

Suburban Psychiatric Associates, L.L.P.

Adult History & Personal Data Questionnaire

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____ Age: _____

Home Phone # _____ Work Phone # _____ Cell Phone # _____

Date of Birth: _____ SS#: _____ Gender: Male Female

Employer / School: _____

Marital Status (check one) Married____ Single____ Separated____ Divorced____ Widowed____

Emergency Contact: _____ Phone: _____

Relationship to Patient: _____

Primary Physician: _____

Address: _____ City: _____ Zip: _____

Referring Physician: _____

Address: _____ City: _____ Zip: _____

Therapist/Counselor: _____

Insurance Provider: _____

Main reason for seeking help at this time: _____

WE DO NOT ACCEPT WORKERS COMPENSATION OR NO FAULT CLAIMS

Suburban Psychiatric Associates, L.L.P.

OFFICE POLICIES

Please familiarize yourself with our office policies. If you have any questions please call during normal office hours which are Monday through Friday from 8:00 a.m. until 6:00 p.m. Our office is open on Saturday from 8:00 a.m. until 2:00 p.m. but the office phone is not on. Office visits are by appointment only and vary according to each practitioner's schedule.

CANCELLATION POLICY

Because the appointment time has been reserved for you, you will be charged for cancellations with less than 24-hours notice, or for a no show. A fee of \$100.00 will be charged for a new patient missed appointment, or appointment cancelled with less than 24 hours notice will be charged the full cost of the session. These charges are not covered by your insurance and are due and payable prior to any further appointments. In the event you must cancel and cannot reach the office personnel, please leave a message on the office voice mail system. Our answering machine will date and time your call. You will also receive an automated call reminding you of your appointment and you may cancel your appointment using this automated system. No fee will be charged if your call is received within the above time frame. Due to the large volume of calls, when calling to schedule or cancel an appointment, your call may go to voicemail. Be assured all calls will be returned by the end of that business day or by the following morning. Therefore, please leave a day and evening phone number where you can be reached.

PATIENT RECORD FEES

There is a fee of \$10.00 for NYS disability forms, as well as for other disability forms that are 1 page or less. More complex forms will be charged up to \$25.00, depending on the length and time involved to complete the form.

Your records, if copied, will cost \$0.75 per copied page. Records requested by other physicians or health professionals rendering active treatment are free of charge.

Dictated reports by your clinician will incur a charge based on the amount of time spent on producing the document.

Court appearances are charged by the half day and will differ from clinician to clinician.

I have read and understood the above policies.

Patient name: _____

Signature: _____

Suburban Psychiatric Associates, L.L.P.

EMERGENCY CALLS

For calls that are an emergency during office hours, please ask to speak to the nursing staff. For emergency calls after business hours, please page your doctor. For calls in which you have questions for the doctor that is non-emergent please ask to speak to our nursing staff, who will take a message and notify the doctor of your call. Remember when the doctors are in session with a patient, they cannot be disturbed. Doctors will be told of your phone call in-between patients and calls will be returned either at the end of business day or in-between patients if time allows. If you call the doctor after office hours and your telephone **CallerID** does not accept "Private or Blocked Calls" the doctor may not be able to return your phone call. The doctor may be calling from home or from a cell phone and **WILL NOT** allow the number to be shown. Please **UNBLOCK** your **CallerID** prior to placing your call to the doctor.

PRESCRIPTION POLICY

All prescription refills must be called in a minimum of one week before your medication runs out. We will not accept prescription refills from walk-in patients. When calling for a prescription refill, or any questions relating to your prescription at ext. 216, your call will always go to voicemail. Please call for prescription refills Monday through Friday between 9:00 a.m. and 5:00 p.m. on our voice mail recording. If phone requests are obtained after 2:00 p.m., your prescription will be handled the next business day. Please talk slowly and clearly and provide the following information:

1. Patient's first and last name with spelling.
2. Medication being requested.
3. Phone number where you can be reached for problems.
4. Pharmacy name and phone number. **TRIPPLICATE PRESCRIPTIONS CANNOT BE CALLED IN AND MUST BE PICKED UP OR MAILED**
5. Whether you want us to call in the prescription, if you will be picking it up or if you want it mailed to you.
 - ❖ **There will be a nominal postage and handling charge added to your account for all mailed prescriptions.**
 - ❖ **We do not call back unless there is a problem.**

If you have been given a triplicate prescription it is regulated by our state government. Please be aware that these prescriptions must be filled within one month. No refills are allowed. Take all medications as prescribed. As with all medications, these have been prescribed for you exclusively, based on knowledge of your personal needs and medical background. Sharing these medications is both medically contraindicated and illegal. Your cooperation is appreciated.

INSURANCE POLICY

**CO-PAYS ARE TO BE PAID AT THE TIME OF YOUR APPOINTMENT,
PER YOUR INSURANCE CONTRACT.**

Co-pays for mental health coverage do vary from one carrier to another, review the back of your insurance card. If you have any questions regarding your co-pays or authorizations, call your insurance carrier.

CONSENT FOR USE / DISCLOSURE OF HEALTH INFORMATION

Patient's Name: _____

Patient's Date of Birth: _____ Patient's SS #: _____

Notice to Patient:

By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment activities and health care operations. If there is not a copy of the Notice accompanying this Consent form, please ask for one. We encourage you to read it since it provides details on how information about you may be used and/or disclosed and describes certain rights you have regarding your health care information.

As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. If we should do so, we will issue a revised Notice. Since revisions may apply to your health care information, you have a right to receive a copy by contacting our Privacy Officer.

You have the right to revoke your Consent by giving written notice to our Privacy Officer. The revocation will not affect actions that were already taken in reliance upon this Consent. You should also understand that if you revoke this Consent we may decline to treat you.

You are entitled to a copy of this Consent Form after you have signed it.

(To Be Completed by Patient or Patient's Representative)

I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations, as described in the notice of privacy practices.

Patient's Signature or Signature of Patient's Representative

Date

Printed Name of Patient's Representative

Relationship to Patient

Our Privacy Officer can be contacted as follows:

Name of Privacy Officer: Lisa M. Peinkofer

Practice Address: 85 Bryant Woods Amherst, New York 14228

Phone: 716.689.3333 • Fax: 716.689.9695 • E-Mail: LisaP@suburbanpsych.org

Suburban Psychiatric Associates, L.L.P.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES For Suburban Psychiatric Associates, LLP

Notice to Patient:

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of the Notice. You may refuse to sign this acknowledgement, if you wish.

I acknowledge that I have received a copy of this office's Notice of Privacy Practices.

Please print your name here

Signature

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written acknowledgment of receipt of our Notice of Privacy Practices from this patient but it could not be obtained because:

- The patient refused to sign.*
- Due to an emergency situation it was not possible to obtain an acknowledgement.*
- We weren't able to communicate with the patient.*
- Other (Please provide specific details)*

Employee Signature

Date

This form does not constitute legal advice and covers only federal, not state law.

1. Over the last two weeks how often have you been bothered by any of the following problems. Read each item carefully, then place an “X” in the appropriate box.

		Not at all	Several days	More than 1/2 the days	Nearly everyday
		0	1	2	3
A.	Little interest or pleasure in doing things				
B.	Feeling down, depressed, or hopeless				
C.	Trouble falling asleep, staying asleep or sleeping too much				
D.	Feeling tired or having little energy				
E.	Poor appetite or overeating				
F.	Feeling bad about yourself, feeling that you are a failure, or feeling that you have let yourself or your family down				
G.	Trouble concentrating on things such as reading the newspaper or watching television				
H.	Moving or speaking so slowly that other people could have noticed, Or being so fidgety or restless that you have been moving a lot more than usual				
I.	Thinking that you would be better off dead or that you want to hurt yourself in some way				
Totals					

GAD-7

	Over the last two weeks, how often have you been bothered by any of the following problems. (circle the best answer)	Not at all	Several days	More than 1/2 the days	Nearly everyday
1.	Feeling nervous, anxious or on edge	0	1	2	3
2..	Not being able to stop or control worrying	0	1	2	3
3..	Worrying too much about different things	0	1	2	3
4..	Poor appetite or overeating	0	1	2	3
5.	Trouble relaxing	0	1	2	3
6..	Being so Restless that it is hard to sit still	0	1	2	3
7..	Feeling afraid as if something might happen	0	1	2	3

- a. Weight loss in the last month ____ lbs.: weight gain ____ lbs.
- b. Sex drive ____ decreased ____ increased
- c. Withdrawing from others ____ yes ____ no
- d. Decreased need for sleep ____ yes ____ no
- e. Periods of increased energy so others find you different ____ yes ____ no
- f. Recurrent / persistent ideas or thoughts that are unwanted ____ yes ____ no
- g. Having to repeat the same ritual or action when not necessary i.e. checking washing, etc ____ yes ____ no
- h. Have you ever tried to cut down on your drinking of alcohol ____ yes ____ no
- i. Have you ever been annoyed by others' complaints about your drinking ____ yes ____ no
- j. Have you ever felt guilty about your drinking ____ yes ____ no
- k. Have you ever taken an 'eye opener' drink ____ yes ____ no
- l. Have you ever heard voices, or seen things that others don't experience ____ yes ____ no
- m. Have you ever believed that others may want to harm you in some way ____ yes ____ no
- n. Have you ever had thoughts about harming someone else ____ yes ____ no

2. Previous Mental Health Treatment

Year	Problem	Therapist/Location	Hospitalization/Medical Treatment

3a. Medical Information

All Current Medications	Dosage	Schedule	Doctor

3b. Have you ever been diagnosed as having the following: (Please check all that apply to you)

- | | |
|---|--|
| <input type="checkbox"/> Heart trouble | <input type="checkbox"/> Vascular (circulation) disease |
| <input type="checkbox"/> Ulcers | <input type="checkbox"/> Thyroid disease |
| <input type="checkbox"/> Seizure disorder | <input type="checkbox"/> Allergies |
| <input type="checkbox"/> Head injury / L.O.C. | <input type="checkbox"/> High blood pressure |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Motor vehicle accidents |
| <input type="checkbox"/> Liver disease | <input type="checkbox"/> Special diets |
| <input type="checkbox"/> Asthma / Bronchitis | <input type="checkbox"/> Surgeries (years / procedures) |

Date of Last Physical ____/____/____

Explanation of Medical Problems _____

4. Sexual / Reproductive History

- a. Sexual dysfunction/difficulties (include fertility problems) _____

- b. History of pregnancy (please include miscarriages / abortions) _____

- c: Present birth control method _____
- d. Menstrual irregularities _____
- e. Date of last menstrual period _____
- f. Are you presently pregnant? _____

5. Substance Use/Abuse

Please indicate use, if applicable, and frequency of the following:

- a. Alcoholic beverages _____
- b. Street drugs (heroin, marijuana, diet pills) _____
- c. Tobacco _____
- d. Caffeine (coffee, tea, soda) _____

6. Background Information (please complete all that apply)

- a. Education (highest grade completed, general performance in school, plans for future education) _____

- b. Employment (current job, problems related to present job, frequency of job changes, future employment goals, any disability) _____

- c. Military Service (branch of service, disciplinary action, service connected disability) _____

- d. Legal problems (DWI's, past or present convictions, litigations, etc.) _____

7. Family Background - ages of parents and siblings (indicate if deceased) _____

- a. Please list any family members (parents, siblings, extended family) who have had any history of emotional or psychiatric illness, alcohol or substance abuse problems - include deceased members _____

- b. Please describe your current marriage or relationship (include length of relationship, occupation, marital problems, and drug, alcohol or emotional problems) _____

- c. Children (include names, ages, disabilities, school problems, alcohol, drug or behavior problems) _____

8. Additional Comments - (Please add any information that may help us better understand your problems as well as what you hope to gain from treatment) _____

9. Allergies: (Please Circle One) Yes No - If yes, please list allergies (including medications)

Suburban Psychiatric Associates, L.L.P.

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003 and will remain in effect until it is amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time by contacting our Privacy Officer, Lisa M. Peinkofer. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.

Abuse or Neglect: We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.

Public Health Responsibilities: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Appointment Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact the Medical Records Department for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be \$.75 for each page and the staff time charged will be \$10.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee. Please contact the Medical Records Department for a fee and/or for an explanation of our fee structure.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. (Example: If you request information on May 15, 2004, the disclosure period would start on April 14, 2003 up to May 15, 2004. Disclosures prior to April 14, 2003 do not have to be made available.)

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) Please contact our Privacy Officer if you want to further restrict access to your health care information. This request must be submitted in writing.

QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. Your complaint should be directed to our Privacy Officer. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us. In writing. Request a Complaint Form from our Privacy Officer. We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

Practice Name: Suburban Psychiatric Associates, LLP
Privacy Officer: Lisa M. Peinkofer, Practice Manager
Telephone: 716.689.3333 Fax: 716.689.9695
E-Mail: Lisap@suburbanpsych.org
Address: 85 Bryant Woods South Amherst, New York 14228

This form does not constitute legal advice and covers only federal, not state law.