Collaborative Minds

ADULT PACKET

IMPORTANT PLEASE READ CAREFULLY AS THIS APPLIES TO YOUR 1ST APPOINTMENT WHICH IS THE INITIAL EVALUATION.

Disclaimer:

Due to Collaborative Minds being a private practice, we can determine future patient establishment prior to or following your Initial Evaluation. If, medical staff determines that your case is one that falls outside our level of expertise, or you require more specialized care you will be given information for referral sources that can further help. An initial evaluation will be done gathering information pertaining to your visit and determining how to further pursue and treat your case meaning an initial evaluation does not guarantee future treatment at Collaborative Minds.

Thank you for your understanding,

- Collaborative Minds Staff

Please read, acknowledge & sign:

We do not under any circumstances get involved with any court case/ work related issues. We will not appear in court for any reason. We will not complete any paperwork for clearance to work or leave such as FMLA. We also do not provide clearance for concealed carry license.

Date: _____ Signature: _____

*****THERE IS A $100 DEPOSIT THAT IS REQUIRED BEFORE SCHEDULING ALL NEW PATIENT APPOINTMENTS FOR ALL COMMERCIAL OR SELF PAY PATIENTS** >> _____ << PLEASE INITIAL ACKNOWLEDGING THE DEPOSIT.***

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New Patient Paperwork Please Print

Office use only: Depression Score: _____ Anxiety Score: _____ ADD/ADHD Score: _____

Date: _____ Primary Care Physician: _____

PATIENT INFORMATION (All information below is required, please complete or your paperwork will be denied.)
First Name: _____ M. I: _____ Last Name: _____
Date of Birth: _____/_____/_____ Age: _____ SSN:____-_____-_____ Sex: M / F Gender identity: _____ marital status:_____
Street Address: _____
City: _____ State: _____ Zip Code: _____
Home # _____ Cell # _____ Work # _____
Emergency Contact: _____
Do we have permission to leave a voicemail? _____ Primary Language: _____
Referred by whom/where: _____ Race/Ethnicity: _____
Do you have any relatives seen here? _____

INSURANCE INFORMATION: (Please include PREFIXS and for ALL Medicaid Patients we need your Bayou Health Plan ID number. PLEASE DO NOT GIVE US YOUR MEDICAID NUMBER THAT STARTS WITH 777)
Insurance Provider: _____ Member ID: _____
Subscriber Name: _____ DOB: _____ SSN: _____-_____-_____
Contact Number: _____ Address: _____

Acknowledgement of Release of Information for Insurance purposes: _____ - INITIAL

Insurance Policy: Please READ BELOW this is very important concerning your insurance:

- Patients with insurance: If our office is contracted with your insurance company, we will file your insurance claim if you provide us with the PROPER information along with a copy of your current insurance card. If your insurance DOES NOT pay within 90 days, you are responsible for the remaining balance and you will be billed accordingly, this includes your insurance being denied for Coordination of Benefits, pre-existing etc. it is your responsibility to know and understand your benefits.

- ALL COPAYMENTS, DEDUCTIBLES OR COINSURANCE PAYMENTS ARE DUE AT THE TIME OF SERVICE. WE DO NOT BILL PATIENTS. We accept all forms of payment except for personal checks. If payment cannot be made at the time of service your appointment will be cancelled and you will have to reschedule.

PATIENTS WITH NO INSURANCE:

All patients without insurance benefits or mental health coverage are also required to pay in full for the services rendered before being seen by the clinician. Please call our office for new patient appointment prices.

TESTING ACCOMODATIONS / COMMERCIAL AND SELF PAY PATIENTS:

We offer testing for ADHD/ADD through the Conner's CPT3 test which is performed in office. We do not accept insurance for the test. If you are interested, please ask the front staff for more information.

ASSIGNMENT OF BENEFTS/CONSENT TO TREAT/COORDINATION OF CARE:

I, _____ consent to treatment at Collaborative Minds. I have the right to refuse treatment and medication, neither can be given unless agreed upon by my doctor. Listed separately are the following discussed; diagnoses, reason my doctor wants me to take the medication, other options to treat problems, the medication that was prescribed and any side effects it may cause. I will talk with my doctor about all medical problems and any medication I am taking. Medication will by documented in EHR. If I refuse medication treatment or general treatment it will be documented accordingly.
If patient is a minor, please print patients name: _____

MANIPULATION MEDICATION WITHOUT CONSENT FROM THE TRAINING PROVIDER WILL RESULT IN IMMEDIATE TERMINATION.

Acknowledge that you agree to the terms stated above: _____ - INITIAL

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES:
I hereby acknowledge that I have received a copy of Collaborative Minds Notice of Privacy Practices: Signature: _____Date:_____

DRUG SCREEN:
All patients are required to perform drug screens. Random screening will also be performed without notice. If you refuse to comply with our policy, you will not be seen at our office. Please initial acknowledging the policy. _____ - INITIAL

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ADULT PACKET

DISCLOSURE INFORMATION:

I, _____ AUTHORIZE Collaborative Minds to discuss my case including medical diagnoses, appointments, medication, medical history, coordination of care and progress note documentations from my visits with ONLY THE FOLLOWING PEOPLE. IF YOU WISH TO NOT HAVE INFORMATION RELEASED TO ANYONE LEAVE BLANK.

Name: _____ Relation:_____ Phone: _____
Name: _____ Relation:_____ Phone: _____
School, Work, Office:_____
Healthcare Provider, Therapist, PCP etc.: _____

If there should be any additions to this list, patient will need to sign additional authorization form. I authorize Collaborative Minds to collaborate with my insurance if they are to request information regarding my Coordination of Care. This may include a review of records for quality of treatment.

PATIENT NO SHOW POLICY:

ALL PATIENTS ARE REQUIRED TO CANCEL THEIR APPOINTMENTS 24 HOURS IN ADVANCE NO EXCEPTIONS. Appointments not cancelled in 24 HOURS in advanced or will be charged the $50.00 fee, 100.00 for New pt visits visits. THIS WILL BE CHARGED TO THE CARD THAT YOU ARE REQUIRED TO HAVE ON FILE. If payment is not received, you will be responsible for this payment before you can reschedule. Patients with excessive missed appointments will be given a warning, followed by termination from care for the next missed appointment. Medicaid patients are only allowed 3 missed appointments per calendar year before being discharged from the clinic. It is your responsibility to remember your appointment.

AUTOMATIC REMINDER CALLS/TEXTS ARE DONE 3 DAYS PRIOR TO YOUR APPOINTMENT.

Signature of Acknowledgement of our No-Show Policy: _____

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Credit Card/ Debit Card Information – THIS IS NOT AN OPTION CARD HOLDER ONLY. We will not accept a debit/credit card unless your name is printed on the card.
Your credit card will need to be updated when it expires. Failure to update card information in a timely manner may have interfere with your ability to make future appointments until updated information is received. I, the undersigned, understand that this form will be valid for the duration of my treatment with Collaborative Minds.
SIGNATURE:_____ Date:_____

This card will only be used for new patient deposit, missed appointments and if you forget your card at the time of your scheduled appointment. If you are not the card holder then we will need the card holder's signature, phone number and a copy of their driver's license.

Please circle	VISA	MASTERCARD	AMERICAN EXPRESS

Patient Name:
Card Holder Name:
Card Number:
CCV: / Expiration Date:
Signature of Card Holder:

Please tell us a little about yourself.

1. What are you wanting to be treated for? (Pertaining to your Mental Health)
_____
_____
2. Please document your current medication with dosages below, medical and psychiatric.
_____
_____
3. Please List ALL medical problems such as heart condition, high blood pressure etc.:
_____
_____
4. Any medication allergies? _____
5. Do you smoke?_____ If so how much?_____ Any drug and/or alcohol_____ if yes please explain:_____
6. Have you ever received Inpatient or Outpatient Mental Health treatment before? If yes, please explain:
_____
_____
7. Do any of your relatives suffer from mental health illness? Please explain if yes: _____
_____
8. Have you ever been discharged from a doctor's care for missed appointments, noncompliance with medications or failure to pay fees? Please explain if yes. _____
_____

Consent to Treat

1. I _____ (patient name) give permission for **Collaborative Minds** to give me medical treatment.

2. I allow **Collaborative Minds** to file for insurance benefits to pay for the care I receive.

   I understand that:
   - **Collaborative Minds** will have to send my medical record information to my insurance company.
   - I must pay my share of the costs.
   - I must pay for the cost of these services if my insurance does not pay, or if I do not have insurance.

3. I understand:
   - I have the right to refuse any procedure or treatment.
   - I have the right to discuss all medical treatments with my clinician.

_____ _____

Patient's Signature Date

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ADULT PACKET

<<ADD/ADHD>>

Answer each question with a Y or N (circle Y for yes, N for No) for each of the following questions. A Yes response would indicate that the behavior, so symptom happens frequently or most of the time.

Y / N 1. Do you have nervous habits like nail biting or playing with small objects in your hands?

Y / N 2. Would you describe yourself as a "worrier"?

Y / N 3. Do you frequently forget or lose things; like car keys, glasses, etc.?

Y / N 4. Do you feel stressed or overwhelmed with having to remember too many things at once?

Y / N 5. Do you tend to pile papers in stacks; intermingling important with not so important items?

Y / N 6. Do you worry about your performance at work, school or home?

Y / N 7. Do you seem to miss or be late for appointments due to being distracted and/or not using Good time management?

Y / N 8. Do you read directions or use a "hands on" approach to putting something together?

Y / N 9. Are standardized multiple choice test difficult for you to take?

Y / N 10. If yes, do you seem to misread the questions, feel overly anxious or need more time than is Given for the test?

Y / N 11. Do you often seem distracted by your own thoughts; to a point that you have a hard time focusing on conversation with someone else?

Y / N 12. Is it hard for you to stick with a task from beginning to end?

Y / N 13. Does it seem that you never have enough time during the day to finish the things you need to finish?

Y / N 14. If so, do you think you underestimate the time you need to accomplish tasks?

Y / N 15. Do you ever experience such things as right-left confusion or difficulties estimating Distances?

Y / N 16. Do you have to read something more than once to completely understand it?

Y / N 17. Do you remember having trouble in school beginning at an early age? Did it seem to you That you had To Work harder than your classmates to get passing grades?

Y /N 18. Do you reverse numbers?

Y / N 19. Would you describe yourself as a procrastinator?

Becks Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.

0 I do not feel sad.
1 I feel sad
2 I am sad all the time and I can't snap out of it.
3 I am so sad and unhappy that I can't stand it.

2.

0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel the future is hopeless and that things cannot improve.

3.

0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 as I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4.

0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5.

0 I don't feel particularly guilty.
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all the time.

6.

0 I don't feel I am being punished
1 I feel I may be punished.
2 I expect to be punished.
3 I feel like I am being punished.

7.

0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8.

0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weakness or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9.

0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself
3 I would kill myself if I had the chance.

10.

0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 it takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.
1 I get tired more easily that I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 my appetite is no worse than usual.
1 my appetite is not as good as it used to be.
2 my appetite is much worse now.
3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard for me to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.

21.

0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero. This would mean you circled zero on each question. You can evaluate your depression according to the table below.

Total Score _____ Levels of Depression

1-10 _____ These ups and downs are considered normal
11-16 _____ Mild mood disturbance
17-20 _____ Borderline clinical depression
21-30 _____ Moderate depression
31-40 _____ Severe depression
Over 40 _____ Extreme depression

Hamilton Anxiety Rating Scale (HAM-A)

Below is a list of phrases that describe certain feelings that people have. Rate the patients by finding the answer which best describes the extent to which he/she has these conditions. Circle on of the five responses for each of the fourteen questions.

0 = Not Present 1 = Mild 2 = Moderate 3 = Severe 4 = Very Serious

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1. **Anxious Mood** **0 1 2 3 4**
Worries, anticipation of the worst, fearful anticipation, irritability.

2. **Tension** **0 1 2 3 4**
Feelings of tension, fatigability, startle response, moved to tears Easily, trembling, feelings or restlessness, inability to relax.

3. **Fears** **0 1 2 3 4**
Of dark, of strangers, of being left alone, of animals, of traffic of Crowds.

4. **Insomnia** **0 1 2 3 4**
Difficulty in falling asleep, broken sleep, unsatisfying sleep and Fatigue on waking, dreams, nightmares, night terrors.

5. **Intellectual** **0 1 2 3 4**
Difficulty in concentration, poor memory.

6. **Depressed Mood** **0 1 2 3 4**
Loss or interest, lack of pleasure in hobbies, depression, early Waking, diurnal swing.

7. **Somatic (muscular)** **0 1 2 3 4**
Pains and aches, twitching, stiffness, myoclonic jerks, grinding of Teeth, unsteady voice, increased muscular tone.

8. **Somatic (Sensory)** **0 1 2 3 4**
Tinnitus, blurring of vision, hot and cold flushes, Feelings of weakness, pricking sensation.

9. **Cardiovascular symptoms** **0 1 2 3 4**
Tachycardia, palpitations, pain in chest, throbbing Of vessels, fainting feelings, missing beat.

10. **Respiratory Symptoms** **0 1 2 3 4**
Pressure or constriction in chest, choking feelings Sighing, dyspnea.

11. **Gastrointestinal symptoms** **0 1 2 3 4**
Difficulty in swallowing, wind abdominal pain, Burning sensations, abdominal fullness, nausea, vomiting**,** borborygmi, looseness of bowels, loss of Weight, constipation.

12. **Genitourinary symptoms** **0 1 2 3 4**
frequency of micturition, urgency or micturition, Amenorrhea, menorrhagia, development of frigidity Premature ejaculation, loss of libido, impotence.

13. **Autonomic symptoms.** **0 1 2 3 4**
Dry mouth, flushing, pallor, tendency to sweat, Giddiness, tension headache, raising of hair.

14. **Behavior at interview** **0 1 2 3 4**
Fidgeting, restlessness or pacing, tremor of hands Furrowed brow, strained face, sighing or rapid Respiration, facial pallor, swallowing etc.

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ADULT PACKET

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. has there ever been a period of time when you were not your usual self and…		
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 you didn't really miss it?	____	____
You were much 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 much 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 into trouble?	____	____
2. if you checked YES to more than one 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?

Please circle one response only

No Problem **Minor Problem** **Moderate Problem** **Serious Problem**

4. Have any of your blood relatives (i.e. children, siblings, parents, grand parents Aunts, uncles) had manic-depressive illness or bipolar disorder?	____	____
5. Has a health professional ever told you that you have manic-depressive illness bipolar disorder?	____	___

No – Suicide Contract

I, _____, hereby agree that I will not harm myself in any way, attempt suicide, or die by suicide.

Furthermore, I agree that I will take the following actions if I am ever suicidal:

1. I will remind myself that I can never, under any circumstances, harm myself in any way, attempt suicide, or die by suicide.

2. I will call 911 if I believe that I am in immediate danger of harming myself.

3. I will call any or all of the following numbers if I am not in immediate danger of harming myself but have suicidal thoughts (please list names, phone numbers, addresses, and any other relevant contact information below):

1-800-SUICIDE (78242433)
24-hour suicide prevention line that can be called from anywhere in the U.S.

4. I will continue talking on the phone with as many people as necessary for as long as necessary until the suicidal thoughts have subsided.

Signature:_____ Date:_____

Witness:_____ Date:_____