NeuroPsychiatry Center - Ravi Kant, MD, P.C.
300 Old Pond Road, Suite 201, Bridgeville, PA 15017
Tel. # 412-220-7323 Fax # 412-220-7325

REGISTRATION

Patient _____
Last Name **First Name** **Middle Initial**

Street Address _____

City _____ **State** _____ **Zip** _____ - _____

Phone Numbers: Cell:_____ **Home:** _____ **SSN:**_____

Sex Assigned at Birth:_____ **Identified Gender:**_____ **Age:** _____ **Birth Date** _____

E-mail: _____

Race: □ White □ Black □ Asian □ Other _____ **Ethnicity** ____ **Preferred Language** _____

Emergency contact _____ **Phone #** _____ **Relationship** _____

If patient is a minor or has a legal representative or guardian, please fill out the information below.
(Guardian/Legal Representative is required to attach supporting legal documentation)

Responsible Party _____

Street Address (if different from patient) _____

City _____ **State** _____ **Zip** _____ - _____

Date of Birth _____ **Phone Number** _____ **E-mail** _____

Insurance Information

1. Primary Insurance _____

Policyholder Name _____ **Relationship to Patient** _____

Date of Birth _____ **Policy #** _____ **Group #** _____

2. Secondary Insurance _____

Policyholder Name _____ **Relationship to Patient** _____

Date of Birth _____ **Policy #** _____ **Group #** _____

√ Can we leave a text or message at the phone number provided with family member/s or on the voicemail for appointment reminders or other information? – Yes □ No □

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

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ASSIGNMENT/RELEASE/CONSENT TO TREATMENT

Patient Name _____ **Date of Birth** ____/____/_____

(All patients/guardians sign below)

I authorize and request treatment/s from **RAVI KANT, M.D**. and/or his associates to perform routine diagnostic procedures and to provide medical treatment as is medically necessary in his/their professional judgment.

I hereby authorize release of protected health information, including mental health and/or substance abuse (drug and alcohol), necessary to file a claim with my insurance carrier and assign benefits otherwise payable to me to **RAVI KANT, M.D. PC** as indicated on the insurance claim form. I understand that this facility and its providers are mandated reporters of any and all suspected or witnessed child abuse and/or neglect. (Section 6383 (b) of Title 23 of the Pennsylvania Consolidated Statutes/Act of July 1, 2015, P.L. 94, No. 15). I also understand that I am financially responsible for any balance not covered by my insurance carrier(s) (including but not limited to deductibles and/or co-payments) and agree to pay the full charges if payment is/are denied by my insurance carrier(s) for any reason or if no insurance coverage exists at the time of services. It is my responsibility to update any changes in insurance. I understand it is mandatory to notify the health care provider of any other party who may be responsible for payments (section 1128 B, Social Security Act and 31 U.S.C. 3801- 3812 provides penalties for withholding this information). Medicare regulations apply. I have received, read and agree with the billing and other office policies.

With my consent, Ravi Kant, M.D., his associates, and office staff can call my home and leave messages on an answering machine or with a person, text, or e-mail me regarding appointments and contact the designated emergency contact person if needed. I may revoke my consent in writing except to the extent that the practice has already acted upon in reliance upon my prior consent. If I do not sign this consent, Ravi Kant, M.D. and his associates may decline to provide services to me. I agree with the above.

All the information provided in this Registration-Assignment/Release/Consent to Treatment is true and current.

Notice of Health Information Practices - Ravi Kant, MD, P.C.

(Copy is available and posted in office for your review or available for download at www.drkant.com)
I have read and understood the above Notice of Health Information Practices. I recognize that this is a federal mandate that this facility must comply with. Patient Initials _____

Notice of Patient Rights and Responsibilities - Ravi Kant, MD, P.C.

(Copy is available and posted in office for your review or available for download at www.drkant.com)
I have read and understood the Patient Rights and Responsibilities provided at the office. Patient Initials _____

Notice of Grievance Procedure – Ravi Kant, MD, P.C.

(Copy is available and posted in office for your review or available for download at www.drkant.com)
I have read and understood the Grievance Procedure provided at the office. Patient Initials _____

Patient Signature _____ Date _____
(If patient is a minor (ages 14-18) he/she must sign this Registration-Assignment/Release/Consent to Treatment)

Print Name _____

Responsible Party Signature _____ Date _____
(Parent/Guardian/Legal Representative)

Print Name _____

Relationship to Patient _____
(Guardian/Legal Representative is required to attach supporting legal documentation)

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OFFICE POLICIES

Patient Name _____ **Date of Birth** ____/____/_____

Insurance Coverage:
Due to frequent changes in insurance coverage (benefits, exclusions, deductibles and/or prescription coverage, etc.), we cannot inform or advise you about your benefits. In some insurance policies, certain diagnoses may be excluded, such as ADHD, Autism, Mental Retardation and related conditions. We do not routinely do the paperwork for non-formulary medicines not covered by your insurance company. You are responsible for keeping track of number of visits allowed in your plan and how many visits you have used with your therapist and prescriber. You will be charged for additional visits. If you do not have insurance coverage, you are responsible for the full charges. Please inquire in advance about our charges if you do not have insurance.

Payments:
It is our policy to collect all **co-payments and/or deductibles** at the time of service unless arrangements are made ahead of time. **We accept checks, cash, and debit or credit cards (Visa, MasterCard American Express or Discover).**

A service charge of **$10.00** plus interest (1.5%/month) will be added to any outstanding balance over 30 days past due. Also, all delinquent accounts (over 90 days past due) may be turned over to a collection agency. An additional **$40.00** as a handling fee and the costs of collection (including attorneys' fees and costs) will be added to the total amount due.

Please note that there are additional fees for any forms or letters that may need to be completed by your provider.

All payments will be charged to your credit card on file (if applicable).

Attendance Policy:
We understand that it is not always possible to keep a scheduled appointment or give 24 hours notice of cancellation. If a pattern of same day cancellation or "No Shows" develop, we reserve the right to bill you a **$50.00** fee for missing a follow up appointment and a **$75.00** fee for missing your initial appointment. Your insurance company is not responsible for this charge. Prescriptions may not be called in for No Show or Canceled appointments.

Additionally, if there are frequent No Show for appointments, outstanding balances despite multiple reminders, inappropriate behaviors, and/or non-compliance with treatments, you may be discharged from the practice.

Lost Prescription Fee:
A service fee of **$20.00** will be charged to replace lost scripts. Scripts will need to be picked up from the office after payment of the fee.

Returned checks – Fee of **$40.00** will be charged for checks returned for any reason.

****Fees may be changed without notice.**

I have read and agree to be legally bound by the terms of these office policies including the financial responsibility provisions hereof. I understand that I am financially responsible for any amounts not covered or paid by my insurance carrier and that I am responsible for providing current insurance information and inform the office of any address and/or insurance changes.

Patient Signature _____ Date _____
(If patient is a minor (ages 14-18), he/she must sign this Office Policy Form)

Print Name _____

Responsible Party Signature _____Date _____
(Parent/Guardian/Legal Representative)

Print Name _____

Relationship to Patient _____
(Guardian/Legal Representative is required to attach supporting legal documentation)

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

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

I consent to and authorize to disclose my protected health information relating to my identity, diagnoses, prognosis, and/or treatment. These records may include information related to medical conditions, tests, mental or behavioral health, substance abuse (drug and alcohol), and HIV-related. These records are called protected health information and are protected by federal and/or state laws.

From:_____
(Name and address of provider or facility releasing records)

To: □ PCP □ Family Member □ Therapist □ Other_____

Name: _____

Address: _____

Phone Number:_____ **Fax Number:** _____

The purpose for this disclosure is: □ Coordination of Care □ Notify PCP of First Appt □ Other_____

I understand that the specific types of records to be released (identify all records or all that apply) are:

□ All records including psychiatric/psychological evaluation □ Insurance claims and payments only

□ Other_____

****Mental or behavioral health, substance abuse, and HIV-related information contained in the parts of the records indicated above will be released through this authorization unless otherwise indicated.****

DO NOT RELEASE: □ Mental/Behavioral Health □ HIV-Related □ Substance Abuse (Drug and Alcohol)

I understand that this authorization is revocable upon my written request and that this consent will remain in force unless revoked in writing by the patient or legal guardian. I also understand that my decision to revoke this authorization may result in my insurance company not being able to pay for my medical care and I will be liable for payment for the services rendered.

Patient Signature _____ **Date** _____
(If patient is a minor (ages 14-18) he/she must sign this Authorization for Release of Protected Health Information Form)

Print Name _____

Responsible Party Signature _____ **Date** _____
(Parent/Guardian/Legal Representative)

Print Name _____**Relationship to Patient** _____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

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Patient Information and Consent Form for Telehealth

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

Introduction:
Telehealth is the delivery of medical or mental health services using interactive video conferencing or a telephone call (when permitted), that enables a provider at a distant location to provide treatment to me. I understand that this consultation will not be the same as a direct in office visit. Telehealth will allow me to receive medical care without the need to visit the office and travel long distance.

I understand that my insurance may not cover telehealth services. If my insurance does not cover telehealth services, I agree that I will be responsible for self-pay charges for the visit. I am aware that during my telehealth appointment, it is important to be in a private location for the duration of the appointment. I am aware that the telehealth sessions will not be recorded. In the event of a transmission failure, I am aware of the contingency plan. I am aware that I can refuse services via telehealth and that such refusal will not be used as a basis to limit the access to other available services. Alternatives to telehealth services may possibly cause delays in service/s due to scheduling issues, need to travel, and/or risks associated with not having the services provided by telehealth.

The interactive electronic systems used in telehealth are known to incorporate network and software security protocols to protect the confidentiality of information and audio/visual data. These protocols include measures to safeguard the data and to aid in protecting against intentional or unintentional corruption. Our practice currently uses HIPAA compliant telehealth platforms. We may use the landline telephone for audio to enhance the security of the information being discussed.

During the telehealth consultation-

a. Details of my medical history, current medications, and results of medical tests will be discussed.
b. Non-medical personnel may be present to assist in operating conferencing equipment, if needed.
c. At times students may be present during the session. I will be informed about who is present in the office.

Potential benefits:

- Increased accessibility to psychiatric care
- Patient convenience

Potential Risks:
As with any medical procedure, there may be potential risks associated with the use of telehealth. These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g., poor resolution) to allow for appropriate medical decision making by Dr. Kant or his associates.
- Dr. Kant or his associates may not be able to provide medical treatment to me using interactive electronic equipment nor provide for or arrange for emergency care that I may require.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Security protocols can fail, causing a breach of privacy of my confidential medical information.
- A lack of access to all the information that might be available in a face to face visit but not in a telehealth session may result in errors in medical judgment.

Alternatives to the use of telehealth:

- Traditional face to face sessions in our office

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Patient Information and Consent Form for Telehealth

My Rights:

- I understand that the laws that protect the privacy and confidentiality of medical information also apply to telehealth.
- **I understand that the technology used by Dr. Kant or his associates is encrypted to prevent the unauthorized access to my private medical information.**
- I have the right to withhold or withdraw my consent to the use of telehealth during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
- I understand that Dr. Kant or his associates has the right to withhold or withdraw approval for the use of telehealth during the course of my care at any time.
- I understand that the all rules and regulations which apply to the practice of medicine in the state of Pennsylvania also apply to telehealth services.

My Responsibilities:

- I will not record any telehealth sessions without written consent from Dr. Kant or his associates. I understand that Dr. Kant or his associates will not record any of our telehealth sessions without my written consent.
- I will inform Dr. Kant or his associates if any other person can hear or see any part of our session before the session begins. Dr. Kant or his associates will inform me if any other person can hear or see any part of our session before the session begins.
- I understand that I, not Dr. Kant or his associates, am responsible for the configuration of any electronic equipment used on my computer for telehealth. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
- **I understand that I must be a resident of the state of Pennsylvania to be eligible for telehealth services from Dr. Kant or his associates.**
- I understand that my initial evaluation may not be done by telehealth except in special circumstances under which I will be required to verify my identity to provider satisfaction before the evaluation.

Telehealth Video Instructions:

1. **Five to ten minutes prior to your appointment, please click on the appropriate link for your provider's telehealth account in the telehealth section of our website**

2. **Type in your first and last name and click "check in"**

3. **Your provider will be with you shortly. Please make sure your microphone is unmuted and your webcam is turned on**

I have read and understand the information provided above regarding telehealth, I have discussed it with Dr. Kant or his associates, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my medical care and authorize Dr. Kant or his associates, to use telemedicine in the course of my evaluation, diagnosis and treatment. If for any reason/s, telehealth will not work for my treatment, then I will need to come to office for ongoing evaluations and treatments.

Patient Signature _____ **Date** _____
(If patient is a minor (ages 14-18) he/she must sign this Authorization for Release of Protected Health Information Form)

Responsible Party Signature _____ **Date** _____
(Parent/Guardian/Legal Representative)

Print Name _____**Relationship to Patient** _____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

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CONSENT TO DISCUSS PROTECTED HEALTH INFORMATION VIA ELECTRONIC COMMUNICATION

Patient Name: _____ Date of Birth: _____/_____/_____

Parent/Legal Guardian Name: _____ Relationship_____

By signing below, I permit NeuroPsychiatry Center to communicate protected health information for the above patient via e-mail at_____@_____._____

E-MAIL RISKS AND YOUR RESPONSIBILITY:

You and your provider/s at NeuroPsychiatry Center (NPC) and its employees and staff have agreed to correspond using e-mail. These e-mails may contain personal protected health information including, mental health issues. You need to be aware of the risks and your responsibilities.

A.) As the internet is not secure or private, unauthorized people may be able to intercept, read, and possibly modify e-mail/s you send or receive from NPC. You must protect your e-mail account and password against unauthorized use. Hackers can get access to your account.
B.) Viruses can be spread via e-mail and some may cause e-mail messages to be sent to unintended people.
C.) E-mails can be copied, printed, and forwarded by recipients; be careful with whom you send or share e-mails.

1. CONDITIONS FOR THE USE OF E-MAIL:

By consenting to the use of e-mail with NPC you agree that:

A.) NPC may forward e-mails, as appropriate, for diagnosis, treatment, billing, and other related reasons. Employees and medical staff other than the intended recipient may have access to your e-mails.
B.) Although NPC will try to read and respond to your e-mail, we may not read your e-mail immediately. If you do not receive a response within a reasonable time, it is your responsibility to contact us to follow up.
C.) You should carefully consider the use of e-mail for the communicating sensitive medical and personal information.
D.) E-mail messages should be **short, clear, and concise**.
E.) NPC reserves the right to save your e-mail including the information contained there in the medical records.
F.) You agree not to abuse the right to communicate with your physician's office and your communications will be professional in content.
G.) E-mail access to staff is being provided as a convenience to our patients and NPC has the right to restrict your ability to communicate with us via e-mail at any time for any reason, including cases where NPC reasonably believes that it is not in your best interest to continue to seek advice via e-mail and an in person appointment is needed or that e-mail is being used excessively in lieu of in person care.

2. INSTRUCTIONS:

A.) You should immediately inform the staff at NPC of any changes in your e-mail address.
B.) **E-mail should be used only for non-sensitive and non-urgent issues such as prescriptions, scheduling, general questions or advice. E-mail is not a substitute for psychotherapy or medication management appointments.**
C.) Please put the patients name and date of birth in the body of the e-mail for proper identification.
D.) If you wish to withdraw your consent to communicate via e-mail, you must inform NPC in writing.

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CONSENT TO DISCUSS PROTECTED HEALTH INFORMATION VIA ELECTRONIC COMMUNICATION

ACKNOWLEDGEMENT AND AGREEMENT

NeuroPsychiatry Center will use reasonable means to protect the privacy of the patient's health information. However because of the risks outlined above, NPC cannot guarantee e-mails will be confidential. Also NPC will not be liable in an event that you or anyone else inappropriately uses or accesses your e-mail. NPC will not be liable for improper disclosure of your health information that is not caused by our intentional misconduct.

NPC is not responsible for e-mail messages that are lost due to technical failure during composition, transmission and/or storage. NPC may impose restrictions to communicate with me by e-mail. I have read and understand the information above, and had any questions answered to my satisfaction. I have received the copy of this consent form. I agree to the guidelines for e-mail communication. I understand that this consent is valid until such time as I revoke the consent outlined above, except to the extent that a staff has already acted in reliance upon this authorization.

Patient Signature _____ **Date** _____
(If patient is a minor (ages 14-18) he/she must sign this Release of Protected Health Information via Electronic Communication Form)

Print Name _____

Responsible Party Signature _____ **Date** _____
(Parent/Guardian/Legal Representative)

Print Name _____

Relationship to Patient _____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

DO NOT SEND E-MAIL FOR EMERGENCIES

GO TO THE NEAREST HOSPITAL, CALL 911, OR CONTACT YOUR COUNTY'S EMERGENCY CRISIS NUMBER

We will not read e-mails on weekends, holidays, or when on vacation.

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PRESCRIPTION REFILL POLICIES AND PROCEDURES

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

Parent/Legal Guardian Name: _____ **Relationship**_____

In order to make the prescribing medication and requesting temporary refills process efficient, we will follow the procedures listed below. Patients or a parent/legal guardian should initial and sign below.

● Check which medications need refilled before coming to your appointment. It is **YOUR** responsibility to get your medications refilled during your visit. Schedule your next visit at least **1 week prior** to running out of your current refill(s).

● If you require a medication refill in-between scheduled appointments, it is **YOUR** responsibility to request it from our website - www.drkant.com and fill in the "Medication Refill Request" online. Refill requests are **NOT** accepted via phone. We need at least **72** hours notice (excluding weekends or holidays) to respond to your request. Please note that we do **NOT** accept medication refill requests from pharmacies.

● Please note that no refills for medication will be sent if you have an outstanding balance.

I understand the above: X_____

● Regular office visits are required for monitoring and prescribing medications as determined by your provider. Medications will not be called in without required office visits.

I understand the above: X_____

● Blood work is needed for some medications to assess the safety and effectiveness. For patients who do not get the blood work done in a timely fashion, we will refuse to fill their prescriptions.

I understand the above: X_____

● If prescribed a controlled substance as identified by the DEA, per office policy, patients must be seen at least every 4-8 weeks, at the discretion of the provider. Refills for controlled substances will only be provided during appointments. Random urine screens may be requested to assess the use of narcotics or abuse of illicit drugs.

I understand the above: X_____

I have read the **Prescription Refills Policies and Procedures** and by initialing above and signing below, I agree to abide by them in full and have been given a copy if requested.

Patient Signature _____ **Date** _____
(If patient is a minor (ages 14-18) he/she must sign this Prescription Refill Policies and Procedures Form)

Print Name _____

Responsible Party Signature _____ **Date** _____
(Parent/Guardian/Legal Representative)

Print Name _____

Relationship to Patient _____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

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E-PRESCRIBING MEDICATION HISTORY CONSENT

Patient Name _____ **Date of Birth** ____/____/____

I understand that NeuroPsychiatry Center utilizes e-prescribing. I understand that e-prescribing allows the practice to send prescriptions electronically to pharmacies, eliminating the need for prescribing via paper, phone, or fax.
E-Prescribing is fast, convenient, legible, secure, cost-effective and safe. In some cases, it also allows the health care provider to access critically important information about patient's current and past medications from pharmacy benefit managers and community pharmacies. This helps to alert the provider to other potential medication interactions or if patient is getting same or similar medications from multiple providers.

I have been given an opportunity to ask questions about the e-prescribing process and have had those questions answered to my satisfaction. I hereby consent to the practice requesting and using my medication history from other health care providers, pharmacies, or third party pharmacy benefit payers for treatment purposes.

Patient Signature _____ **Date** _____
(If patient is a minor (ages 14-18) he/she must sign this Authorization for E-Prescribing Medication History Consent Form)

Print Name _____

Responsible Party Signature _____ **Date** _____
(Parent/Guardian/Legal Representative)

Print Name _____

Relationship to Patient _____
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Name _____ DOB ____/____/____ Date_____

PERSONAL CRISIS PLAN

My Triggers**:** _____

_____

Thoughts/Inside Warnings: _____

_____

Outside Warning Signs: _____

_____

When Notice My Triggers I will: _____

_____

When Others Notice I'm Upset I'd like them to: _____

_____

Things That Help Me Stay Better Now: _____

_____

Things That Help Me Stay Well on a Regular Basis: _____

_____

Things That Make Me Feel Worse: _____

_____

*If I'm feeling unsafe, I will go to the ER of local hospital, call Suicide Hotline 1-800-273-8255, or call my county's crisis number.

Patient Signature _____ Date _____
(If patient is a minor (ages 14-18) he/she must sign this Registration-Assignment/Release/Consent to Treatment)

Print Name _____

Responsible Party Signature _____ Date _____
(Parent/Guardian/Legal Representative)

Print Name _____

Relationship to Patient _____
(Guardian/Legal Representative is required to attach supporting legal documentation)

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Name _____ DOB ____/____/____ Age_____

Parents/Legal Guardians _____

**** If minor is not living with both parents or minor has a legal guardian, a legal custody agreement MUST be provided in order for the minor to be seen. ****

*****If patient is under the age of 14 years, please have ALL parents/legal guardian(s) sign consent for treatment documentation as well as release of information*****

You will be responsible for full payment if your insurance company denies payment for any reasons

Co-Payments are due at each visit. Bring all relevant medical records with you. (No X-Ray)

Current healthcare providers	Address	Phone	Fax
General Practitioner:			
Therapist/Psychologist:			
Other Health Care Provider:			

Who can we thank for recommending our practice? _____

Current Pharmacy: Name _____ City _____ Zip _____ Phone _____

Allergies: Y N If yes what? _____

Reaction(s) _____

Height - _____ **Weight** - _____

Chief Complaints (Please circle)

Depression	Y	N	Psychosis	Y	N
Anxiety	Y	N	Attention/Concentration	Y	N
Panic Attacks	Y	N	Eating Disorder	Y	N
Hypomanic/Manic Episodes	Y	N	Drugs/Alcohol	Y	N
Anger	Y	N			

Other: _____

Current stressors (Please circle)

School	Y	N	Social	Y	N	Family	Y	N
Medical	Y	N	Pain/Disability	Y	N	Work/Job	Y	N

Other: _____

Describe in your own words your current symptoms:

_____

_____

History

When did your symptoms start? ____Years or ____ Months ago Have you had similar symptoms in the past? Y N

What, if any, triggered the symptoms? _____

_____

What has been helpful to control the symptoms? _____

_____

Mood Symptoms:

Circle the appropriate answer, then rate IF YES: ***(Rate symptoms on scale of 0 to 10; 0 good, 10 worse)***

Depression	Y	N	0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Mania/Hypomania	Y	N	0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10
Anger/Irritability	Y	N	0-----1-----2-----3-----4-----5-----6-----7-----8-----9-----10

Depression:

Irritability	Y	N				
Tearfulness	Y	N				
Loss of Interests/ Motivation	Y	N				
Decreased Appetite	Y	N	Weight loss	Y	N	How much
Increased Appetite	Y	N	Weight gain	Y	N	How much
Difficulty falling or staying asleep	Y	N	Total Hours of Sleep per day			_____hrs.
Fatigue	Y	N				
Negative Thoughts	Y	N	Self-Injury		Y	N
Low Self Esteem	Y	N	Suicidal Thoughts		Y	N
Social isolation	Y	N	Thoughts of Death/Dying		Y	N
Feeling Worthless	Y	N				
Feeling Hopeless/Helpless	Y	N	Access to firearms		Y	N
Homicidal Thoughts	Y	N	If yes, is firearm in secure location?		Y	N

Would you reach out to someone if you feel strongly suicidal? Y N Who? _____

(You can call ER of local hospital / Suicide Hotline 1-800-273-8255 / Resolve Crisis Hotline 1-888-796-8226)

Hypomania/Mania:

Has there ever been a period of time when you were not your usual self and:

You were much more talkative?	Y	N
You had much more energy?	Y	N
You were more social or outgoing than usual?	Y	N
You did things that were unusual or that other people might have thought were excessive, foolish or risky?	Y	N
You spent excessive amounts of money or got your family into trouble?	Y	N

Anxiety:

Excessive Worrying Y N How often? _____

If yes give examples _____

_____

_____

Do you find it difficult to control the worry?	Y	N	Bothered by Crowds	Y	N
Restlessness	Y	N	Avoid Going Places	Y	N
Fatigue	Y	N	Social Isolation	Y	N
Irritability	Y	N	Muscle Tension	Y	N
Difficulty falling or staying asleep	Y	N			

Panic Attacks: Y N How often? _____

Duration? _____ Where? _____

Triggers? _____

Panic Attack Symptoms:

Palpitations	Y	N	Nausea	Y	N
Chest pressure	Y	N	Fear of Dying	Y	N
Sweating/Chills	Y	N	Dizziness	Y	N
Shakiness	Y	N	Numbness/Tingling	Y	N
Out of Breath	Y	N	Fear of Losing Control	Y	N
Feelings of Choking	Y	N	Fear of Being Trapped	Y	N

Obsessions	Y	N	Describe: _____
Repetitive Behaviors	Y	N	Describe: _____
Fears	Y	N	Describe: _____
Flashbacks	Y	N	Describe: _____
Nightmares	Y	N	Describe: _____
Delusions	Y	N	Describe: _____
Paranoia	Y	N	Describe: _____
Hallucinations	Y	N	Describe: _____

Cognitive Symptoms

Long Term Memory Intact----------Impaired a Little----------Impaired a Lot

Short Term Memory Intact----------Impaired a Little----------Impaired a Lot

Make Careless Mistakes	Y	N	Forgetful	Y	N
Difficulty Sustaining Attention	Y	N	Easily Confused	Y	N
Easily Distracted	Y	N	Word Finding Difficulties	Y	N
Fail to Finish Tasks	Y	N	Difficulties with Info. Processing	Y	N
Frequently Lose Things	Y	N	Restless/Fidgety	Y	N
Impulsive	Y	N	Intrusive and interrupting often	Y	N
Reading	Y	N	Math	Y	N
Issues with classroom behaviors	Y	N	Concerns from teachers	Y	N

Normal Hearing Y N Normal Vision Y N

If no, please describe: _____

Physical Changes (If Yes, Describe Symptoms and Identify Treatment)

Do you suffer from any physical symptoms? (Ex: headaches, nausea, severe PMS, etc) Y N

If yes please describe: _____

Past Psychiatric History:

Out Patient Treatments (where and for what reason): _____

Inpatient Treatments (where and for what reason): _____

Therapists/Psychiatrist(s) seen: _____

Medications tried in the past: _____

History of suicide attempt(s)? Y N

If yes provide details: _____

Family History:

Medical problems Y N If yes, who? _____

Diagnosis: _____

Emotional problems Y N If yes, who? _____

Diagnosis: _____

Alcohol/Drug Abuse Y N If yes, who? _____

Describe: _____

Patient's Past Medical History

Diabetes Y N High Blood Pressure Y N Neurological Disorders Y N
Fibromyalgia Y N Seizures Y N High Cholesterol Y N
Hypothyroidism Y N
Other

Surgeries Y N Please describe:
Hospitalizations Y N Please describe:

Have you ever suffered a stroke, head bleed, concussion or other type of head injury? Y N
If yes, please explain:

Developmental History:

Issues during pregnancy Y N Use of drugs/Alcohol/Tobacco during pregnancy Y N
Normal Labor & delivery Y N
If no, please explain:

At what age did you/your child begin: Walking: Talking Toilet training

Developmental delays Y N
If yes, please describe

Any significant medical problems during early childhood including hospitalizations Y N
If yes, please describe

Are your/your child's immunizations up to date? Y N

Social History

Who are you currently living with? _____

Are your parents currently married? Y N

If no and the patient is under the age of 14, BOTH parents must complete the consent for treatment and release of information documents and a legal custody agreement must be provided*

School name: _____ Grade: _____

Special Education Y N Repeated any grade Y N

Discipline problems Y N

If yes, please describe: _____

_____

Involved in Sports Y N If yes, what sports do you play? _____

Attend Alternative School Program? Y N Name: _____ IEP or

Service Agreement Y N Reasons: _____

Any school testing done Y N Results: _____

If applicable: Are you currently working? Y N

Do you spend time with friends after school or on weekends? Y N

Do you enjoy being around friends Y N

Are you bullied at school, on the bus or on social media? Y N

If yes: please describe _____

_____

Involved in community/social activities? Y N

Please Circle: Church/Temple Clubs Sports AA/NA Volunteer work Other:_____

Hobbies _____ Last enjoyed _____

Do you have a history of past physical/psychological/sexual abuse, neglect, trauma, domestic violence, or have you witnessed domestic violence? Y N

If yes, please describe: _____

_____ If yes, have you had treatment for the trauma? Y N

If you have not received treatment, would you like to address the trauma during treatment? Y N

Caffeinated Drinks Y N _____cups per day

Social History

Current Tobacco Use Y N If yes, do you want to quit? Y N

Type of Usage:

Amount Per Day: How Often? How Long?

Have you ever received treatment? Y N Do you want treatment? Y N

Former Tobacco Use Y N

When Did You Start? When Did You Quit?

Drink Alcohol Y N _____drinks per day/week for_____years

Have you ever received treatment? Y N Do you want treatment? Y N

Impact social/family life Y N

Have you ever felt that you should cut down on your drinking? Y N

Have people annoyed you by criticizing your drinking? Y N

Have you ever felt bad or guilty about your drinking? Y N

Have you ever had a drink first thing in the AM to steady your nerves? Y N

Do your family/friends complain about your alcohol/drug use? Y N

Current Drug Use/Misuse Y N

IV drug use Y N

Type of Usage:

Amount Per Day: How Often? How Long?

Have you ever received treatment? Y N Do you want treatment? Y N

Former Drug Use/Misuse Y N

Type of Usage:

Amount Per Day: How Often? How Long?

Current Medications (bring the bottles with you)

	Name	Dose	How Long	For What	Who Prescribed
1.					
2.					
3.					
4.					
5.					
6.					

Do you take any over the counter and/or herbal/natural products? Y N

If yes, please list:

Do you take any medications that belong to a friend/family member? Y N

If yes, please list:

What do you identify as your strengths? - _____

What do you identify as your weaknesses? - _____

What are your perceived barriers to treatment, if any? - _____

Any other relevant information _____

I **certify that I have reviewed the above information provided by me, and to the best of my knowledge it is true and complete. I am aware that this information may be released to other parties such as insurance co., attorneys, and other medical professionals/hospitals as per my consent/authorizations, or via court orders as allowed by prevailing federal, state and/or local laws. This information may be shared with treating professionals and/or law enforcement authorities without your consent in case of an emergency, when relied upon in good faith. I will hold Dr. Kant and/or his designees harmless for any loss, injuries, damage that may arise from the actions taken.**

I/We will be responsible for payment of charges billed if payments are denied by the insurance company/ies for any reason/s. It is my responsibility to update my insurance information for billing whenever there are any changes.

Patient Signature_____
(If the patient is a minor (age 14-18) and received mental health and/or substance abuse treatment, S/he must sign this release)

Patient Name_____

Parent/Guardian/Legal Representative of Patient Signature_____

Parent/Guardian/Legal Representative of Patient Name_____

Relationship to Patient_____
(Guardian/Legal Representative may be required to attach supporting legal documentation)

Date_____

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Credit Card Authorization Form

Please complete all fields. You may cancel this authorization at any time by contacting us in writing. This authorization will remain in effect until canceled.

Credit Card Information
Card Type: □ MasterCard □ VISA □ Discover □ AMEX □ Other_____
Cardholder Name (as shown on card): _____
Credit Card Number: _____
Expiration Date (mm/yy): _____
Cardholder ZIP Code (from credit card billing address): _____
CVV (3 digits on the back of the card): _____

I, _____ authorize NeuroPsychiatry Center to charge my credit card listed above for services provided. This can include self-pay fees, co-payments, deductible, and other charges such as no-show fees, and services not covered under my insurance. I understand my credit card will not be charged more than $300 at one time. I understand that my information will be saved on file for future transactions on my account. I am responsible for keeping this information updated in a timely manner. This authorization will apply to any credit card updates in the future. I am aware that NeuroPsychiatry Center will be unable to notify me before processing this card on file and that my card may be charged at any time at the discretion of NeuroPsychiatry Center for the reasons listed above. These circumstances DO NOT apply to medical assistance recipients.

_____ _____

Patient/Guardian Signature Date