West End Consultation Group

Psychiatric History Form

Name:		Date:	
Age:		Date of Birth:	

Social/Family History:

Single/Married/Divorced/Widowed/Partnered	Partner's Name:

Children's names	Ages

Education Level	
Current School	
Occupation	
Military Service	
Legal Problems or Prior Legal Charges	

Is there any known mental illness in the family?	
If so, who, and what is the diagnosis?	
Any drug or alcohol abuse in family members? If so who?	
Have you ever been emotionally, physically or sexually abused?	
Have you suffered any recent losses, such as a death in a loved one, loss of job, divorce, etc?	

Substance Use:

Have you ever been in treatment for drug or alcohol problems?	
If yes, for which substance(s)	
If yes, where were you treated and when	
How many days per week do you drink alcohol?	
Do you think you may have a problem with drugs or alcohol?	
Have you used any street drugs in the past 3 months?	
Have you ever abused any prescription medications?	
If yes, which ones and for how long	

–

Substance Use (cont)

Check if you have ever tried the following			
Drug	Yes	No	If yes, how long and when did you last use
Methamphetamine			
Cocaine			
Stimulants (pills)			
LSD or hallucinogens			
Marijuana			
Pain Killers (not as prescribed)	asdf		
Ecstasy			
Inhalants			
PCP			
Kratom			
Ketamine			
Cough Syrup (DXM)			
Bath Salts			
Other substances			

Tobacco History	
Do you smoke cigarettes currently?	
If yes, how many packs per day?	
If in the past, when did you quit?	
Do you chew tobacco?	

Previous Psychiatric Treatment:

Past or current psychotherapy, including therapist's name and dates of therapy:

Current and past psychiatrists, including Psychiatriststst's name and dates of treatment:

Past Psychiatric Hospitalizations, including dates, locations, and length of stays;

Any past suicide attempts? If yes, give approximate dates:

Past psychiatric medication trials (include approximate dates):

Medical History:

Your Primary Care Physician	
Medication Allergies	
Current Height	
Current Weight	

Current Medications (include all medications, including psychiatric and supplements):

Any Personal History of: (check if yes)			
Illness	Yes	Illness	Yes
Thyroid Disease		Anemia	
Liver Disease		Chronic Fatigue	
Diabetes		Asthma/Respiratory Problems	
Kidney Disease		Stomach or intestinal problems	
Cancer (type)		Fibromyalgia	
Heart Disease		Epilepsy or seizures	
High Cholesterol		High Blood Pressure	
Hearing Loss		Vision Loss	
Chronic Pain		Head Trauma	
Sleeping problems		Sexual problems	
Eating Problems-if yes, describe			
Other health problems or concerns			

Any past surgeries-list	

West End Consultation Group
1550 Utica Ave S, Suite 450
St Louis Park, MN 55416
Phone (952) 856-8452 Fax (952) 746-4383

PATIENT INFORMATION

Patient's Name: *(Last)* *(First)* *(Middle)*	Birth Date:	Age:	Spouse's Name:
Home Address:	City:	State:	Zip Code:
Patient's Social Security Number:	Home Phone:	Gender:	Marital Status *(Circle One):* Married Divorced Widowed Single
Patient's Employer:	Work Phone Number:	Emergency Phone Number:	Occupation:

RESPONSIBLE PARTY INFORMATION

Responsible Party Name: *(Last)* *(First)* *(Middle)* *(DOB)*	Responsible Party Home Phone Number:
	Responsible Party Social Security :
Responsible Party Address: *(City)* *(State)*	Responsible Party Employer :

INSURANCE INFORMATION

Primary Insurance:	Subscriber(s) Policyholder's Name/DOB:	Contract No: Identification No:
Insurance Company Address:	Relationship to Responsible Party: Self Spouse Son Daughter *(Circle One)*	
Secondary Insurance:	Subscriber(s) Policyholder's Name:	Contract No: Identification No:
Insurance Company Address:	Relationship to Responsible Party: Self Spouse Son Daughter *(Circle One)*	

RECORDS RELEASE:
I hereby authorize the release of any information (Medical and billing) by West End Consultation Group, to my insurance company on behalf of myself as needed for payment and continued treatment

Signed: _____ Date: _____

ASSIGNMENT OF BENEFITS:
I herby authorize payment of medical benefits to West End Consultation Group, for services rendered to myself and/or dependents.

Signed: _____ Date: _____

_____ _____

A COPY OF THIS AUTHORIZATION SHALL BE VALID AS THE ORIGINAL: I understand that I am financially responsible for charges not covered by the assignment of benefits above and that if this illness be such that it is not covered by the policy contract, I will be responsible for making payments of the entire bill. I understand that there will be a 1% finance charge monthly, 12% annually, as well as collection fees added to my bill if this account is not paid within 90-days.

Signature of Responsible Party: _____ Date: _____

West End Consultation Group

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MISSED APPOINTMENT AND CANCELLATION POLICY

For the convenience of all our patients and staff, we respectfully request that you cancel your scheduled appointment a minimum of 24 hours in advance (Saturdays and Sundays hours are not included in this calculation). (For example, if you need to schedule an appointment scheduled for Monday at 10:00am, you will need to cancel on Friday the week before at 10:00am at the latest, in order to avoid the late cancellation fee.) Receiving cancellation information in advance allows us to schedule and to serve other patients.

We recognize that unforeseen circumstances can arise and appointments cannot be canceled in advance. With that in mind, we ask that you leave your cancelation message 24hrs in advance. We will forgive a single missed appointment as a courtesy. However, after one missed appointment or late cancellation you will be charged the fee for that appointment. This fee is not covered by insurance carriers and will be your responsibility to pay before your next visit.

We reserve the right to dismiss patients from our practice after two missed appointments in any 12 month period.

By signing below I agree that I have read and understand the above policy on missed appointments.

Printed Name:_____

Signature:_____Date:_____

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CONTRACT FOR TREATMENT WITH CONTROLLED MEDICATIONS

The purpose of this contract is to protect your treatment with controlled medications and to protect our prescriber's ability to prescribe controlled medications.

Your physician or nurse practitioner may be prescribing you medications that have been classified by the Drug Enforcement Agency (DEA) as having the potential of producing dependence and addiction. State and federal laws prohibit the transfer of these medications to any other person. Furthermore, the controlled medications should be kept in the bottle dispensed by the pharmacist.

No telephone or fax refills will be allowed for controlled substances except for extreme emergencies. If the prescribed medications are stolen or lost they will not be replaced. You must keep all controlled out of reach of children, preferably locked away. You must not keep controlled substances in your car. **You MUST be seen to get a new prescription, and No early refills or changes in your medication will be allowed**. You must keep your scheduled appointment in order to receive controlled substances. To continue with controlled substances you are required to be examined on a regular basis. It is your responsibility to make your appointment in advance.

All your medications should be filled at the same pharmacy. Any misuse or abuse of medications will result in termination of services. Should you need to consult other physicians, you must let your West End Consultation Group (WECG) prescriber know what (if any) other medications were prescribed and who prescribed them. You may be required to give, at random, a urine specimen, blood test, or saliva test to determine that you are not using any other addicting substances and that you are taking your medication as prescribed. Your long-term goal in treatment is to continue to explore the use of non-addicting medications.

The risks and potential benefits for treatment with controlled medications have been fully explained to me, and are understood, including but not limited to physical dependency, addiction, withdrawal, and over-dosage. I am aware that attempts to obtain a controlled medication under false pretense is illegal. I understand that tampering with a written prescription is a felony. I will not alter my doctor's prescription at any time for any reason, as it is unlawful to do so.

My signature denotes that I fully understand this contract and am willing to abide by these rules. I understand that failure to comply with this Contract will result with my being discharged from care at WECG with a thirty day notice to find another health provider. I also acknowledge that I was given a copy of this contract.

Patient Name:_____Date of Birth: _____

_____

Patient Signature Date

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INSURANCE COVERAGE AND DENIAL OF PSYCHIATRIC MEDICATIONS

Approximately 30% of the psychiatric medications recommended as the best medication option for patient's conditions are denied coverage by the patient's insurance. All efforts are made at our clinic to recommend medications covered by a patient's insurance if the covered medication is appropriate and the best option for a patient's condition and symptoms. If the insurer denies coverage on a medication that we recommend, we work with patients to find alternatives that are covered by their insurance.

If a medication prescribed by one of our prescribers is denied coverage by your insurance plan, we will contact you to set an appointment with your prescriber to find an alternative medication that that is on your insurance plan's covered medication list. If no good alternative is found on the covered medication list, your prescriber will work with you to complete the Prior Authorization at an appointment. Doing Prior Authorizations accurately requires review of history in order to accurately document response to prior medications and to document other justifications for recommending the medication your insurer denied. Your input will be needed for accurate completion of the Prior Authorization form or completion of the Prior Authorization phone call if you and prescriber decide that there are no good treatment options for your condition from your insurer's list of covered medications.

To help make informed medication decisions at your appointments, please plan ahead by bringing an updated copy of your insurance list of covered medications.

By signing below I agree that I have read and understand the above policy on insurance medication coverage and denials.

Printed Name:_____

Signature:_____Date:_____

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Authorization for Release/Exchange of Information

This form provides your providers at West End Consultation Group with written permission to communicate between each other regarding your treatment. The exchange of information between providers at WECG is for providing optimal care. Examples of the need for exchange of your treatment information between the providers at WECG include, but are not limited to:

- Coordination of Care between your therapist and prescriber
- Coverage of care by other providers when on call
- Consultation between the providers for guidance and collaboration on best treatment options

I_____ _____
Patient Name DOB

hereby authorize the release and/or exchange of information about my care between the providers at West End Consultation Group.

Information to be Released or Exchanged
(check all that apply)

☐ Intake and history
☐ Treatment Progress
☐ Diagnosis and Treatment Plan
☐ Psychiatric Progress Notes
☐ Therapy Progress Notes
☐ Psychological Test Reports
☐ Medical History
☐ Laboratory Reports
☐ Verbal Consultation
☐ Billing & Payment
_____ Other (specify)_____
☐ All of the Above

This release shall be valid until the termination of treatment or until withdrawn in writing by the patient during the course of treatment.

_____ _____ _____
Signature of Patient Printed name Date

_____I have received a copy of this signed authorization: (please initial):_____yes ☐ no_____ ☐

West End ConsultationGroup

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In order to facilitate your care, we have developed certain policies and procedures that we feel are important in establishing a working partnership. Please read this document carefully and initial each item below to acknowledge your understanding. Your signature is required for treatment to commence. Thank you.

PRESCRIPTION POLICY

Our office receives a large-volume of calls and faxes daily for medication refill requests. Many refill requests are a result of an increase in auto-refill requests being sent by pharmacies. Many refill requests come from patients who do not schedule a follow-up appointment within the recommended time for a follow-up. Many other refill requests come from patients who cancel follow-up appointments without rescheduling another follow-up within the time frame to prevent an interruption in medications.

All refill requests must be reviewed for accuracy and documented in the patient chart prior to authorizing the refill. Please help keep your care running smoothly by tracking how much medication you have and how many refills remain on the prescription, and ensure you have an appointment to see the doctor before you're out of medication.

Follow-up appointments are needed to appropriately assess your condition and the impact of any medications prescribed. Even if a patient responds favorably to a medication addition/change, a follow-up appointment is necessary to appropriately assess the impact of the medication addition/change. At the follow-up appointment assessments are made to determine if continuing medications are the appropriate course of treatment.

Please initial the following prescription policies below.

_____No medications will be prescribed if you have not been seen in SIX months. Your chart will be closed and in order to reopen it you will need to attend an appointment.

_____Auto-refills will be denied. Ask your pharmacy to take your prescriptions off of auto-refill

_____A $50 fee will be charged to replace each lost or stolen prescription for a controlled substance and may be grounds for terminating from the practice.

_____There is no guarantee urgent requests for refills (technically new prescriptions) that are made outside of appointments will be met. Refills may be denied if appointment has been missed or is overdue. Patients who repeatedly request refills (technically new prescriptions) outside of appointments may be discharged from the practice

_____If a medication is refilled outside of an appointment, a $50 fee will be charged for each medication refill outside of appointments. If a medication refill is authorized outside of an appointment, there will only be an authorization for enough medication to provide sufficient medication until a follow-up appointment is attended, with a maximum quantity for 4 weeks. A follow-up appointment must be attended within 4 weeks so a medication can be continued beyond this.

The recommended time for a follow-up appointment is discussed at the appointment. Recommendations for a time until a follow-up appointment are based on medical judgment and the usual and customary standards of care. Your input about the time for a follow-up appointment is appreciated and taken into consideration. Please help keep your care running smoothly by making your follow-up appointments at the end of your appointment, with the follow-up appointments scheduled no later than the time-frame recommended at the appointment. If an appointment needs to be rescheduled, please make certain to reschedule your appointment before your medication runs out. Please plan ahead when needing to reschedule as a late cancellation may limit appointment availability. Medication refills may not be authorized for late cancellations of appointments

Patient Name:_____Date of Birth:_____

_____

Patient Signature Date

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Authorization for Release/Exchange of Health Care Information

I_____ _____
Patient Name DOB

hereby request and authorize the exchange of information about my care as I have initialed below between the providers at West End Consultation Group and

Name:_____At_____

Address:_____

City, State:_____Zip code:_____

Information to be Released or Exchanged (Initial all that apply)

_____ Emergency Room/Urgent Care Records
_____ Hospital Records, including progress notes and admission and discharge summaries
_____ Outpatient and Clinic Medical Records and Progress Notes
_____ Initial Psychiatric Evaluation records
_____Psychiatric Progress Notes
_____Therapy Progress Notes
_____Psychological Test Reports
_____Medical History
_____Laboratory Reports
_____ Verbal Consultation
_____ Billing & Payment statements and records
_____Consultation Reports
_____Other (specify)_____

Purpose(s) of this consent: By signing this form, you will consent to our use and disclosure of you protected health information to carry out treatment, payment activities, and health care operations.

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to West End Consultation Group.

I understand that my records are protected by state and federal data privacy regulations, and that alcohol, and drug abuse records may be further protected by Federal Law (42CFR Part 2); these records cannot be released without my consent unless specifically directed by law

I understand that I have the right to refuse to sign this consent

I understand that this consent does not specifically authorize the re-disclosure of the information received from other sources, unless I authorize it

This release shall be valid until the termination of treatment or until withdrawn in writing by the patient during the course of treatment.

_____

Signature of Patient Printed name Date

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Billing/Payment Policy

West End Consultation Group (WECG) is dedicated to providing you with high quality mental health care. We are in network providers with several insurance companies and will submit invoices to them for payment on your behalf.

1. Clients wishing to use insurance benefits need to provide West End Consultation Group with their current insurance information when scheduling the first appointment. You will be requested to send a copy of your insurance card at the time you schedule your appointment.
2. Verification of benefits is not a guarantee of payment and it is the clients' responsibility to call the customer service number on the back of their insurance card to have a full understanding of what services are covered. Please contact your insurer prior to your first appointment in order to understand your benefits.
3. It is also the clients' responsibility to notify WECG of any insurance changes. Failure to do so, which could result in a claim denial, will then be the responsibility of the client to pay.
4. It is your responsibility to know your co-pay, deductible, and co-insurance prior to your initial appointment.
5. West End Consultation Group does not do Single Case Agreements with insurers for appointments. If we receive Single Case Agreement forms from your insurer, you will need to pay for your appointments and send receipt for your payment to the insurer for reimbursement.
6. The fees for appointments with the different providers at WECG will be provided upon request. Payments are accepted by means of check, cash, or credit card. A NSF fee of $40.00 will be collected on all returned checks.
7. CO-PAYMENTS, in the form of check, cash, or credit card must be made at the time of service. We cannot waive co-pays, co-insurance or deductibles.
8. If your insurance company requires a co-insurance and/or deductible to be paid by you, this amount is due when the claim is processed. WECG requires a credit card on file for all clients with a deductible and/or co-insurance. Your credit card, encrypted and stored securely, will be charged at the end of the month for any unpaid balance in that account billing cycle.
10. Clients have the option to pay their WECG balances online by going to the WECG website.
11. Statements will be provided to clients monthly with balances due and payment is required upon receipt. Services may be temporarily interrupted for past due balances until arrangements for payment is made.

My signature below means that I understand and agree with all of the points above.

Patient Name:_____Date of Birth:_____

_____

Patient Signature Date

WEST END CONSULTATION GROUP

1550 Utica Ave S

St. Louis Park, MN 55416

HIPAA Notice of Privacy Practices

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

We respect your privacy,and work very hard to maintain the confidentiality of your treatment with us and of your records. We will not disclose your information to others unless you tell us to do so, or unless the law authorizes or requires us to do so .

This information will include Protected Health Information (PHI), as defined by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and by Minnesota state law related to health care access and disclosure.

The law protects the privacy of the health information we create and obtain in providing care and services to you. For example, your protected health information includes your symptoms, test results, diagnoses, treatment, health information from other providers, and billing and payment information relating to these services. Federal and state law allows us to use and disclose your protected health information for purposes of treatment and health care operations. State law requires us to get your authorization to disclose this information for payment purposes.

Examples of Use and Disclosures of Protected Health Information for Treatment, Payment, and Daily Operations

For treatment:

Information obtained will be recorded in your medical record and used to help decide what care may be right for you. We may also provide information to others providing your care. This will help them stay informed about your care . For example, we may share your medical information with other physicians and health care providers, hospitals, rehabilitation therapists, laboratories, nurse case managers, worker's compensation adjusters, etc. to ensure that the medical provider has the necessary medical information to diagnose and provide treatment to you.

For payment:

Unless you pay us directly for your care, we request payment from your health insurance plan. Health plans need information from us about your medical care. Information provided to health plans may include your diagnoses, treatments recommended, and prescriptions provided.

Daily Operations:

We may call you by your first name in the waiting room when your provider is ready to see you. We may use or disclose your Protected Health Information, as necessary, to contact you to remind you of your appointment

- We use your medical records to assess quality and improve services
- We may use and disclose your information to conduct or arrange for services, including:
- medical quality review by your health plan ;
- accounting, legal, risk management, and insurance services;
- audit functions, including fraud and abuse detection and compliance programs.

<u>Disclosures without Authorization</u>

We may use and disclose your protected health information without your authorization as follows:

- **To Report Suspected Abuse or Neglect** to public authorities.
- **To Comply With Workers' Compensation Laws** if you make a workers' compensation claim.
- **For Public Health and Safety Purposes as Allowed or Required by Law** to prevent or reduce a serious, immediate threat to the health or safety of a person or the public; to public health or legal authorities; to protect public health and safety; to prevent or control disease, injury, or disability; to report vital statistics such as births or deaths.
- **Business Associates**: We may share health information about you with business associates who are performing services on our behalf. For example, we may contract with a company to serve and maintain our computer systems, or to do our billing, or to physicians or therapists who are covering for West End Consultation Group providers. Our business associates are obligated to safeguard your health information. We will share with our business associates only the minimum amount of personal health information necessary for them to assist us. Please know and understand that all of our business associates are obligated to comply with the same HIPAA privacy and security rules in which we are obligated.
- **For Disaster Relief Purposes.** For example, we may share health information with disaster relief agencies to assist in notification of your condition to family or others.
- **Food and Drug Administration:** We may disclose health information about you to the FDA, or to an entity regulated by the FDA, in order, for example, to report an adverse event or a defect related to a drug or medical device.
- **For Health and Safety Oversight Activities.** For example, we may share health information with the Department of Health.

- **Judicial or Administrative Proceedings:** We may disclose health information about you in the course of a judicial or administrative proceeding, in accordance with our legal obligations. As sometimes required by law, we may disclose your Protected Health Information for the purpose of litigation to include: disputes and lawsuits; in response to a court or administrative order; response to a subpoena; request for discovery; or other legal processes. However, disclosure will only be made if efforts have been made to inform you of the request or obtain an order protecting the information requested. Your information may also be disclosed if required for our legal defense in the event of a lawsuit.
- **For Law Enforcement Purposes** such as when we receive a subpoena, court order, or other legal process, or you are the victim of a crime.
- **To Coroners, Medical Examiners, Funeral Directors.** We may disclose health information to a coroner or medical examiner to identify a deceased person and determine the cause of death. In addition, we may disclose health information to funeral directors , as authorized by law, so that they may carry out their jobs.
- **Practice Ownership Change:** If our medical practice is sold, acquired, or merged with another entity, your protected health information will become the property of the new owner. However, you will still have the right to request copies of your records and have copies transferred to another physician.
- **For Specialized Government Functions.** For example, we may share information for national security purposes.
- **Public Safety:** Consistent with our legal and ethical obligations, we may disclose health information about you based on a good faith determination that such disclosure is necessary to prevent a serious and imminent threat to the public or to identify or apprehend an individual sought by law enforcement, or and individual who may pose a threat to himself or others.
- **To Correctional Institutions** if you are in jail or prison, as necessary for your health and the health and safety of others.
- **For Work-Related Conditions That Could Affect Employee Health.** For example, an employer may ask us to assess health risks on a job site.
- **To the Military Authorities of U.S. and Foreign Military Personnel.** For example, the law may require us to provide information necessary to a military mission.
- **In the Course of Judicial/Administrative Proceedings** at your request, or as directed by a subpoena or court order.
- **Organ and Tissue Donations.** If you are an organ donor, we may use or disclose health information to organizations that help procure, locate and transplant organs in order to facilitate an organ, eye or tissue donation and t ransplant at ion.
- **Incidental Disclosures.** We may use or disclose health information incident to a use or disclosure permitted by the HIPAA Privacy Rule so long as we have reasonably safeguarded against such incidental uses and disclosures and have limited them to the minimum necessary information.
- **Limited Data Set Disclosures.** We may use or disclose a limited data set (health information that has certain identifying information removed) for purposes of research, public health, or health care operations. This information may only be disclosed for research, public health and health care operations purposes. The person receiving the information must sign an agreement to protect the information .

Uses and disclosures not in this Notice will be made only as allowed or required by law or with your written authorization

Your Health Information Rights

The health and billing records we create and store are the property of West End Consultation Group. The protected health information in it, however, generally belongs to you . You have a right to:

- Receive, read, and ask questions about this Notice.
- Ask us to restrict certain uses and disclosures. You must deliver this request in writing to us and we will try to comply with any request made;
- Request and receive from us a paper copy of the most current Notice of Privacy Practices for Protected Health Information .
- You have the right to obtain an electronic copy of medical records: You have the right to request an electronic copy of your medical record for yourself or to be sent to another individual or organization when your Protected Health Information is maintained in an electronic format. We will make every attempt to provide the records in the format you request; however, in the case that the information is not readily accessible or producible in the format you request, we will provide the record in a standard electronic format or a legible hard copy form. Record requests may be subject to a reasonable, cost based fee for the work required in transmitting the electronic medical records
- Have us review a denial of access to your health information-except in certain circumstances
- You have the right to request Amendments. At any time if you believe the Protected Health Information we have on file for you is inaccurate or incomplete, you may request that we amend the information. Your request for an amendment must be submitted in writing and detail what information is inaccurate and why. Please note that a request for an amendment does not necessarily indicate the information will be amended.
- When you request, we will give you a list of disclosures of your health information. The list will not include disclosures to third-party payers. You may receive this information without charge once every 12 months. We will notify you of the cost involved if you request this information more than once in 12 months.
- Ask that your health information be given to you by another means or at another location. Please sign, date, and give me your request in writing.
- Cancel prior authorizations to use or disclose health information by giving us a written revocation.

Your revocation does not affect information that has already been released. It also does not affect any action taken before we have it. Sometimes, you cannot cancel an authorization if its purpose was to obtain insurance.

Our Responsibilities

We are required to:

- Keep your protected health information private
- Give you this Notice
- Follow the terms of this Notice. We have the right to change our practices regarding the protected health information we maintain . If we make changes, we will update this Not ice. You may receive the most recent copy of this Notice by calling and asking for it, by viewing it on our website, or by visiting my office to pick one up.

To Ask for Help or to Register a Complaint: If you believe your privacy rights have been violated, you may file a written complaint by mailing it to us at West End Consultation Group at address above. Or if you wish to file a complaint with the Secretary of the United States Department of Health and Human Services, please go to the website of the Office for Civil Rights (www.hhs.gov/ocr/hipaa/), call 202-619-0257 (toll free 877-696-6775)

Patients' Acknowledgment of Receipt of Notice of Privacy Practice

West End Consultation Group
1550 Utica Ave S Ste 450
St. Louis Park, MN 55416

Patient Name:_____ Birth Date:_____

Patient Signature:_____ Date:_____

Patients' Consent to send information to insurance company:

By signing this form, I consent to and authorize West End Consultation Group to send my bills for medical care and treatment to my insurance company or other payor, to the extent my insurance company, or other payor, is required to pay the bill under the terms of my insurance policy or by law.

Patient Signature:_____ Date:_____

PHQ-9

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things	☐	☐	☐	☐
Feeling down, depressed, or hopeless	☐	☐	☐	☐
Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
Feeling tired or having little energy	☐	☐	☐	☐
Poor appetite or overeating	☐	☐	☐	☐
Feeling bad about yourself—or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
Moving or speaking so slowly that other people could have noticed. Or the opposite—being so fidgety or restless that you have been moving around a lot more than usual	☐	☐	☐	☐
Thoughts that you would be better off dead, or of hurting yourself in some way	☐	☐	☐	☐
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?	☐	☐	☐	☐
Totals				

GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all =0	Several days =1	More than half the days =2	Nearly every day =3
Feeling nervous, anxious or on edge	☐	☐	☐	☐
Not being able to stop or control worrying	☐	☐	☐	☐
Worrying too much about different things	☐	☐	☐	☐
Trouble relaxing	☐	☐	☐	☐
Being so restless that it is hard to sit still	☐	☐	☐	☐
Becoming easily annoyed or irritable	☐	☐	☐	☐
Feeling afraid as if something awful might happen	☐	☐	☐	☐
Totals				