PATIENT INFORMATION

Name:_____ Male ( ) Female ( ) Date of Birth: _____
SS#: _____ Marital Status: Married ( ) Single ( ) Other ( )

Address: _____
_____
_____

Phone #'s (Home): _____
(Cell): _____
(Work): _____

Email Address: _____
Referred by: _____

Preferred Pharmacy: _____
Primary Care Physician: _____

Employment Status: Employed ( ) Retired ( ) Other ( )

Employer Name & Phone #:
_____
_____

Emergency Contact(s) (Name & Phone #):
_____
_____
_____
_____
_____

Guarantor (Person responsible for payment):
Name: _____
Address: _____
_____
_____
Phone #: _____
SS#: _____ DOB: _____

I understand that I am officially responsible for all charges.

Signed: _____ Date: _____

INTAKE FORM FOR DR HINES

To minimize time spent on the following in the appointment, please fill this form out to the best of your ability:

NAME: _____ DATE OF BIRTH: _____ AGE: _____

RACE: _____ MARITAL STATUS: _____ EMPLOYMENT STATUS: _____

WHAT IS THE BEST WAY TO REACH YOU AND MAY WE LEAVE A MESSAGE: _____

MAY WE CALL YOU TO REMIND YOU OF YOUR APPOINTMENT? _____

Who referred you to Dr. Hines? _____
May we send him/her a copy of this evaluation?_____

What is the nature of your/their concerns? _____

_____

_____

_____

Are you on disability or currently seeking disability benefits? _____ If so, what condition are you on disability for?_____

Who is your primary care physician? _____
May I send him/her a copy of your evaluation? _____
Who is your current psychotherapist or counselor? _____
May I send him/her a copy of your evaluation? _____

PSYCHIATRIC HISTORY

Have you had any prior trials of psychiatric medications, including antidepressants, stimulants, or antipsychotics? _____ If so, please list:

NAME OF DRUG	DOSE	HOW LONG TAKEN	RESPONSE

Have you ever been hospitalized for psychiatric reasons? _____ If so, please list when, where and why you were hospitalized: _____

Do you have any history of suicide attempts? ____ If so, what was the means of your attempt _____

Do you have any history of violence? _____ If yes, please describe: _____

Any legal charges pending? _____
Do you have access to guns? _____

SUBSTANCE ABUSE HISTORY

Have you received treatment for drug or alcohol treatment? _____ If so, please when and where you received treatment: _____

Do you currently drink alcohol? _____
How many drinks do you have per day/week/month? _____
Do you currently use illegal drugs or prescribed drugs in a manner not approved? _____ If so, please list the substances: _____
Do you currently think you have an alcohol or drug problem? _____ If yes, why? _____

MEDICAL HISTORY

Please list your current medical problems (hypertension, diabetes, etc.):

(If more room is needed, please use the back of this form)

CURRENT MEDICATIONS	DOSAGE	INSTRUCTIONS FOR USE

Please list any herbal medications, vitamins or supplements used:

_____

_____

_____

Are you allergic to any medications and what happens if you take that medicine, i.e. codeine = hives:

_____

_____

FAMILY MEDICAL HISTORY

What illnesses run in your family and what is their relationship to you (example: maternal grandfather – colon cancer)?

_____

_____

_____

_____

What psychiatric illnesses run in your family (addiction, bipolar disorder, depression, etc.) and how are they related to you?

_____

_____

_____

Has anyone in your family (including extended family) committed suicide? _____
Has anyone in your family responded well to a specific psychiatric medication? _____ If so, which one? _____

SOCIAL HISTORY

Who is your employer? _____
How long have you worked there? _____
What is your profession? _____

Have you ever been married? _____ If so, how many times? _____
How long has your current marriage lasted? _____

Do you have children? _____ If so, how many and what are their ages: _____

_____

Do they live with you? _____

If you are currently in an exclusive relationship that is not marriage, please list this and how long you've been involved: _____

_____

What is your highest level of education? _____
Where did, or do you attend school? _____
What is or was your major, if applicable? _____

Where did you grow up? _____
Parents still married or remarried? _____

How would you describe your childhood?

_____
_____
_____
_____

Do you consider yourself heterosexual, homosexual, or bisexual? (You may answer this in session, if you prefer.) _____

What activities do you enjoy doing?

_____
_____
_____

Do you exercise fairly regularly? _____

REVIEW OF SYSTEMS

Is there anything bothering you physically today? _____ If so, please list:

_____
_____
_____
_____
_____
_____

What is your goal for treatment?

_____
_____
_____
_____
_____
_____

Five Points Psychiatry Rules, Regulations, and Suggestions

These are the policies that guide this office. We have found that things run most smoothly when patients and Five Points' staff and doctor abide by these simple rules:

1. Medication refills may take up to 48 hours to call in or be available for pick-up. Calling late on a Friday afternoon or a weekend and paging the doctor on call and expecting your medication to be filled right away can lead to disappointment. Please check your medication and call early. Also, do not expect a refill on your medication if you have not recently seen the doctor.

2. If you wish to cancel an appointment, please call no later than 24 hours before the scheduled appointment time. If we do not hear from you, you will be charged for the missed appointment. The fee will be $125.00. This includes no call, no shows and same day cancellations. Extenuating circumstances will be considered and are at the discretion of the doctor.

3. Medications that are controlled substances that are lost, stolen, or otherwise not in possession cannot be refilled less than 28 days after the last refill. Due to the fact that some may become addicted to certain medications prescribed by the doctor, unfortunately, this rule must be applied to all. If you call for an early refill for any controlled substance, it cannot be done.

4. Only page for the doctor in an emergency. This includes: thoughts of hurting self or others, concerns about a patient's ability to care for his or herself, and/or severe medication side effects, such as fever, stiff muscles, confusion, acting strangely, etc. All other calls should be reserved for normal business hours. Every effort will be made to return calls on the same business day; however, you call may have to be returned the next business day.

5. Due to the enormous amounts of paperwork requests Dr. Hines receives, he must charge for filling out paperwork. This includes requests for disability. The charge for this is $180 per hour. Requests for letters are numerous as well, and to keep these reasonable, they will be charged at $75 per letter. This is not for simple excuses for appointments, but such things as writing letters for withdrawal from school, letters for a patient's work, requests for special arrangements, etc. This charge is unfortunate but the paperwork burden makes it a necessity.

6. If you feel that you are not getting the care you deserve, please let the doctor know. We are here to help you and do not want to waste your time or money. Please let us know by talking to us directly, writing letters, or filling out a survey as to inform us of ways we can better serve you. We feel this is our mission in life and take it very seriously, and one of the ways we improve is to hear constructive criticism from you. Do not be intimidated.

7. There is always someone on call for emergencies. Just call the office phone number, it will roll over to the answering service. Dr. Hines will call back on weekdays, and the community psychiatrist covering will call back on weekends. Please see above rules on when to call.

Please sign here to let us know you understand these rules and that failure to abide by them can lead to dismissal from the practice. Thank you for choosing Five Points Psychiatry.

Steven Hines, M.D.

_____

I agree to the above Rules and Regulations

_____

I agree to the above Rules and Regulations

HIPAA NOTICE OF PRIVACY PRACTICES

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

PLEDGE REGARDING PROTECTED HEALTH INFORMATION:
Five Points Psychiatry, LLC (FPP) understands that protected health information about you and your mental health is personal. We are committed to protecting health information about you. This Notice applies to all of the records of your care generated by FPP, whether made by FPP, our personnel, or any related professional from whom we have received information.

This notice will tell you about the ways in which we may use and disclose protected health information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of protected health information. The law requires us to:

- **Make sure that protected health information that identifies you is kept private;**
- **Notify you about how we safeguard protected health information about you;**
- **Explain how, when and why we use and disclose protected health information;**
- **Follow the terms of the Notice that is currently in effect.**

We are required to follow the procedures in this Notice. We reserve the right to change the terms of this Notice and to make new notice provisions effective for all protected health information that we maintain by:

- **Posting the revised Notice in our office**
- **Making copies of the revised Notice available upon request**

HOW WE MAY USE AND DISCLOSE PROTECTED HEALTH INFORMATION ABOUT YOU:
The following categories describe different ways that FPP or an office assistant may use and disclose protected health information without your written authorization:

- **FOR TREATMENT. FPP and staff may use and disclose protected health information to contact you as a reminder that you have an appointment for treatment, or to call and reschedule an appointment, at the office of FPP. We may use and disclose protected health information to tell you about or recommend possible treatment options or alternatives or health-related benefits or services that may be of interest to you.**
- **FOR PAYMENT OF SERVICES. We may use and disclose protected health information about you so that the treatment and services you receive at the office of FPP may be billed to you and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your treatment information about services you received by FPP so your mental health plan will pay us or reimburse you for the service. We may also tell your health plan about the services you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.**
- **FOR HEALTHCARE OPERATIONS. We may use and disclose protected health information about you for FPP for business operations, such as filing, organizing and managing client information. These uses and disclosures are necessary to run this office and make sure that all of our patients receive quality care. Subject to applicable state law, in some limited situations the law allows or requires us to use or disclose your health information for purposes beyond treatment, payment, and operations. However, some of the disclosures set forth below may never occur at our facility.**
    - **As Required By Law: We will disclose protected health information about you when required to do so by federal, state or local law.**
    - **Health Risks: We may disclose protected health information about you to a government authority if we reasonably believe you are a victim of abuse, neglect or domestic violence. We will only disclose this type of information to the extend required by law, if you agree to the disclosure.**

I understand that:

- **I may revoke this authorization at any time in writing and present my written revocation to the FPP facility.**
- **The revocation will not apply to information that has already been released in response to this authorization or to my insurance company when the law provides my insurer with the right to contest a claim under my policy.**
- **I may refuse to sign this authorization.**
- **Disclosure of health information is voluntary.**
- **I need not sign this authorization to ensure treatment nor will it affect my payment status.**
- **Any disclosure of information carries with it the potential for an unauthorized redisclosure.**
- **I may inspect or have a copy of the information described on this form if I ask for it.**
- **I get a copy of this form after I sign it.**

Unless otherwise revoked, this authorization will expire on the follow date, event or condition:

- **If I fail to specify an expiration date, event or condition, this authorization will expire in ninety (90) days.**
- **If I have questions about the disclosure of my protected health information, I can contact the Office Manager of Five Points Psychiatry, LLC.**

AUTHORIZATION IS VALID FOR 90 DAYS FROM THE DATE OF SIGNATURE UNLESS OTHERWISE INDICATED.

I have read the above and authorize the disclosure of the protected health information as stated.

_____ _____

Signature of Patient or Legal Representative **Date**

_____

If signed by Legal Representative, relationship to patient