WVU Medicine

BEHAVIORAL MEDICINE AND PSYCHIATRY

2004 PROFESSIONAL COURT
MARTINSBURG, WV 25401
(PHONE) 304-596-5780 (FAX) 304-596-5781

Office Policies

Insurance and Treatment Authorization

Required for All Appointments: At each visit you must bring your current insurance card, photo identification, and a method of payment. We accept cash, check, credit/debit cards. Failure to provide your insurance card with co-pay or payment in full (if no insurance) may result in your appointment being rescheduled. Additionally, please notify our staff of any address or insurance changes before your appointment.

Payment for Services: Payment for services rendered is required at the time of the visit***. We do not bill*** except under unusual circumstances that have been approved.

Insurance: We have made prior arrangements with many insurers and health plans. We will bill those plans with which we have an agreement and will collect any required co-payment at the time of service. In the event your health plan determines a service to be "NOT COVERED," you will be *responsible for the complete charge*. In that event, we will bill you and payment is due upon receipt of that statement.

Medicare: We will bill Medicare for you. We do accept Medicare assignment; however, the patient is responsible for the yearly DEDUCTIBLE plus the 20% Medicare doesn't pay if you do not have a secondary insurance.

Emergencies: Our office does not provide "emergency services." If the patient during the course of his/her treatment has an urgent concern, an appointment will be scheduled as soon as possible. If the patient has a critical emergency, he/she may need treatment in the hospital or emergency room, and will be referred for that purpose.

After Hour Calls: The office has an answering service that you may leave a message with after office hours. They will page the physician. We will call the *answering service* back and they will give him the message. He will then decide what action to take.

Cancellation Policy: Please notify our office ***24 hours in advance*** if an appointment will be missed to avoid being charged for the time that was reserved for you. ***Failure to show up for more than two appointments consecutively without notification will result in automatic termination and referral.***

****Controlled medications:** It is the policy here at WVU Medicine Behavioral Medicine and Psychiatry that the physician will not re-write any controlled medications before it is time for them to be filled again. It is *your* responsibility to maintain safeguard of your prescriptions once you leave the office. We *will not* make any exceptions.

Prescription refills: Please contact your pharmacist to request maintenance medication refills. If you do not have additional refills authorized, the pharmacy will need to fax a refill request to our office for approval. **Call your pharmacist at least five (5) business days ahead** of the need for a refill. Before we approve a refill request we will need to look at your chart, verify the proper dosage, check for the appropriate response to the drug, and see if any lab test is needed prior to filling your medication. If you have a prescription that has to be hand written, please call the office and make the request. There will be no refills approved Saturday, Sunday or holidays.

Confidentiality: Medical records are confidential. Information contained herein will not be released without written consent of the patient or guardian.

Documents/Forms to be filled out: Please allow at least ten **(10) days** for any documents/forms, etc. to be completed by the physician. If an address or fax number is provided to us as to where it needs sent, we will mail or fax the forms for you. Otherwise, we will call you when they are finished and ready to be picked up.

PATIENT AGREEMENT:

I have read the office policies and agree to abide by them.

I, the undersigned, hereby authorize examination and any other medical services deemed necessary by the Healthcare providers of WVU Medicine Behavioral Medicine and Psychiatry. I authorize the Healthcare providers of WVU MEDICINE Behavior Medicine and Psychiatry to release to my insurance company information concerning healthcare, advice, treatment, or supplies provided to me.

I, the undersigned, authorize payment of medical benefits to WVU MEDICINE for services rendered to me. I understand that I am financially responsible for any amount not covered by my insurance contract. I authorize release of information acquired in the course of my examination and treatment to any other Healthcare provider(s) involved in my care.

Medicare Authorization: I, the undersigned, authorize the Healthcare provider of WVU MEDICINE to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed to determine benefits payable for related services. I authorize the same information to be sent to my secondary insurance carrier. I authorize the payment of Medicare benefits to WVU MEDICINE Behavioral Medicine and Psychiatry for any services furnished to me.

Signature of patient or legal guardian:____**Date:**___________________________

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PLEASE PRINT

Patient Information: **Pharmacy Name and Town:**____

Patient Name: ____
Last First Middle Initial

Prior Last Names:____________________________________ Race: African American Asian Caucasian
Hispanic Native American Other

Social Security Number:________-________-________ Date of Birth: ________/________/________

Sex: M F T Marital Status: Single Married Divorced Widow Separated
Sexual Orientation: Heterosexual Homosexual Bisexual Asexual Questioning Other

Mailing Address:____ City:_________________________________

State: _______________ Zip: ________________ Email Address: ____
Phone: Home: ____ (permission to leave message? Yes or No)
Cell: ____ (permission to leave message? Yes or No)
Other: ____ (permission to leave message? Yes or No)

Preferred Contact Number: __________________________________ (permission to leave message? Yes or No)

Guarantor Information: (Person responsible for the payment. Parent /Guardian if under age 18)
Guarantor Name: ____
Last First Middle Initial
Guarantor relationship to patient: ____
Social Security Number:________-________-________ Date of Birth:________/________/________
Mailing Address:____ City:_________________________________
State: _______________ Zip: ________________ Phone: _______________________________________
Cell / Other: ___________________________________

Insurance Information:
Name of Primary Insurance:_________________________________ Policy ID Number:______________________

Subscriber Name:___________________________________ Subscriber Social Security #______-______-______
Subscriber relationship to patient:_____________________ Subscriber Date of Birth: ______/______/________
Insurance Address:____
Group Number:______________________________ Subscriber Employer / Group Name:___________________
Insurance Effective Date: ______/______/________Subscriber work status: FT PT Retired

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(Please fill out secondary insurance if applicable)

Insurance Information:

Name of Secondary Insurance:______________________________ Policy ID Number:______________________
Subscriber Name:__________________________________ Subscriber Social Security #______-______-______
Subscriber relationship to patient:____________________ Subscriber Date of Birth: ______/______/________
Insurance Address:____
Group Number:_____________________________ Subscriber Employer / Group Name:__________________
Insurance Effective Date: ______/______/________Subscriber work status: FT PT Retired

Emergency Contact Information:

Person to notify / Next of kin: ____
Last First Middle Initial

Mailing Address:____ City:_________________________________

State: ______________ Zip: _______________ Phone: _____________________________________

Relationship to Patient: ____

Protected Health Information Permission: **(Optional)**

I ____give WVU MEDICINE Behavioral Medicine and Psychiatry permission to disclose future appointments and protected health information with the person listed below:

Name:____ Phone Number:______________________

Patient Signature:____ Date:________________________

Patient Employer Information:

Work Status: FT PT Retired Unemployed FT Student PT Student

Employer Name:____

Mailing Address:____

City: ____________________________________ State:_______________________ Zip:___________________
Phone:__________________________________ Department:_________________________________

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BEHAVIORAL MEDICINE AND PSYCHIATRY
<u>Controlled Medications Agreement</u>

Patient Name (PRINT): ____Date of Birth: ___________________

Certain controlled medications (such as stimulants, benzodiazepines, and opiates) can be very useful in the treatment of some psychiatric conditions. However, these medications do have the potential for misuse/abuse. As a result, local, state, and federal agencies closely monitor these medications. This agreement will clearly define the conditions under which medications such as these will be prescribed.

Patient's Primary Care Provider:____

Medications Prescribed: ____

Prescribing Provider: ____

Patient's Pharmacy and Town:____

1. I understand that I am responsible for all of my controlled medications and prescriptions for such medications. If my prescription is lost, misplaced, stolen, confiscated, etc., it cannot be re-written. If my medication is lost, misplaced, stolen, used up early, confiscated, etc., it cannot be replaced.
2. I understand that all of my symptoms may not be relieved by the medication, and that the medication may be discontinued if it causes and deterioration in my functioning.
3. I understand that these medications are intended to be part of an overall treatment plan, not as a substitute for other therapeutic recommendations. Therefore, I agree to follow any and all recommendations made by my provider to the best of my ability; this includes keeping all scheduled appointments with my provider and following up promptly with consultants and/or other modes of therapy as directed.
4. I agree to not abuse or misuse alcohol, prescription medications, or illegal drugs while taking my medication. I understand that my provider may at any time request that I take a drug screening test and /or bring my medications to my appointment to be counted. I understand that if I fail to report for a medication count or appointment as requested, I may be discharged from treatment. Refusal to take a drug test when requested can be grounds for immediate discharge from treatment.
5. I understand that some controlled medications can cause fatigue or drowsiness. I agree that I will not drive or operate machinery if I experience such side effects.

6. I agree that I will inform my provider promptly about any side effects I may experience with the medication.
7. I understand that refills of controlled substances will be made only during regular office hours, not on weekends, holidays, or at night. If I need assistance with a refill of a controlled medication, I will notify my provider at least 5 days in advance.
8. I agree to have all of my controlled medication prescriptions filled at ***ONE (1) pharmacy (named above)***. If there is a need to switch pharmacies, I will inform my provider prior to the change.
9. I agree that the provider named in this agreement will be the only physician to prescribe the controlled medications listed in this agreement. In addition, I understand that I am not to fill prescriptions for any controlled medication of any kind from any other provider until I have first spoken with my provider at WVU MEDICINE Behavioral Medicine and Psychiatry. (*if in doubt, consider it to be a controlled medication until you check with our office and are told otherwise.)*
10. I agree to take my mediation ***exactly*** as prescribed by my provider. If I feel that my medication needs to be changed in any way, I will not make changes until specifically directed by my provider to do so.
11. I understand that if I fail to follow these guidelines, I may be discharged from the practice at my provider's option. In addition, I understand that my provider may notify my other providers, other medical facilities, and/or other authorities if it is reasonably suspected that I am misusing my medications or prescriptions in any way.
12. It is conceivable that a true emergency situation could arise that might result in an exception to the above guidelines. Such situations could include severe weather conditions, emergency travel, legal problems, family illness/death, or accidents. However, I understand that it will be up to my provider to judge what constitutes an emergency.
13. I understand that certain medications may pose a risk of harm to an unborn baby or a breast-fed child. Therefore, I agree to let my provider know in advance if I plan to become pregnant, or to notify my provider immediately if I discover that I am pregnant.
14. I understand that I am responsible for the safekeeping of my medications and that they are not to be shared, sold, traded, or used by anyone other than myself.
15. I agree that my provider at WVU Medicine Behavioral Medicine and Psychiatry has permission to discuss any aspects of my treatment with dispensing pharmacists and/or other healthcare providers if my provider deems it necessary for improving my treatment or for reasons of accountability. It is my responsibility to make sure that copies of any of my records (from any source) are available for my provider to review if requested.
16. I understand that if my provider becomes uncomfortable providing treatment to me for any reason, I may be discharged from the practice with a referral to another provider if necessary. Such reasons could include (but are not limited to) known or suspected illegal behavior , threats or other violent behavior, known or suspected dishonesty with my provider, multiple missed appointments, or demonstrated inability to keep my medications/prescriptions safe from loss, theft, or destruction.
17. I agree to be bound by these guidelines, and that I have read, understood, and accepted all of them.
18. I give my provider permission to cooperate fully with any and all relevant authorities if, in the course of a legal investigation, any questions arise concerning my treatment; in such case, confidentiality will be waived and these authorities will be granted access to our records of your treatment.

19. I give permission to share my records consisting of medications, diagnoses, progress reports, this contract, etc., with my Primary Care Provider (named above).
20. I understand that my medications are to be kept only in the bottles (or other containers) as they are dispensed by the pharmacy.
21. I understand that one long-term goal of my provider is to make sure that my condition is being treated with the lowest effective dose of any controlled medication, and that therefore periodic adjustments to the dose might be necessary.
22. I understand that it is my responsibility to make sure that the office is provided with my correct contact information (to include at minimum my address and phone number) at all times; this includes contact information even for a place where I may just be staying temporarily, such as with a friend, relative, etc.
23. I acknowledge that I have been given a copy of this agreement.

____ _________________________

Patient's Signature Date

____ _________________________

Provider's Signature Date

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Patient History Form

Patient's Name: ____Todays Date: ____

Date of Birth: ____

Main reason for today's visit: ____

Current Symptoms Checklist:

( ) Depressed Mood	( ) Racing thoughts	( ) Excessive worry	( ) Anxiety Attacks
( ) Unable to enjoy activities	( ) Impulsivity	( ) Sleep pattern disturbance	( ) Avoidance
( ) Increase in risky behavior	( ) Hallucinations	( ) Loss of Interest	( ) Increased libido
( ) Concentration/forgetfulness	( ) Decrease need for sleep	( ) Suspiciousness	( ) Change in appetite
( ) Excessive guilt	( ) Excessive Energy	( ) Fatigue	( ) Increased irritability
( ) Decreased libido	( ) Crying spells	( ) Other____	

Past Mental Health History:

Outpatient treatment ( ) Yes ( ) No If yes, please describe when, by whom and nature of treatment.

Reason Dates By Whom

____

____

____

____

Psychiatric Hospitalization: ( ) Yes ( ) No If yes, please describe for what reason, when and where.

Reason Date(s) Hospitalized Where

____

____

____

____

Developmental History:

Where there any complications with your mother's pregnancy or with your birth, or were you born prematurely?

( ) Yes ( ) No ( ) Unsure

Did you experience any difficulty learning to walk, talk, read, write or reach any other developmental milestone(s)?

( ) Yes ( ) No ( ) Unsure

Was there any type of child abuse in your family?

( ) Yes ( ) No ( ) Unsure

How many siblings do you have? ____

How would you describe your childhood?

____

Educational History

Were you ever formally tested for and/or diagnosed with a learning disability? ( ) Yes ( ) No ( ) Unsure

If "yes", please explain: ____

How many years of education have you completed? ___________

Social History

Have you ever experienced a traumatic event like being robbed, assaulted, raped or having been in combat?

( ) Yes ( ) No ( ) Unsure

Are you involved in any lawsuit or legal matter with whom you want the doctor's help by sending reports, evaluations, etc. to an attorney or to the court? ( ) Yes ( ) No

Have you ever had legal problems, arrests, been in jail or prison? ( ) Yes ( ) No

If "yes", please explain: ____

____

____

Please list anything else you think is important for your provider to know about your psychological or social history:

____

____

Medical History

Which of the following conditions are you currently being treated or have been treated for in the past? (Please Check)

General Medical:

( ) Heart disease	( ) Shortness of breath	( ) Eye disorder/Glaucoma	( ) Diabetes
( ) Atrial Fibrillation	( ) COPD/emphysema	( ) Osteoarthritis	( ) Colitis
( ) Heart Attack	( ) Thyroid Problems	( ) Ear Problems	( ) Ulcer
( ) High cholesterol	( ) Liver problems/ Hepatitis	( ) Swollen Ankles	( ) Asthma
( ) Kidney/bladder problems	( ) High blood pressure	( ) Lung problems/cough	( ) Stroke
( ) Low blood pressure	( ) Sinus problems	( ) Headaches/Migraines	( ) Seizures
( ) Heartburn (reflux)	( ) Seasonal Allergies	( ) Arthritis	
( ) Anemia or blood problems	( ) Tonsillitis	( ) Ulcers/colitis	
( ) Other________________________			

Neurological:

( ) Memory Problem	( ) Alzheimer's Disease	( ) Lewy Body Disease
( ) Parkinson's Disease	( ) Vascular Dementia	( ) Fronto-temporal Dementia
( ) Multiple Systems Atrophy	( ) Huntington's Disease	( ) Progressive Supranuclear Palsy
( ) ALS (Lou Gherig's Disease)	( ) Essential Tremor	( ) Dystonia
( ) Multiple Sclerosis	( ) Head or Brain Injury	( ) Epilepsy or other seizure disorder
( ) Stroke		

Cancer:

( ) Breast Cancer	( ) Prostate Cancer	( ) Lung Cancer
( ) Ovarian Cancer	( ) Brain Cancer	( ) Radiation
( ) Cervical Cancer	( ) Other (type:)	( ) chemotherapy

Sleep:

( ) Restless Leg Syndrome	( ) Insomnia	( ) Nightmares
( ) REM Sleep Behavior Disorder	( ) Sleep Apnea	( ) Narcolepsy
( ) Periodic Limb movements		

Mind-Body, Auto-Immune and Immune-Deficiency:

( ) Lupus	( ) Irritable Bowel Syndrome	( ) Psychogenic seizure (non-epleptic seizures)
( ) Psychogenic movement disorder	( ) Other conversion disorder	( ) Chronic Fatigue Syndrome/SEID
( ) Fibromyalgia	( ) Endometriosis	( ) Rheumatoid Arthritis
( ) HIV	( ) AIDS	

Other-Gynecological:

( ) Infertility	( ) Abnormal PAP	( ) Menopause
( ) Sexually transmitted Disease	( ) Miscarriage	( ) Loss of Infant

Have you ever had a concussion, head injury, brain injury, seizures or loss of consciousness?

( ) Yes ( ) No ( ) Unsure

If "yes", please explain: ______________________________

Have you ever undergone an evaluation of your memory, thinking or other cognitive/mental abilities before?

( ) Yes ( ) No ( ) Unsure

If "yes", where, when and with whom? ______________________________

What was the diagnosis as you remember it? ______________________________

Has a doctor ever told you that you should not drive? ______________________________

Please list your surgical history:

____
____
____
____
____

Please list your doctors' names and specialties:

____
____
____
____
____

Family Psychiatric History: Has anyone in your family been diagnosed with or treated for:

( ) Post Traumatic Stress
( ) Substance Abuse
( ) Anxiety
( ) Alcohol abuse
( ) Schizophrenia
( ) Suicide
( ) Depression
( ) Bipolar disorder
( ) Other __________________
( ) Anger
( ) Violence
( ) ADHD

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No

If YES, Please answer the following. If NO, please skip.

- **Do you currently feel that you do not want to live**? ( ) Yes ( ) No
- How often do you have these thoughts? ______________________________
- When was the last time you had thoughts of dying? ______________________________
- Has anything happened recently to make you feel this way? ______________________________
- On a scale of 1 – 10 (ten being the strongest) how strong is the desire to kill yourself currently? ________________________
- Would anything make it better?______________________________
- Have you ever thought about how you would kill yourself? ______________________________
- Is the method you would use readily available? ______________________________
- Have you planned a time for this? ______________________________
- Is there anything that would stop you from killing yourself?______________________________
- Do you feel hopeless and/or worthless? ______________________________
- **Have you ever tried to kill or harm yourself before?** ______________________________

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substance? ______________________________

If yes, where were you treated and when? ______________________________

How many days per week do you drink any alcohol?______________________________

What is the least number of drinks you will drink in a day? ______________________________

What is the most number of drinks you will drink in a day? ______________________________

In the past 3 months, what is the largest amount of alcoholic drinks you have consumed in one day? ______________

Have you ever felt you should cut down on your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones and for how long? ______________________________

Have you abused prescription medications? ( ) Yes ( ) No

If yes, which ones and for how long? ______________________________

Check if you have ever tried any of the following:

( ) Methamphetamine ( ) Cocaine ( ) Stimulants ( ) Heroin ( ) Hallucinogens / LSD
( ) Marijuana ( ) Ecstasy ( ) Methadone ( ) Alcohol ( ) Pain killers (not prescribed)
( ) Tranquilizer/sleeping pills ( ) Other ______________________________

____

____

____

Tobacco History:

Have you ever smoked cigarettes? ( ) Yes ( ) No

Do you currently smoke? ( ) Yes ( ) No

If yes, how many packs per day on average? ______________________________

How many years have you smoked? ______________________________

In the past? ( ) Yes ( ) No

How many years did you smoke? ______________________________

When did you quit? ______________________________

Have you ever used smokeless tobacco (chewing tobacco)? ( ) Yes ( ) No

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Allergy and Medication List

Patient Name:____ Date of Birth: ______/______/_______

Allergies:

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

Current Medications: (Including Supplements, Vitamins, and Herbal Medications)

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____
9. ____
10. ____
11. ____
12. ____
13. ____