|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Name | | Date of Birth: | | **Gender (circle): M  F** | | Marital Status: **MARK** **ONE**  Single Married Widowed Divorce | |
| Address: | | | | | | State: | Zip Code |
| Phone Number | Email: | | **Claim Number:** | | In Case of an Emergency Who should we Contact?  **Husband Wife Friend  Other**  Name: Ph#: | | |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Date of Injury** | | **Nature of Injury / Incident:** | | **Employer Name:** |
| **Employee Status:**  **Active  Medical Leave Terminated Other** | | | | **Employer Address:** |
| **Workers Compensation Insurance Carrier** | | | **Telephone Number:** | **Adjuster’s Name:**  **Phone Number:** |
|  | **Claimant’s Attorney, Adjuster and Case Manager Information** | | | |
| |  | | --- | | **Attorney’s Name:** | | **Phone#:** | | **Law Firm Address:** | | **Nurse Case Manager Name: Phone#:** | | **Employer/Carrier Attorney’s Name:** | | **Phone#:** | | | | | | |

|  |  |  |  |
| --- | --- | --- | --- |
| **Primary Care Physician** | **Phone Number:** | **Fax Number:** | |
| **Do you currently see a Mental Health Therapist or**  **Psychologist? Yes No** | | **Name:** | **Telephone Number:** |

**CLINICAL INFORMATION**

I hereby declare all above information is true to the best of my knowledge. I also have read MindHope office Polices on their website and/or a copy available on the waiting room area and I agree to the terms established. I authorize my Worker’s Compensation Insurance Carrier and/or my Attorney to make direct payment to MindHope of Oviedo for the service(s) that will be provided to me. If I settle my case, and continue to attend my scheduled follow-up appointments after my settlement I agree to be financially Responsible to pay MindHope for the visits. I understand that failure to fulfill the financial obligation as I have agreed may have Legal implications.

**Patient or Guarantor Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES**

**HON HOW WE USE AND DISCLOSE YOUR HEALTH INFORMATION**

Our **Notice of Privacy Practices** explains in detail your rights and how we can use and share

your information. A copy of this information is available for your review at the reception desk.

By signing this form, you are acknowledging that we have made this information available to

you and you agree to the terms and conditions therein.

When we examine, diagnose, treat, or refer you, we will be collecting what the law calls

Protected Health Information (PHI) about you. We use this information to decide on what

treatment is best for you and to provide that treatment. There are circumstances when we

may also share this information with others who provide treatment to you or need it to arrange

payment for your treatment or for other business or government functions.

If you do not sign this consent form agreeing to the terms of our Notice of Privacy Practices, **WE**

**CANNOT TREAT YOU**. If you are concerned about some of your information, you have the right

to ask us not to use it for treatment, payment or administrative purposes. You will have to tell

us specifically what you want in writing. Although we will try to respect your wishes, we are

not required to agree to these limitations. However, if we do agree, we promise to comply with

your wish to the extent that the law requires.

Patients Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRINT NAME**

I acknowledge that **MINDHOPE OF OVIEDO** has made a copy of their Notice of Privacy Practices

available to me effective: Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature (patient or authorized representative): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship/Authority (if signed by authorized representative): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**TREATMENT AND COMMUNICATION CONSENT FORM**

I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, do hereby voluntarily consent to **care** and **treatment** by **MindHope of Oviedo**. I acknowledge that no guarantees have been made as to the result of evaluation or treatment. I also understand that some medication might cause adverse reactions or side effects. My provider will not be liable for any such untoward short or long-term effects (adverse effects/ Side effects etc). I am aware that I am an active participant in the treatment/counseling process and that I share responsibility for my treatment. I hereby authorize the Providers (physicians/therapists/nurses assigned), to provide psychiatric/psychological care which includes Psychotropics (Medications: oral/injections etc). It is my sole responsibility to maintain compliance or to take the necessary steps to remain complaint. I understand this treatment contract can be terminated any time from either party for any reason. **I understand that my initial Psychiatric Evaluation visit does not guarantee the continuation of care at MindHope of Oviedo. *If is determine that I continue treatment I Agree to comply with the doctor’s treatment plan.***

**COMMUNICATION**I also understand that **MindHope** staff is not obligated to receive or return any phone call after hours. In the event of an emergency, It is imperative that I or someone next to me call **911** immediately**.** I authorized **MindHope of Oviedo** Psychiatric team to call my cell or home phone number to leave messages of appointment reminders or any other messages that do not include any personal information. For messages that need to disclose personal information I authorize MindHope Team to communicate with me via phone or email in regards to my care. In case of a Guardian or Caregiver, we need related supportive documents.

***By Signing this document, I agree to consent Treatment and ways of Communication.***

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

Patient/ Guardian **Print Name**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:**

Patient/Guardian **Signature**

**CONSENT FOR ELECTRONIC PRESCRIBING**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

MindHope of Oviedo is enrolled in an electronic prescribing program. This program is meant to help our providers with understanding what medications our patients are currently using and to give them the best possible treatment.

***By signing this form***, you consent to MindHope of Oviedo retrieving electronic prescribing information. This consent will only be valid for one year. A new consent will be required every year. I agree that MindHope of Oviedo may request and use my prescribing medication history from other healthcare providers.

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

Print name of patient (or authorized representative)

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:**

Signature of patient (or authorized representative)

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date**:

**Witness**

Reason patient is unable to sign and representative's relationship to patient or authority to sign on behalf of patient:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Benefits of Electronic Prescribing E-Prescribing eliminates handwriting errors/illegibility and gives both physicians and pharmacists access to a patient’s prescription history to reduce the chance of the wrong drug being dispensed.**

|  |  |  |
| --- | --- | --- |
| **PATIENT HEALTH QUESTIONNAIRE**  **All questions contained in this form(s) are strictly confidential** | | |
| |  |  |  |  |  | | --- | --- | --- | --- | --- | | **Patient Name** | **Date of Birth** | **Claim Number** | **Date of Accident** | **Adjuster’s Name** | |  |  |  |  |  |   **and will become part of your medical record.** | | |
| **Health HISTORY/Mental health history** | | |
| **List any medical problems that other doctors have diagnosed:** | | |
| **1.** | | |
| **2.** | | |
| **3.** | | |
| **4.** | | |
| **Do you have any pain in your body? YES NO rate your pain 10 been extremely painful: 1 2 3 4 5 6 7 8 9 10** | | |
| **Is this pain interfering with your work and/or personal life? YES NO** | | |
| **Have you ever had a blood transfusion? Yes No When:** | | |
| **Surgeries:** | | |
| Year | Reason | Hospital |
|  |  |  |
|  |  |  |
| **Other hospitalizations** | | |
| Year: | Reason: | Hospital: |

|  |  |  |
| --- | --- | --- |
| **List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers** | | |
| Medication Name | Strength | Frequency Taken |
|  |  |  |
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|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **Allergies to medications** | | |
| Name the Medication | Reaction You Had | |
|  |  | |
|  |  | |
|  |  | |
|  |  | |

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| --- | --- | --- |
|  |  | **HISTORY OF MENTAL HEALTH PROBLEMS** |

|  |  |  |
| --- | --- | --- |
| Is stress a major problem for you? | Yes | No |
| What stresses you the most? |  |  |
| Do you feel depressed? YES NO How long have you been feeling depressed?Click or tap here to enter text. |  |  |
| Do you panic when stressed? | Yes | No |
| Do you dislike yourself? | Yes | No |
| If you feel angry, do you tend to keep quiet about it initially, but later erupt and really lose your temper? | Yes | No |
| Have you experienced repeated or unexpected “attack” during which you suddenly are overcome by fear for no apparent reason | Yes | No |
| Do you have upsetting or distressing thoughts, impulses, or images that happen in your mind over and over again? | Yes | No |
| Has there ever been a period of time when 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? | Yes | No |
| Do you cry frequently? | Yes | No |
| Have you ever attempted suicide? **YES NO** How long agoClick or tap here to enter text.  Was this your first time **YES NO** If No how many other times have you attempted suicide?Click or tap here to enter text. What made you change your mind?Click or tap here to enter text. |  |  |
| Have you ever seriously thought about hurting yourself? YES NO Please explain:Click or tap here to enter text.  Have you ever thought of hurting someone else?  Any mental health hospitalization or Rehabilitation in the last 2 years? Yes No How long ago?Click or tap here to enter text. | Yes | No |
| Do you have trouble sleeping? | Yes | No |
| Have you ever been treated at a methadone clinic or receive Suboxone treatment in the last two years? | Yes | No |
| Have you ever been to a counselor? **YES  NO** How long ago?Click or tap here to enter text. |  |  |
| Have you ever seen a psychiatrist before?  **YES NO** How Long?Click or tap here to enter text. |  |  |

**PLEASE CHECK ALL THAT APPLIES TO YOU**

**Depressed  Sadness Crying Spells Loss of Interest Anxiety Panic Attack**

**Irritability Rages Fearfulness Feelings of hopelessness Insomnia**

**Feelings of helplessness Hypersomnia Fatigue Forgetfulness**

**Poor concentration Headaches Weight loss No appetite**

**Increased appetite  Bingeing Thoughts of Suicide**

|  |
| --- |
| When was the last time you saw your Psychiatrist?Click or tap here to enter text. |

**PRINT COMPLETED FORM, SIGN IT AND BRING IT TO YOUR APPOINTMENT**

**Patients Name:** Click or tap here to enter text.

**PATIENT FAMILY/FRIEND AUTHORIZATION FORM**

**Patient Name: DOB:**

The purpose of this form is to give **MindHope of Oviedo** authorization to speak to a family member or a friend that may call on your behalf to request information regarding your medical history (mental health related ONLY) or to confirm or cancel an appointment. Please understand that for your security and for you own protection we have established a strict policy regarding family members or friends that will call on your behalf. Please be advise that when you sign this form you are authorizing us to **ONLY** provide information to those individuals that you have listed below. If any other person calls on your behalf and is NOT listed below, **WE WILL NOT PROVIDE THEM WITH ANY INFORMATION.** If after you signed this form, you realized that you want to add another person to this list you need to personally come by the office to add this person to the existing form. We will NOT take any phone calls with instructions regarding this matter.

**Print Name Phone Number Relation to Patient**

|  |  |  |
| --- | --- | --- |
|  |  |  |
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|  |  |  |

***Note: This authorization form is Only to be used related to family and/or friends requests. You will be completing a different Authorization form to Authorized Medical Offices or any other official requests of your records.***

**Patient’s Signature: Date:**

|  |
| --- |
| **PHARMACY PREFERENCE**  **MindHope is a Certified Medication Dispensing Facility.** Dr.Figueroa is a ***Certified Dispensing Physician*** that can dispense medications at this location. For your convenience we can dispense your medications here, ***however the prescription may be filled at any pharmacy of your choice and/or authorized by Workers Compensation.***  **If you have a pharmacy of preference**, MindHope will be send your medication prescriptions to the Pharmacy of your choice or the pharmacy on the back of the card you may have. This will be electronically sent via the e-prescribing method.  **You understand that it is your responsibility** to notify MindHope team immediately if you change pharmacy preference or if they send you a new card with new pharmacy information. A new pharmacy preference form will need to be completed and signed so that MindHope Team can update your records.  **You also understand that failure to notify MindHope Team** of any change of Pharmacy may result in a **delay** in obtaining your medications.  Name of Preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Fax Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Patient Signature:** I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ have read and understand the options regarding pharmacy preference. |

**PHQ-9 DEPRESSION ASSESSMENT FORM**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Mark with an “X” to indicate your answer**  1. Little interest or pleasure in doing things | Not at all | Several days | More than half the days | Nearly every day |
| 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 | 0 | 1 | 2 | 3 |
| **After you have added each individual column then add the total of the three columns and write that total number in the TOTAL SCORE SECTION** |  |  |  |  |

**Patient Name: Date**

|  |  |  |  |
| --- | --- | --- | --- |
|  |  | + |  |

**= 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**

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