institute of Attention & Mood (IAM) and Huntsville Neuropsychiatric Services, LLC (HNS) to communicate with my primary care provider, referring provider, pharmacy, and other healthcare professionals involved in my care as permitted by law. This authorization may be revoked in writing at any time, except to the extent action has already been taken.

Consent for Treatment

I voluntarily consent to psychiatric evaluation, treatment, medication management, testing, telehealth services, and other clinically appropriate healthcare services. I understand that treatment recommendations and prescribing decisions are based solely on the provider's professional judgment.

As part of our commitment to education and training, our practice serves as a teaching facility and may include medical, nursing, counseling, or other healthcare students in patient care activities under the supervision of a licensed provider.

Patients may be asked to allow a student to observe or participate in their appointment. Participation by a student is intended to enhance the educational experience while maintaining the quality of patient care. Patients have the right to decline the presence or participation of a student at any time without affecting their treatment, services, or relationship with the practice.

Evaluation or treatment by this practice does not guarantee the prescription, continuation, refill, or dosage increase of any medication, including controlled substances.

Emergency Services

IAM and HNS are outpatient practices and do not provide emergency services. Patients experiencing a medical or psychiatric emergency, including thoughts of self-harm or harm to others, should call 911, contact 988, or go to the nearest emergency department.

IAM and HNS telephone messages, portal messages, emails, and prescription requests are reviewed during normal business hours. Electronic communications should not be used for emergencies and may not receive an immediate response.

Patient Conduct, Social Media, & Recording Policy

IAM and HNS maintain a zero-tolerance policy for threats, harassment, abusive language, intimidation, violence, sexual misconduct, theft, property damage, or disruptive behavior toward staff, providers, patients, or visitors. Violations may result in dismissal from the practice and/or notification of law enforcement when appropriate.

To protect patient privacy and maintain professional boundaries, providers and staff do not accept personal social media friend or follow requests from current patients.

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

Any audio or video recordings of psychotherapy sessions are used solely for training, supervision, and quality improvement purposes. Recordings will not be released without the patient's separate written authorization, except as required by law. Recordings may be securely destroyed following completion of the educational or supervisory review process. Patients have the right to decline recording of their session, and such refusal will not affect their access to care or treatment.

Appointments & Attendance

A minimum of 24 hours' notice is required to cancel or reschedule an appointment. Late cancellations, late reschedules, and missed appointments (no-shows) may incur a fee of $25 to $75, depending on the appointment type and provider. Repeated missed appointments may result in discharge from the practice.

Financial Responsibility

I understand that all copayments, deductibles, coinsurance, self-pay balances, and other patient-responsible charges are due prior to or at the time of service, including telehealth appointments.

Patients are responsible for providing accurate and current insurance information and notifying the practice of any changes before appointments. Patients remain financially responsible for services not covered by insurance.

Patients are required to maintain a valid payment method on file. I authorize IAM and HNS to charge my card on file for approved patient-responsible charges, including copayments, no-show fees, administrative fees, urine drug screen fees, and outstanding balances in accordance with practice policies.

Returned payments, declined transactions, or chargebacks may result in additional administrative fees and restriction of future payment methods.

Accounts exceeding $200 may result in non-emergency appointments being postponed, rescheduled, or withheld until the balance is reduced or acceptable payment arrangements have been established.

Patients remain responsible for unpaid balances and any reasonable collection costs, attorney fees, or court costs permitted by applicable law.

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.

Administrative Requests

Forms, letters, disability paperwork, prior authorizations, record summaries, and other administrative requests may be subject to fees ranging from $25–$75 based on complexity and provider time.

Disability, FMLA, and Emotional Support Animal (ESA) documentation requires an established treatment relationship of at least six months and is completed solely at the provider's discretion and time frame.

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

Controlled Substance Agreement

Controlled substances include, but are not limited to, stimulants, benzodiazepines, opioids, and other medications regulated by state or federal law.

Patient Responsibilities - I agree to:

• Take medications only as prescribed and not alter doses without provider approval.
• Store medications securely and never share, sell, or distribute prescribed medications.
• Inform my provider of all current or changed medications, supplements, medical conditions, hospitalizations, substance use, or other significant changes to my health.
• I understand some medications may carry increased risk when combined with underlying medal conditions. I may be asked to provide a Medical Clearance Letter for my safety and medications may be on hold or not given till my provider has received the needed information.
• Obtain controlled substance prescriptions only from IAM/HNS providers unless otherwise pre-approved by my provider.
• Use one pharmacy whenever possible and notify the practice of any pharmacy changes prior to prescription being sent. We are unable to keep moving prescriptions to several pharmacies due to convenience or shortage.
• Avoid combining controlled substances with alcohol, illicit drugs, or non-prescribed controlled substances.
• Attend required follow-up appointments and comply with monitoring requirements.
• Plan ahead for refills (especially for travel) and understand that early refills are not authorized.
• Submit refill requests at least four (4) business days before medication is needed through your Healow App.
• Understand that lost, stolen, damaged, or misplaced medications may not be replaced.
• Understand that refill requests outside scheduled appointments are not guaranteed and may require an appointment.

Provider Responsibilities & Medication Management - I understand that:

• Prescribing decisions are made solely at the provider's clinical discretion.
• Controlled substances may be reduced, modified, discontinued, or not prescribed when clinically indicated.
• Positive drug screens for non-prescribed or illicit substances, medication misuse, failure to comply with monitoring requirements, withholding relevant medical information, or failure to follow treatment recommendations may result in modification or discontinuation of controlled substance treatment.
• IAM and HNS may require evaluation and treatment by a substance use disorder or other specialized treatment program as a condition of continued care. Failure to comply with recommended evaluation or treatment may result in termination of the provider-patient relationship in accordance with applicable laws, regulations, and professional standards.
• IAM and HNS reserve the right to terminate the provider-patient relationship for noncompliance, repeated missed appointments, abusive behavior, nonpayment, medication misuse, or other circumstances consistent with applicable laws, regulations, and professional standards.

Acknowledgment

I certify that I have read, understand, and agree to comply with these policies and treatment requirements. I understand that failure to comply may affect my treatment, prescriptions, and continued care with the practice. The parent or legal guardian signing below represents that they have legal authority to consent to treatment and accept responsibility for compliance with practice policies and financial obligations.

Patient/Guardian Signature: _____ Date: _____

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

HIPAA AUTHORIZATION FORM

(PERMISSION FROM PATIENT/PATIENT'S LEGAL GUARDI AN 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: _____

Name: _____ Phone #: _____ Relationship: _____

Name: _____ Phone #: _____ Relationship: _____

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

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
☐	☐	☐	☐

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