LoCiceroHealth

Adult Psychiatry New Patient Forms

Please do not mail or fax this form.
Bring it with you to your appointment.

.

Patient Name: _____

Address: _____
Street **City** **State** **ZIP Code**

Email address: _____

Home phone: (_____) _____ **Cell phone**: (_____) _____

Date of Birth: _____ **Sex**: M / F **Marital status:** _____

Social Security #: _____ **Driver License #:**_____

Student: Y / N **If yes:** Full- or Part-time **Are you Hispanic or Latino:** Y / N

Circle one or more of the following groups in which you consider yourself to be a member:

American Indian or Alaska Native Black or African American Native Hawaiian or Pacific Islander

Asian White or Caucasian Unknown Prefer not to respond

Languages Spoken: English Spanish Other: _____

Occupation: _____

Employer: _____

Address: _____
Street **City** **State** **ZIP Code**

Phone: (_____) _____ **Extension:** _____

Emergency Contact: _____

Relationship to patient:_____

Primary phone: (_____) _____ **Alternate phone**: (_____) _____

Address: _____
Street **City** **State** **ZIP Code**

Primary Insurance Company: _____

Claims Address: _____
Street City State ZIP Code

Name of Insured: _____ **ID # of Insured:** _____

Group # of Insured: _____ **Relationship to Insured**: _____

Date of Birth of Insured: _____ **Social Security # of Insured:** _____

Secondary Insurance Company: _____

Claims Address: _____
Street City State ZIP Code

Name of Insured: _____ **ID # of Insured**: _____

Group # of Insured: _____ **Relationship to Insured**: _____

Date of Birth of Insured: _____ **Social Security # of Insured**: _____

AUTHORIZATION TO RELEASE INFORMATION AND ASSIGNMENT OF BENEFITS

I authorize the release of any medical information necessary to process this claim. I permit a copy of this authorization to be used in place of the original.

Date: _____ **Signature:** _____

I hereby authorize LoCicero Health to apply for benefits on my behalf for covered services rendered. I request that payment from my insurance company be made to LoCicero Medical Group or to the party who accepts assignment.

I certify the information I have provided with regard to my insurance is correct.

I permit a copy of this authorization to be used in place of the original. This authorization may only be revoked by either me or my insurance company in writing.

Date: _____ **Signature:** _____

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand that I will be responsible for payment of any allowable charge that my insurance coverage does not pay. I also understand that I will be responsible for services rendered that are not considered a covered benefit by my insurance company.

Date: _____ **Signature:** _____

PATIENT SELF DETERMINATION ACT QUESTIONNAIRE

In order to comply with the Omnibus Budget Reconciliation Act of 1990 and Chapter 745, Florida Statutes, please answer the following questions.

Declaration to Decline Life-Prolonging Procedure (LIVING WILL)

( ) I HAVE MADE SUCH A DECLARATION.

( ) I HAVE **NOT** MADE SUCH A DECLARATION.

Health Care Surrogate

( ) I HAVE DESIGNATED A HEALTH CARE SURROGATE.

( ) I HAVE **NOT** DESIGNATED A HEALTH CARE SURROGATE.

Durable Power of Attorney

( ) I HAVE APPOINTED A DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

( ) I HAVE **NOT** APPOINTED A DURABLE POWER OF ATTORNEY FOR HEALTH CARE DECISIONS.

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT.

Signature of Patient or Representative Date

I have been provided with information regarding the PATIENT SELF DETERMINATION ACT, but decline to answer the above questions.

Signature of Patient or Representative Date

YEARLY RECONFIRMATION

I acknowledge that this information remains accurate.

Signature of Patient	Date	Signature of Patient	Date
Signature of Patient	Date	Signature of Patient	Date
Signature of Patient	Date	Signature of Patient	Date

LoCicero Health Psychiatry

110 South MacDill Ave
Suite 300
Tampa, FL 33609
Phone: 813.876.7073
Fax: 813.877.1277
lociceromedicalgroup.com

Date of Appointment: _____
Age: _____

Today's Date: _____

Adult Patient History Questionnaire

Name:
Preferred Name:
Date of Birth:

Referred By:

What Are Your Concerns That Brought You In Today?

Please Check All Symptoms That You Are Currently Experiencing:

☐ Sad Mood	☐ Racing Thoughts	☐ Panic Attacks	☐ Excessive Dieting
☐ Low Energy/Fatigue	☐ Concentration/Memory Difficulties	☐ Fear of Leaving the House	☐ Focused on Body Weight or Image
☐ Hopelessness	☐ Increased/Decreased Sexual Interest	☐ Fear of Driving	☐ Change in Weight

☐ Guilt	☐ Decreased Appetite	☐ Fear of Specific Situations/Things	History of Trauma/Victim of Abuse ☐
☐ Worthlessness	☐ Increased Appetite	☐ Fear of Being in Public	☐ Offender of Abuse
☐ Crying Spells	☐ Difficulty Falling Asleep	☐ Upsetting Thoughts	☐ Hearing Voices Others Do Not
☐ Decreased Motivation	☐ Excessive Sleeping	☐ Repetitive Thoughts or Behaviors	☐ Seeing Images Others Do Not
☐ Loss of Interest in Usual Activities	☐ Early Morning Waking	☐ Excessively Orderly or Perfectionistic	☐ Bizarre Ideas
☐ Irritability	☐ Suicidal Thoughts	☐ Periods of "Lost" Time	☐ Recent Upsetting Change or Loss
☐ Hyperactivity	☐ Thoughts of Harming Others	☐ Excessive Anger / Aggressiveness	☐ Alcohol Abuse
☐ Impulsiveness	☐ Self Harm/Cutting	☐ Difficulty Trusting Others	☐ Drug Abuse
☐ Elevated Mood	☐ Anxious/Worried	☐ Binge Eating / Purging	☐ Overuse of Prescription Medication

Medications: Please list all medications or supplements that you are **currently** taking.
Include psychiatric and medical medications.

Medication	**Dose** *(mg, units,mL, etc)*	**Doses per day** *(AM, twice daily, at bedtime, etc)*
1.		
2.		
3.		
4.		
5.		
6.		

Have you experienced a head injury? If so, please explain what happened, your age, and if you were unconscious:_____

_____

_____

_____

Primary Care Physician:
Clinic Address and Phone Number:

Current Medical Diagnoses *i.e. asthma, diabetes, seizures, etc*	Treatment?
1.	
2.	
3.	
4.	

Previous Surgeries	Approximate Date	Location/Hospital
1.		
2.		
3.		

Previous Hospitalizations	Approximate Date	Location/Hospital
1.		
2.		
3.		

Medication Allergies:
Food Allergies:

Past Psychiatric History

Have you ever seen a psychiatrist? If so, please provide information about providers, dates, and treatment rendered.

_____

_____

_____

Have you ever seen a psychologist?

_____

_____

_____

Have you ever seen a therapist (*i.e. LMHC, LCSW, LMFT*)?

Have you ever been hospitalized for psychiatric reasons? If so, where and when?

Developmental History:

Any Learning Disabilities (*i.e. reading, dyslexia, writing, math, etc)*?:

Attended Special Education Classes?:

Received Any Developmental Services (*i.e. physical, speech, occupational therapy, etc*)?:

Social History:

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered

Lives With (Name, Age, and Relation to Yourself):

Highest Grade Attended:

Occupation and Employment (*specialty, where you work, and how long*):

Military history:

Arrest History or Pending Legal Issues (*i.e. divorce, disability, bankruptcy, etc)*:

Family History: Please indicate if there is a family history of the following conditions and **WHO** is affected with the condition.

Anxiety	Heart disease
Depression	Sudden cardiac death
Bipolar disorder	Cancer
ADHD	Alcoholism
Autism	Drug abuse
Eating Disorders	Thyroid problems
Learning disabilities	Seizures
Other psychiatric conditions?	Other medical conditions?

Substance Abuse History: Please circle all that you have used in the past 2 years:

Alcohol Frequency of use:	Marijuana (weed) Frequency of use:
Cocaine (crack, coke) Frequency of use:	Tobacco Frequency of use:
Opiates (heroin, pain killers, methadone) Frequency of use:	Benzodiazepines (Xanax, Klonipin, Ativan, Valium) Frequency of use:
MDMA (ecstasy) Frequency of use:	LSD (acid, hallucinogens) Frequency of use:
Over the Counter (cough syrup, triple C's) Frequency of use:	Bath Salts, Spice, K2 Frequency of use:
Amphetamines (speed, Adderall, Ritalin) Frequency of use:	Inhalants (dusters, whip its) Frequency of use:

Other: Frequency of use:	Other: Frequency of use:

In the past two years, there have been one or more episodes of memory loss due to substance abuse?

Yes ☐ **or No** ☐

There are personality changes due to the use of substances. **Yes** ☐ **or No** ☐

In the past 5 years, there has been one or more arrest due to substance or alcohol use? **Yes** ☐ **or No** ☐

Someone close to you thinks you may have a serious substance abuse problem. **Yes** ☐ **or No** ☐

There is a history of serious problems with the use of substances. **Yes** ☐ **or No** ☐

There is a history of substance abuse treatment. **Yes** ☐ **or No** ☐

Past Psychiatric Medication

Anti Depressants	**Response (Good, Fair, Poor)**	**Antipsychotic**	**Response (Good, Fair, Poor)**
Amitriptyline (Elavil)		Olanzapine (Zyprexa)	
Bupropion (Wellbutrin)		Perphenazine (Trilafon)	
Citalopram (Celexa)		Pimozide (Orap)	
Clomipramine (Anafranil)		Quetiapine (Seroquel)	
Desipramine (Norpramin)		Risperidone (Risperdal)	
Doxepin (Sinequan)		Asenapine (Saphris)	
Escitalopram (Lexapro)		Thioridazine (Mellaril)	
Fluoxetine (Prozac)		Thiothixene (Navane)	
Fluvoxamine (Luvox)		Trifluperazine (Stelazine)	
Imipramine (Tofranil)			
Mitrazapine (Remeron)		**Mood Stabilizers**	
Nefazodone (Serzone)		Carbamazepine (Tegretol)	
Nortriptyline (Pamelor)		Gabapentin (Neurontin)	
Paroxetine (Paxil)		Lamotrigine (Lamictal)	
Phenelzine (Nardil)		Lithium (Lithobid, etc)	
Dexvenlafaxine (Pristiq)		Topiramate (Topamax)	
Sertraline (Zoloft)		Valproic Acid (Depakote, etc)	
Tranylcypromine (Parnate)			
Trazodone (Desyrel)		**ADHD Medications**	
Venlafaxine (Effexor)		Amphetemine salts (Adderall, etc)	
		Clonidine (Kapvay, Catapres)	
AntiAnxiety		Dexmethylphenidate (Focalin)	

Alprazolam (Xanax)		Guanfacine (Intuniv, Tenex)	
Buspirone (Buspar)		Methylphenidate (Ritalin, Concerta, Daytrana, etc)	
Chlordiazepoxide (Librium)		Strattera (Atomoxetine)	
Clonazepam (Klonopin)		Vyvanse (Lisdexamfetamine)	
Clorazepate (Tranxene)			
Diazepam (Valium)		**Miscellaneous**	
Flurazepam (Dalmane)		Thyroid (Synthroid, Cytomel)	
Hydroxyzine (Vistaril)		Dilantin (Phenytoin)	
Lorazepam (Ativan)		Propranolol (Inderal)	
Oxazepam (Serax)		Naltrexone (Revia)	
Temazepam (Restoril)		Benztropine (Cogentin)	
Triazolam (Halcion)		Trihexyphenidyl (Artane)	
Zolpidem (Ambien)		L-Dopa	
Antipsychotic			
Aripiprazade (Abilify)		**Other Medications**	
Fluphenazine (Prolixin)			
Haloperidol (Haldol)			
Lurasidone (Latuda)			

Record of Disclosures of Protected Health Information

Date	Disclosed To Whom Addressed or Fax No.	Description of Disclosure	By Whom Disclosed
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

LoCicero Health
2605 W. Swann Ave., Suite 600
Tampa, FL 33609
Tele: (813) 876-7073
Fax: (813) 877-1277

PRIVATE PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

PATIENT OF RECORD DISCLOSURES

In general, the HIPAA privacy rules give the individual the right to request a restriction on uses and disclosures of private information (PHI). The individual is also provided the right to request confidential communication of PHI, be made by alternative means, such as sending correspondence to the individual's office instead of home.

I wish to be contacted in the following many (check all that apply):

[ ] Home Telephone: _____
- [ ] O.K. to leave message with detailed information
- [ ] Leave message with call back number only

[ ] Work Telephone: _____
- [ ] O.K to leave message with detailed information

[ ] Written Communication
- [ ] O.K. to mail to my home address.
- [ ] O.K. to mail to my work/office address
- [ ] O.K. to fax to: _____

[ ] Other: _____

Name: _____ Date of Birth: _____

Signature: _____ Date: _____

The Privacy Rule generally requires healthcare providers to take responsible steps to limit the use of disclosure of PHI, and for the PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to the use made pursuant to an authorization requested by the individual. Healthcare entities must keep records of PHI disclosures. Information provided below, if completed properly, will provide adequate record.
Note: Uses and disclosures for TPO may be permitted without prior consent in emergency.

QUICK INVENTORY OF DEPRESSIVE SYMPTOMATOLOGY (SELF-REPORT)
(QIDS-SR)

NAME: _____ TODAY'S DATE _____

Please circle the one response to each item that best describes you for the past seven days.

1. Falling Asleep:

   0 I never take longer than 30 minutes to fall asleep.
   1 I take at least 30 minutes to fall asleep, less than half the time.
   2 I take at least 30 minutes to fall asleep, more than half the time.
   3 I take more than 60 minutes to fall asleep, more than half the time.

2. Sleep During the Night:

   0 I do not wake up at night.
   1 I have a restless, light sleep with a few brief awakenings each night.
   2 I wake up at least once a night, but I go back to sleep easily.
   3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.

3. Waking Up Too Early:

   0 Most of the time, I awaken no more than 30 minutes before I need to get up.
   1 More than half the time, I awaken more than 30 minutes before I need to get up.
   2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
   3 I awaken at least one hour before I need to, and can't go back to sleep.

4. Sleeping Too Much:

   0 I sleep no longer than 7-8 hours/night, without napping during the day.
   1 I sleep no longer than 10 hours in a 24-hour period including naps.
   2 I sleep no longer than 12 hours in a 24-hour period including naps.
   3 I sleep longer than 12 hours in a 24-hour period including naps.

5. Feeling Sad:

   0 I do not feel sad
   1 I feel sad less than half the time.
   2 I feel sad more than half the time.
   3 I feel sad nearly all of the time.

6. Decreased Appetite:

   0 There is no change in my usual appetite.
   1 I eat somewhat less often or lesser amounts of food than usual.
   2 I eat much less than usual and only with personal effort.
   3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

7. Increased Appetite:

   0 There is no change from my usual appetite.
   1 I feel a need to eat more frequently than usual.
   2 I regularly eat more often and/or greater amounts of food than usual.
   3 I feel driven to overeat both at mealtime and between meals.

8. Decreased Weight (Within the Last Two Weeks):

   0 I have not had a change in my weight.
   1 I feel as if I've had a slight weight loss.
   2 I have lost 2 pounds or more.
   3 I have lost 5 pounds or more.

9. Increased Weight (Within the Last Two Weeks):

   0 I have not had a change in my weight.
   1 I feel as if I've had a slight weight gain.
   2 I have gained 2 pounds or more.
   3 I have gained 5 pounds or more.

10. Concentration/Decision Making:

    0 There is no change in my usual capacity to concentrate or make decisions.
    1 I occasionally feel indecisive or find that my attention wanders.
    2 Most of the time, I struggle to focus my attention or to make decisions.
    3 I cannot concentrate well enough to read or cannot make even minor decisions.

11. View of Myself:

    0 I see myself as equally worthwhile and deserving as other people.
    1 I am more self-blaming than usual.
    2 I largely believe that I cause problems for others.
    3 I think almost constantly about major and minor defects in myself.

12. Thoughts of Death or Suicide:

    0 I do not think of suicide or death.
    1 I feel that life is empty or wonder if it's worth living.
    2 I think of suicide or death several times a week for several minutes.
    3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

13. General Interest:

    0 There is no change from usual in how interested I am in other people or activities.
    1 I notice that I am less interested in people or activities.
    2 I find I have interest in only one or two of my formerly pursued activities.
    3 I have virtually no interest in formerly pursued activities.

14. Energy Level:

    0 There is no change in my usual level of energy.
    1 I get tired more easily than usual.
    2 I have to make a big effort to start or finish my usual daily activities (for example, shopping, homework, cooking or going to work).
    3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

15. Feeling slowed down:

    0 I think, speak, and move at my usual rate of speed.
    1 I find that my thinking is slowed down or my voice sounds dull or flat.
    2 It takes me several seconds to respond to most questions and I'm sure my thinking is slowed.
    3 I am often unable to respond to questions without extreme effort.

16. Feeling restless:

    0 I do not feel restless.
    1 I'm often fidgety, wringing my hands, or need to shift how I am sitting.
    2 I have impulses to move about and am quite restless.
    3 At times, I am unable to stay seated and need to pace around.

<u>To Score</u>:

1. Enter the highest score on any 1 of the 4 sleep items (1-4) ____
2. Item 5 ____
3. Enter the highest score on any 1 appetite/weight item (6-9) ____
4. Item 10 ____
5. Item 11 ____
6. Item 12 ____
7. Item 13 ____
8. Item 14 ____
9. Enter the highest score on either of the 2 psychomotor items (15 and 16) ____

TOTAL SCORE (Range 0-27) ____

Scoring Criteria	
0–5	Normal
6–10	Mild
11–15	Moderate
16–20	Severe
≥21	Very Severe

Revised 5/1/00

LIMITS ON CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a physician. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. There are other situations that require only that you provide written, advance consent. Your signature on this agreement provides consent for those activities as follows:

- Disclosures required by health insurers or to collect overdue fees are discussed elsewhere in this agreement.
- If a patient threatens to harm himself/herself, I may be obligated to seek hospitalization for him/her, or to contact family members or others who can help provide protection.

There are some situations where I am permitted or required to disclose information without either your consent or authorization:

- If you are involved in a court proceeding and a request is made for information concerning your diagnosis and treatment, such information is protected by the physician-patient privilege law. I cannot provide any information without your written authorization, or a court order. If you are involved in or contemplating litigation, you should consult with your attorney to determine whether a court would be likely to order me to disclose information. Generally, it is not in your best interest to break your confidentiality
- If a government agency is requesting the information for health oversight activities, I may be required to provide it for them.
- If a patient files a complaint or a lawsuit against me, I may disclose relevant information regarding that patient in order to defend myself.

There are some situations in which I am legally obligated to take actions which I believe are necessary to attempt to protect others from harm and I may have to reveal some information about a patient's treatment. These situations are unusual in my practice.

- If I have reasonable cause to suspect child abuse or neglect, the law requires that I file a report with the Family Independence Agency. Once such a report is filed, I may be required to provide additional information.
- If I have reasonable cause to suspect the "criminal abuse" of an adult patient, I must report it to the police. Once such a report is filed, I may be required to provide additional information.
- If a patient communicates a threat of physical violence against a reasonably identifiable third person and the patient has the apparent intent and ability to carry out that threat in the foreseeable future, I may have to disclose information in order to take protective action. These actions may include notifying the potential victim (or, if the victim is a minor, his/her parents and the County Department of Social Services) and contacting the police, and/or seeking hospitalization for the patient.

If such a situation arises, I will make every effort to fully discuss it with you before taking any action, and I will limit my disclosure to what is necessary.

While these written exceptions to confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have

now or in the future. The laws governing confidentiality can be quite complex, and I am not an attorney. In situations where specific advice is required, formal legal advice may be needed.

If you become involved in legal proceedings that require my participation, you will be expected to pay for all of my professional time, including preparation and transportation costs, even if I am called to testify by another party. Because of the difficulties of legal involvement, I charge $1,000.00 per hour for preparation and attendance at any legal proceeding.

FORMS POLICY

We do not complete leave forms (from work or for disability) of any kind on patients who have not been established with the psychiatric practice for less than 6 months.

EMOTIONAL SUPPORT ANIMALS

We do not provide letters for emotional support animals.

MEDICATION MANAGEMENT

By working together, it is agreed upon that there will only be one clinician providing psychotropic medications. If psychotropic medications are prescribed by an outside provider that is not discussed with me, you will be discharged from my practice. If you begin taking controlled medications of any kind, it is your responsibility to notify me. If you are on a controlled medication, in-person office visits are required once yearly.

MINORS AND PARENTS

Patients under 18 years of age who are not emancipated and their parents should be aware that the law may allow parents to examine their child's treatment records. They should also be aware that patients over 14 years old can consent to and control access to information about their own treatment. While privacy in psychiatry is crucially important, particularly with teenagers, parental involvement is also essential to successful treatment. Therefore, it is usually my policy to request an agreement from any patient between 14 and 18 and his/her parents allowing me to share general information with parents about the progress of treatment and the child's attendance at scheduled visits. Any other communication will require the child's authorization, unless I feel that the child is in danger or is a danger to someone else, in which case I will notify the parents of my concern. Before giving parents any information, I will discuss the matter with the child, if possible, and do my best to handle any objections he/she may have.

SIGNATURE

Your signature below indicates that you have read the information in this document and agree to abide by its terms during our professional relationship.

Name (print) _____

Signature _____

Date of birth _____