NEW PATIENT REGISTRATION

Insurance Name:_____Insurance ID:_____

Name: (LAST)_____ (FIRST):_____ (MI):_____

DOB: _____ **SS:** _____ **SEX: (M) / (F)**

Address: _____**Apt:** _____

City: _____ **State:** _____ **Zip:** _____

Phone: H: _____ **Cell:** _____ **Email:** _____

Primary Care Physician: _____

Past Psychiatrist: _____

Current Therapist:_____

Emergency contact:

Name: _____ Relationship: _____ Ph: _____

Name: _____ Relationship: _____ Ph: _____

Please sign: Both signatures are necessary

I am fully responsible for all payment for services rendered by the Doctors and or staff of ***Reflections of Health, Inc.*** *not paid by my Medical Insurance Company.*

Signature:_____ **Date:** _____

I also give permission for this office to use a laboratory to process any test the Doctors and / or staff members of ***Reflections of Health, Inc*** *feel is necessary.*

Signature:_____ **Date:** _____

TO RECEVING AGENCY: PROHIBITION OF REDISCLOSURE:
THIS INFORMAT IONHAS BEEN DISCLOSED TO YOU FROM RECORDS WHOSE CONFIDENTIALLY IS PROTECTED. ANY FURTHER REOISCLOSURE IS STRICTLY PROHIBITED UNLESS THE PATENT PROVIDES SPECIFIC WRITTEN CONSENT FOR THE SUBSEQUENT DISCLOSURE OF THIS INFORMATION.

PATIENT CONSENT FORM

SECTION A:

PATIENT GIVING CONSENT

NAME: (LAST)_____ (FIRST)_____ (MI)_____

DOB:_____

SECTION B:

TO THE PATIENT: (***PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY)***

Purpose of Consent:

By signing this form, you will consent to our use and disclosure of your Protected Health Information to carry out treatment and payment activities.

Notice of Privacy Practice:

You have the right to read our Notice of Privacy Practice before you decide whether to sign this Consent. Our Notice provides a description of our treatment payment activities and healthcare operations, of the uses and disclosures we make of your protected health information, and of other important matters about your protected health information. We encourage you to read it carefully and completely before signing this Consent. We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will post in our office as well as issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of our protected health information that we maintain. You may obtain a copy of our Notice of Privacy Practices, including any revisions of *our* Notice, at any time by contacting:

CONTACT PERSON: **Reflections of Mental Health, Inc.**
ADDRESS: **18425 NW 2nd Ave Suite 404B**
Miami Gardens, FL 33169
PH: (305)549-8100 FX: (786) 565-3015

Right to Revoke

You will have the right to revoke this Consent at any time by giving us written notice of your revocation submitted to the Contact Person / Department listed above. Please understand that revocation of this Consent will not affect any action we took in reliance on this Consent before we received your revocation, and that we may decline to treat you or continue treating you revoke this Consent.

SIGNATURE

*I,*_____*have* had full opportunity *to read* and consider the contents of this Consent form and your Notice of Privacy Practices. I understand that by signing this form. I am giving my consent to use and disclosure of my protected health information to carry out treatment, payment activities and healthcare operations.

Signature:_____ ***Date:***_____

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PATIENT RIGHTS

- Right to refuse and/or terminate treatment at any time.
- Right to access and obtain a copy of your health information.
- Right to an accounting of disclosures made on your health information.
- Right to request an amendment to your health information.
- Right to request confidential communications. Request that we communicate with you about your health information at alternative locations
- Right to restrict certain disclosures of your health information.
- Right to complain if you feel that we have used or disclosed your health information inappropriately.
- The right to know the ways in which Reflections of Mental Health, Inc uses and discloses your health information for treatment, payment, and health care operations.
- The right to authorize and revoke release of medical or health information.

I hereby certify and understand the above patient rights.

NAME OF PATIENT:_____

BIRTH DATE:_____ ***SOCIAL SECURITY #:***_____

SIGNATURE OF PATIENT:_____ ***DATE:***_____

SIGNATURE OF WITNESS:_____ ***DATE:***_____

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OFFICE POLICIES

(Update effective July 1, 2017)

PLEASE READ, INITIAL, AND SIGN THE FOLLOWING INFORMATION CONCERNING THE POLICIES OF THIS OFFICE. YOU WILL BE GIVEN A COPY FOR YOUR RECORDS.

_____**A. INSURANCE PAYMENT ORDER:**

I, (your name) _____ hereby authorize Reflections of Mental Health Inc. to use my information when conducting business with my insurance company. I understand that my health information will be used, as needed, to obtain payment for my health care services from my insurance providers. This may include certain activities the Reflections of Mental Health, Inc. staff may need to undertake before my health care insurer approves or pays for health care services recommended for me; such as determining eligibility or coverage for benefits, reviewing services provided to me for medical necessity, and undertaking utilization review activities.

_____**B. PAYMENT POLICY:**

You are responsible for all co-payments and/or fees at the time of service, otherwise billing fees will be incurred. If another party is responsible for your payments, please let us know prior to your visit so that we may make the necessary arrangements.

A fee of **$35.00** will be charged for any return checks, along with a processing fee.

_____**C. CANCELLATION POLICY:**

Appointments are scheduled according to each patient's needs and the availability of the physician. The time of your appointment is reserved for you. All cancellations and/or rescheduling of appointments **MUST** be done **at least 24 hours in advance.** Failure to call in advance to cancel their appointment will be considered a **NO SHOW** will incur a **$25.00** cancellation/no show fee. Confirmation calls are done as a courtesy to patients; however, there are times we cannot make them. Please do not rely on our call.

_____**D. MAINTAINING PATIENT STATUS:**

In regards to mental health, it is very important that you be seen on a regular basis. At the end of each appointment, you will be given a follow-up appointment. It is recommended that you make the follow-up appointment before you leave our office in order to schedule the most convenient time for you. If you fail to keep and/or maintain follow-up appointments for a period of **six month (180 days) or greater**, we will conclude that you have terminated the patient-physician relationship and would no longer be an active patient.

_____**E. TERMINATION OF CARE:** Dr. Samuel reserves the right to terminate the patient-physician relationship if the patient is repeatedly noncompliant with treatment recommendations despite repeated redirection and use of available resources and/or inability to maintain a therapeutic relationship due to repeated conflicts or inability to maintain professional boundaries. The termination of care will be provided in writing via certified mail along with list of treatment providers.

_____**F. MEDICATION REFILLS:**

We handle all refills during your regular scheduled appointments. If a medication refill becomes necessary, please provide us with your pharmacy phone number, medication name and how you are currently taking your medication. **No medication refills via telephone or fax will be provided if you have not been seen by the provider greater than 90 days. Refills for medications may be subject to a $25 fee.**

_____**G. CHANGES TO TREATMENT PLAN/MEDICATION REGIMEN**

No changes to medication or dosage will be done via telephone. All changes to treatment plan/medication regimen will be done via scheduled face-to-face visit either in office or secure video tele-psychiatry.

_____**H. CONFIDENTIALITY:**

Your patient records are strictly confidential. For this reason, no information concerning you as a patient is released without your written consent. Disclosure of information to anyone such as another doctor, an attorney and/or a family member must be requested by written authorization by the patient. In an emergency situation when you, the patient, are at imminent risk of death or serious medical consequence; minimal, critically relevant information to assist in preventing dire medical consequences that may result if that relevant information is not released. In the case of a minor, their legal guardian must sign the authorization. **The physician is legally bound to break doctor-patient confidentiality in cases of threat of harm to self or others, medical emergency, and in reports of child or geriatric abuse.**

_____**I. FMLA Forms/Medical Reports/Correspondence/Disability Forms**

While medical reports to insurance companies and employers are necessary for you to access benefits, they are not medically necessary for your treatment. Therefore, we charge for these additional tasks. Please allow 5 to 7 days for completion of your requests after we have all the appropriate releases and/or information to complete the forms. Paperwork is billed at **$25 or more** based on the complexity. No exceptions!!!!

_____**J. EMERGENCY SITUATIONS**

In the case of a psychiatric emergency call 911 or go to your local emergency room.

I have read and understand the information above.

_____	_____	_____
Signature of patient or guardian	Witness	Date

PATIENT AUTHORIZATION OF RELEASE FORM

I HERBY GIVE MY PERMISSION TO:_____

TO RELEASE A COPY OF MEDICAL / HOSPITAL RECORDS TO INCLUDE AND NOT LIMITED TO:

COMPLETE MEDICAL RECORD
DRUG and ALCOHOL RECORD EMERGENCY RECORDS DISCHARGE HISTORY/PHYSICAL
CONSULTATION HIV(AIDS) TESTING OPERATVE RECORD
PATHOLOGY PROGRESS NOTES
PHYSICIAN *ORDERS*
PSYCHIATRIC
RADIOLOGY
LABORATORY

TO: Reflections of Mental Health, Inc
18425 NW 2nd Ave
SUITE 404B
Miami Gardens, FL 33169
PH: (305) 549-8100 FX: (786) 565-3015

This authorization is subject to revocation at any time, by written request, except to the extent that action has been taken in reliance thereon, and in any authorization expires without express revocation one (1) year the data that appears below.

I HEREBY RELEASE THE FACILITY *FROM* ANY LIABILITY WHICH MAY ARISE AS A RESULT OFTHE USE *OF THE* INFORMATION CONTAINED IN THE ECORDS RELEASED.

NAME OF PATIENT:_____

BIRTH DATE:_____ ***SOCIAL SECURITY #:***_____

SIGNATURE OF PATIENT:_____ ***DATE:***_____

SIGNATURE OF WITNESS:_____ ***DATE:***_____

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SPECIFIC AUTHORIZATION FOR PSYCHOTROPIC MEDICATIONS

I, the undersigned, a O patient, or O guardian hereby authorize the professional staff to prescribe the specific medication for treatment of my condition limited to the mental health medication indicated on the next page as my primary medication(s) recommended.

State law requires informing you about:

1. The proposed medications and dosage range and frequency;
2. The proposed treatment;
3. Common short- and long-term effects of my proposed medication, including contraindications and clinically significant interactions with other medications;
4. Alternative medications;
5. Approximate length of care.

I further understand that a change of medication dosage range from those listed or on the attached will require my expressed and informed consent.

I understand that my consent can be revoked orally or in writing prior to, or during the treatment period.

The information I have relied upon to make the decision to consent to treatment, including full disclosure of each of the above subjects, is attached to this authorization and signed by me. I have read and had this information fully explained to me, and I have had the opportunity to ask questions and receive answers about the treatment. I am aware that I can request written information regarding the medications.

Signature of Patient	Date (mm/dd/yyyy)
Physician Signature	Date (mm/dd/yyyy)
Signature of: (check one when applicable) O Guardian*	Date (mm/dd/yyyy)

• The patient shall always be asked to sign this authorization form. However, if the patient is a minor, is incapacitated, or is incompetent to consent to treatment, the consent of his or her guardian, guardian advocate, or health care surrogate/proxy is required. Court orders, letters of guardianship, or advance directives must be retained in the clinical record if a person other than the patient signs the consent for treatment. The guardian, guardian advocate, or health care surrogate/proxy must agree to keep the facility informed of their whereabouts during the term of the hospitalization. Facilities may devise unique disclosure forms or use commercially prepared forms, but in either case must include all statutorily required elements.

SPECIFIC AUTHORIZATION FOR PSYCHOTROPIC MEDICATIONS

Initial	ANTIPSYCHOTIC	Usual Dose	ROUTE
	Abilify (aripiprazole)	10-30 mg	
	Clozaril (clozapine)	25-900 mg	
	Geodon (ziprasidone)	20-160 mg	
	Haldol (haloperidol)	0.5-60 mg	
	Haldol Decanoate (haloperidol)	25-300 mg every month	
	Loxitane (loxapine)	25-250 mg	
	Mellaril (thioridazine)	10-800 mg	
	Navane (thiothixene)	1-60 mg	
	Prolixin (fluphenazine)	2-40 mg	
	Prolixin Decanoate (fluphenazine)	12.5-75 mg every 2 weeks	
	Risperdal (risperidone)	1-16 mg	
	Serentil (mesoridazine)	10-400 mg	
	Seroquel (quetiapine)	25-800 mg	
	Stelazine (trifluoperazine)	2-80 mg	
	Thorazine (chlorpromazine)	25-2000 mg	
	Trilafon (perphenazine)	4-64 mg	
	Zyprexa/Zydis (olanzapine)	2.5-20 mg	
	STIMULANT	Usual Dose	ROUTE
	Adderall (amphetamine sulfate)	2.5-40 mg	
	Concerta (methylphenidate)	18-54 mg	
	Dexedrine (dextroamphetamine)	2.5-60 mg	
	Ritalin (methylphenidate)	2.5-60 mg	
	Strattera (atomoxetine)	5-100 mg	
	ANTIHYPERTENSIVE	Usual Dose	ROUTE
	Catapress (clonidine)	0.05-0.6 mg	
	Tenex (guafacine)	1-2 mg	
	ANXIOLYTIC	Usual Dose	ROUTE
	Ativan (lorazepam)	0.5-10 mg	
	Buspar (buspirone)	15-60 mg	
	Klonopin (clonazepam)	0.5-4 mg	
	Librium (chlordiazepoxide)	5-300 mg	
	Valium (diazepam)	2-40 mg	
	Xanax (alprazolam)	0.25-6 mg	
	OTHER	Dose	ROUTE

Initial	MOOD STABILIZER	Usual Dose	ROUTE
	Depakote (divalproex)	250-3000 mg	
	Eskalith/Lithobid (lithium carbonate)	300-1800 mg	
	Lamictal (lamotrigine)	5-500 mg	
	Lithium (lithium carbonate)	300-2400 mg	
	Neurontin (gabapentin)	100-800mg	
	Tegretol (carbamazepine)	100-800 mg	
	Topamax (topiramate)	25-400 mg	
	ANTIDEPRESSANT	Usual Dose	ROUTE
	Anafranil (clomipramine)	25-250 mg	
	Celexa (citalopram)	20-60 mg	
	Desyrel (trazodone)	50-600 mg	
	Effexor (venlafaxine)	25-375 mg	
	Effexor SR (venlafaxine)	37.5 -225 mg	
	Elavil (amitriptyline)	10-300 mg	
	Norpramin (desipramine)	10-300 mg	
	Pamelor (nortriptyline)	10-200 mg	
	Paxil (paroxetine)	10-60 mg	
	Prozac (fluoxetine)	10-80 mg	
	Tofranil (imipramine)	10-300 mg	
	Serzone (nefazodone)	50-600 mg	
	Wellbutrin (bupropion)	75-450 mg	
	Wellbutrin SR (bupropion)	100-400 mg	
	Zoloft (sertraline)	25-200 mg	
	ANTIHISTAMINE	Usual Dose	ROUTE
	Benadryl (diphenhydramine)	25-100 mg	
	Vistaril/Atarax (hydroxyzine)	10-400 mg	
	ANTICHOLINERGIC	Usual Dose	ROUTE
	Artane (trihexyphenidyl)	1-15 mg	
	Cogentin (benztropine)	0.5-6 mg	
	HYPNOTIC	Usual Dose	ROUTE
	Dalmane (flurazepam)	15-30 mg	
	Somnote (chloral hydrate)	500-2000 mg	
	Restoril (temazepam)	7.5-30 mg	
	OTHER	Dose	ROUTE

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ 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 days	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 _____

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's 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 that best describes how you have felt and conducted yourself over the past 6 months. Please give this 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 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 boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you 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 them 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

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (☑) the answer that best applies to you.
Please answer each question as best you can.

	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 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 in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.