TREATMENT AGREEMENT

At Alpha Psychiatric Associates, we are committed to providing the highest quality of treatment. Please read and sign our financial and care policy prior to your first appointment.

1. Payment is due at the time of service.
2. Our providers are credentialed with several insurance providers. Our website lists the credentials of our providers and the networks of insurance carriers that we participate in. If we are not contracted with your insurance carrier or if you are self-pay client, you are responsible for full payment at the time of service. You may ask us before the appointment for typical service charges, noting that the actual charge depends on the services provided during the visit. If you have deductibles, you are responsible for paying the contracted rate for your insurance carrier until you meet your deductible obligations with your carrier for the year. Copayments are to be paid during each visit. You are responsible to notify our office of all changes to your insurance. Outpatient Mental health visits, normally, do not need prior authorizations, however, we request you to be aware of your coverage limitations such as if you have mental health coverage, or for Out of State carriers if you are required to contact your insurance carrier before visiting specialists in North Carolina. You are responsible for payments regardless of the determination done by your insurance carrier.
3. Insurance will not pay for missed appointments. Unless cancelled at least 24 hours (business day) in advance, it is our policy to charge the office rate for the missed appointment. Reminder texts and/or emails are considered only a courtesy. You are ultimately responsible for keeping a record of the day and time of your appointment.
4. Please note that we are unable to accept text messages to cancel an appointment. Please call or email. During the inclement weather, please check if our office is open, we expect you to call to notify us if you can't drive.

I, _____have reviewed the Policies and Procedures of Alpha Psychiatric Associates PLLC and understand and agree to these policies. I understand that payment for all professional services rendered is the responsibility of the patient or the guarantor.

I also have reviewed the Notice of Privacy Practices for Alpha Psychiatric Associates. I understand that as part of my health care, Alpha Psychiatric Associates maintains paper and/or electronic records that contain Protected Health Information I understand that Alpha Psychiatric Associates maintains a Notice of Privacy Practices that provides a complete description of Protected Health Information uses and disclosures. The most recent version of this Notice is displayed in the waiting room area and is available on the practice's website.

I understand that after treatment begins, I have the right to withdraw my consent to treatment at any time and for any reason. However, I will make every effort to discuss my concerns about my progress with my provider before ending treatment with them.

I understand that no specific promises have been made to me by my provider or anyone at Alpha Psychiatric Associates about the results of treatment, the effectiveness of the procedures, medications that will be prescribed, or the number of sessions necessary for treatment to be effective.

Providers may terminate their care agreement for non-complinace by patient such as not keeping up with follow-up appointments, not taking medications and defaulting on payment obligations.

I authorize Alpha Psychiatric Associates to submit claims to insurance carriers and Medicare on my behalf and assign reimbursed benefits to be paid directly to Alpha Psychiatric Associates. I am responsible for any non-covered services, supplies, co-payments and deductibles. The acceptance and assignment will be in force for all future services by all practitioners from Alpha Psychiatric Associates.

_____ _____

Signature of the patient/Guardian Date

Printed Name/Relationship of the Guardian: _____

Alpha Psychiatric Associates
North Carolina

NEW CLIENT HEALTH HISTORY

Demography

Name: _____

Address: _____

_____

Phone Mobile: Home: Work:

Email:

Date of Birth: SSN:

Gender: Marital Status: Race:

Employment Status: Employer:

Referred by:

Health History

Primary Care: _____ Office/Name Location: _____

Reason for appointment: _____

Preexisting conditions

Have you had any of the following conditions? Yes/No

	Seizures, Epilepsy			HIV			High Cholesterol
	Head Trauma, loss of consciousness			Hepatitis B or Hepatitis C			Diabetes, Pre-Diabetes
	Acid Reflux			Vitamin D deficiency			High Blood Pressure
	Irritable Bowel Syndrome			Vitamin B12 deficiency			Low Thyroid, High Thyroid
	Migraine Headaches			Sleeping problems			Stroke of TIA (mini stroke)
	Chronic Sinusitis			Heart Disease			Chronic Pain
	Cancer			Kidney Disease			Pituitary Tumor
	Eating disorders			Sleep disorders			

Other: If any _____

_____

Current Medications

Name	Strength	Frequency:	Reason

Medication you are allergic to

Name	Reaction/Severity

Surgical History

Surgery	Date	Reason

Past Psychiatric Treatment

Hospitalizations

Suicide attempts

Self Harm

Other Info

Substance Use History

Substance	How much	Are you or your family concerned?
Alcohol		
Caffeine		
Nicotine		
Street Drugs		
Others		

Social Information

Area of concern	Problems	Was it addressed in the past?
Development (pre-birth to childhood)		
Education History		
Work History		
Interpersonal issues (verbal, physical)		
Legal (DUI, Other criminal)		

Family History

Relationship	Mental Health concerns	Was it addressed by mental health professional in the past?
Spouse		
Children		
Siblings		
Parents		
Others (if relevant)		

Life Style

Hobbies	
Exercise	
Pets	
Living with family/friends	
Other if relevant	

I understand that providing accurate and complete health history information is required for a proper diagnosis and an effective care plan.

Signature: _____ Date: _____

Alpha Psychiatric Associates
North Carolina

Review of Systems

Name: _____ **Date of Birth:** _____ **Date:** _____

General:	O Weight loss O Weight gain O Fever chills O Fatigue O Sweats O Sleep issues
Use	O Smoking __ packs / day O Caffeine __ cups / day O Drinks __ Per Week
Skin:	O Rash O Pigmented moles O Frequent Sunburns O Skin Cancer
Head:	O Headache O Dizziness O Seizures O Fainting O Stroke O Head injury O Memory loss
Eyes:	O Double vision O Blurry vision O Red eyes O Eye allergies O Drainage from eyes
Ears:	O Hearing issues O Ear infection O Ringing O Vertigo O Stopped up O Hearing aids
Nose:	O Hay fever O Nose bleeds O Allergies O Sinus problems O Loss of smell O Runny nose
Mouth:	O Dental cavities O Dentures O Bleeding gums O Tooth pain O Canker sores
Throat:	O Difficulty swallowing O Frequent sore throat O Speech problems
Neck:	O Swollen lymph nodes O Thyroid prob O Lumps O Goiter O Neck pain O Neck injury
Breasts:	O Lumps O Pain O Discharge O Skin changes (texture/color/other)
Lungs:	O Asthma O Shortness of breath O Cough O Wheezing O Tuberculosis O Pneumonia
Heart:	O Chest pain O Murmurs O Palpitations O Heart disease O Irregular pulse O Angina
Digestion:	O Poor appetite O Nausea, vomiting O Heartburn O Abdominal pain O Constipation O Diarrhea
	O Abnormal bowel movements O Blood in stool O Liver or gallbladder problems
Urinary:	O Frequent or painful urination O Blood in urine O Urinary accidents
Genital:	O Infection O Warts O Herpes O Impotence O Rapid ejaculation
	O Vaginal Dryness O Loss if interest in sex O Penile or vaginal discharge
Hands & Arms:	O Pain in arms O Pain in hands or fingers O Wrist pain O Numbness O Weakness
Legs & Feet:	O Pain in legs O Knee pain O Hip pain O Foot pain O Tingling O Numbness O Weakness
Back & Spine:	O Low back pain O Mid back pain O Upper back pain O Back injury
Hormones:	O Thyroid disease O Unable to tolerate hot, cold O Frequent urination O Increased Thirst
Blood:	O Anemia O Easy Bruising

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Name: _____ **Date of Birth:** _____ **Date:** _____

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	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 figety 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	0	1	2	3
	Add columns			
*(Healthcare professional: For interpretation of **TOTAL**, please refer to accompanying scoring card)*		**TOTAL:**		

10. 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 _____

Mood Disorder Questionnaire

Name: _____ **Date of Birth:** _____ **Date:** _____

Please answer to the best of your ability:

1. Has there ever been a period of time when you were not your usual self and…	***YES***	***NO***
… you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
… you were so irritable that you shouted at people or started fights or arguments?	☐	☐
… you felt much more self-confident than usual?	☐	☐
… you got much less sleep than usual and found that you didn't really miss it?	☐	☐
… you were more talkative or spoke much faster than usual?	☐	☐
… thoughts raced through your head or you couldn't slow your mind down?	☐	☐
… you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
… you had more energy than usual?	☐	☐
… you were much more active or did many more things than usual?	☐	☐
… you were much more social or outgoing than usual, for example, you telephoned friends in the Middle of the night?	☐	☐
… you were much more interested in sex than usual?	☐	☐
… you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
… spending money got you or your family in trouble?	☐	☐
2. If you checked YES for more than one of the above, have several of these ever happened During the same period of time?	☐	☐

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems ☐ Minor problem ☐ Moderate problem ☐ Serious problem

Two questions about yourself:

1. During the past month, have you often been bothered by feeling down, depressed or hopeless?	☐	☐
2. During the past month, have you often been bothered by little interest or pleasure in doing things?	☐	☐

Generalized Anxiety Disorder 7-item (GAD-7) scale

Name: _____ **Date of Birth:** _____ **Date:** _____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
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. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med*. 2006;166:1092-1097.

Alpha Psychiatric Associates
North Carolina

Adult ADHD Self-Report Scale (ASRS-vI.I) Symptom Checklist

Name: _____**Date of Birth:** _____**Date:** _____

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box hat best describes how you have felt and conducted yourself over the past 6 months. Please give the completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things done in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
PART A					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing a boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to your directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					
PART B					