MIDWEST RESEARCH GROUP
ST. CHARLES PSYCHIATRIC ASSOCIATES
4801 WELDON SPRING PARKWAY • SUITE 300
ST. CHARLES, MO 63304

Patient Information:

Name: _____ _____ _____
(LAST) (FIRST) (M.I.)

Address : _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

SSN: _____ DOB: _____ Marital Status: _____ Sex: _____

Employer: _____ PCP: _____ Therapist: _____

Referred by _____ Drug Allergies: _____

Emergency Contact: _____ Telephone Number: _____

Responsible Party:

Name: _____ _____ _____
(LAST) (FIRST) (M.I.)

Address : _____ City, State, Zip: _____

Home Phone: _____ Work Phone: _____ Cell Phone: _____

Relationship to Patient: _____ Employer: _____

Primary Insurance:

Policy Holder _____

Ins. Company _____

Ins. ID # _____

Policy/Group # _____

Effective Date _____

Birth Date of Policy Holder _____

Social Security # of Policy Holder _____

Employer _____

Secondary Insurance:

Policy Holder _____

Ins. Company _____

Ins.ID # _____

Policy/Group # _____

Effective Date _____

Birth Date of Policy Holder _____

Social Security # of Policy Holder _____

Employer _____

PLEASE READ:
ALL PROFESSIONAL SERVICES RENDERED ARE CHARGED TO THE PATIENT. NECESSARY FORMS WILL BE COMPLETED TO HELP EXPEDITE INSURANCE CARRIER PAYMENTS. HOWEVER THE PATIENT IS RESPONSIBLE FOR ALL FEES, REGARDLESS OF INSURANCE COVERAGE. PAYMENT IS ALSO EXPECTED FOR SERVICES WHEN RENDERED UNLESS OTHER ARRANGEMENTS HAVE BEEN MADE IN ADVANCE WITH OUR OFFICE MANAGER. THIS ELECTRONIC SIGNATURE IS CONSIDERED AS AN ORIGINAL.

I AUTHORIZE ST. CHARLES PSYCHIATRIC ASSOCIATES TO EXCHANGE AND OBTAIN INFORMATION WITH IT'S AFFILIATED THERAPISTS AND TO CONTACT MY PRIMARY CARE PHYSICIAN, AS NOTED ABOVE IN REGARDS TO ANY AND ALL TREATMENT. THIS ELECTRONIC SIGNATURE IS CONSIDERED AS AN ORIGINAL. ****FAILURE TO CANCEL APPOINTMENT WITHOUT 24 HOUR NOTICE WILL RESULT IN A FEE OF $45.00 FOR M.D. AND/OR $90.00 FOR THERAPIST**.

INSURANCE AUTHORIZATION AND ASSIGNMENT:
I HEREBY AUTHORIZE ST. CHARLES PSYCHIATRIC ASSOCIATES AND IT'S AFFILIATED THERAPISTS TO FURNISH INFORMATION TO INSURANCE CARRIERS CONCERNING MY ILLNESS AND TREATMENTS AND I HEREBY ASSIGN TO THE PHYSICIAN(S) AND THERAPIST(S) ALL PAYMENTS FOR MEDICAL SERVICES RENDERED TO MYSELF OR MY DEPENDENTS. I UNDERSTAND THAT I AM RESPONSIBLE FOR ANY AMOUNT NOT COVERED BY INSURANCE. THIS ELECTRONIC SIGNATURE IS CONSIDERED AS AN ORIGINAL.

_____ _____ _____
Signature of Patient or Legal Guardian | Signature of Insurance Policy Holder | Date

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Statement of Confidentiality

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in State or Federal regulations

I have read and understand the above statement. This electronic signature is considered as an original.

PATIENT SIGNATURE/RESPONSIBLE PARTY DATE

Consent for Treatment

I, _____, hereby give my consent for necessary medical evaluations and treatments. This electronic signature is considered as an original.

I hereby authorize this office to release medical records pertaining to my condition to all appropriate parties for the purpose of coordinating my medical care and/or obtaining insurance payment.

Signature Relationship to Patient Date

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You May Refuse to Sign This Acknowledgement. This electronic signature is considered as an original.

I, _____, have received a copy of this office's Notice of Privacy Practices.

Print Name: _____

Signature: Date: _____

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ○ Individual Refused to Sign
- ○ Communication barriers prohibited obtaining the acknowledgement
- ○ An emergency situation prevented us from obtaining acknowledgement
- ○ Other (Please Specify)

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ADULT CONFIDENTIAL QUESTIONNAIRE

DATE:

NAME: AGE:

DATE OF BIRTH: OCCUPATION:

MARTIAL STATUS: NUMBER OF CHILDREN:

EDUCATION (HIGHEST GRADE):

1. Briefly describe the **problem** for which you have sought help.

2. How long has this been a problem?

3. Have you ever previously consulted a psychiatrist, psychologist, or counselor?
   Were you given a diagnosis?

4. Have you ever taken **psychiatric medication**? Please List:

5. Have you ever been **psychiatrically hospitalized**? List dates and hospitals:

6. Have you ever suffered from **depression,** even if not treated?
   How is your mood now?

7. Do you have any difficulties with **sleep, appetite, or concentration**? Please describe:

8. Do you have periods of **unusually high or low energy**? Please describe:

9. Have you ever felt life was not worth living or **felt suicidal**?
Have you ever attempted suicide?

10. Have you ever suffered from **anxiety**, even if not treated?

11. Have you experienced **panic attacks**? Please describe:

12. Do you experience fear or **anxiety in public or open spaces**?
Have these feelings ever made it difficult to travel or leave your home?

13. Do you find it difficult to be seen in public or **speak in front of a group**?

14. Do you have unrealistic fears (**phobias**) of certain objects or situations?

15. Do you experience **irresistible urges** to perform certain activities such as hand washing or door locking?

16. Do certain **thoughts** keep **running** through your mind that you are unable to stop?

17. Were you treated for **hyperactivity** or **attention deficit disorder** as a child or adolescent?

18. How many days of the week do you have an **alcoholic drink**?

19. Have you or others ever felt that you were a **problem drinker**?

20. What **recreational drugs** have you tried?

21. Are you a **smoker**? If yes, would you like to quit?

22. Has anyone in your **extended family** had an emotional or mental illness?

MEDICAL

23. Who is your **family physician**? When was your last **physical exam**?

24. Please list **current and past medical problems**. Include surgeries, major illnesses, and hospitalizations:

25. Please list all **medications** you are currently taking, including dosages.

26. Are you **allergic** to any medication? Please list.

27. Please list any **physical complaints** that are troubling you.

SOCIAL

28. Are you currently married or in a relationship?

29. Please rate the quality of that relationship (excellent, good, fair, some problems, major problems).

30. Who currently lives at home with you?

31. What is your longest period of employment?

32. How is your present job going?

33. What are the biggest stressors in your life right now?

34. Have you ever experienced any legal difficulties (lawsuits, arrests, etc.)?

35. What do you hope to accomplish during this treatment?

THE MOOD DISORDER

Instructions: Please answer each question to the best of your ability.

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

☐ No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
8. 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	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

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

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	◯	◯	◯	◯	◯
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?	◯	◯	◯	◯	◯
3. How often do you have problems remembering appointments or obligations?	◯	◯	◯	◯	◯
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	◯	◯	◯	◯	◯
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	◯	◯	◯	◯	◯
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?	◯	◯	◯	◯	◯
7. How often do you make careless mistakes when you have to work on a boring or difficult project?	◯	◯	◯	◯	◯
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	◯	◯	◯	◯	◯
9. How often do you have difficulty concentrating on what people say, even when they are speaking to you directly?	◯	◯	◯	◯	◯
10. How often do you misplace or have difficulty finding things at home or at work?	◯	◯	◯	◯	◯
11. How often are you distracted by activity or noise around you?	◯	◯	◯	◯	◯
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	◯	◯	◯	◯	◯
13. How often do you feel restless or fidgety?	◯	◯	◯	◯	◯
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?	◯	◯	◯	◯	◯
15. How often do you find yourself talking too much when you are in social situations?	◯	◯	◯	◯	◯
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	◯	◯	◯	◯	◯
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	◯	◯	◯	◯	◯
18. How often do you interrupt others when they are busy?	◯	◯	◯	◯	◯

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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.

Protecting your privacy

Protecting your privacy and your medical information is at the core of our business. We recognize our obligation to keep your information secure and confidential whether on paper or the Internet. At St. Charles Psychiatric Associates (hereinafter referred to as "**the Practice**"), privacy is one of our highest priorities.

Keeping your information

Keeping the medical and health information we have about you secure is one of our most important responsibilities. We value your trust and will handle your information with care. Our employees access information about you only when necessary to provide treatment, verify eligibility, obtain authorization, process claims and otherwise meet your needs. We may also access information about you when considering a request from you or when exercising our rights under the law or any agreement with you.

We safeguard information during all business practices according to established security standards and procedures, and we continually assess new technology for protecting information. Our employees are trained to understand and comply with the information principles.

Working to meet your needs through information

In the course of doing business, we collect and use various types of information, like name and address and claims information. We use this information to provide service to you, to process your claims and bring you health information that might be of interest to you.

Keeping information accurate

Keeping your health information accurate and up-to-date is very important. If you believe the health information we have about you is incomplete, inaccurate or not current, please call or write us at the telephone number or address listed below. We take appropriate action to correct any erroneous information as quickly as possible through a standard set of practices and procedures.

How - and why - information is shared

We limit who receives information and what type of information is shared.

X *Sharing information within **the Practice***. We share information within our company to deliver you the health care services and the related information and education programs specified in your plan.

X *Sharing information with companies that work for us.* To help us offer you our services, we may share information with companies that work for us, such as claim processing and mailing companies and companies that deliver health education and information directly to you. These companies act on our behalf and are obligated contractually to keep the information that we provide them confidential.

X *Other.* Patient-specific personally identifiable data is released only when required to provide a service for you and only to those with a need to know, or with your consent. Data is released with the condition that the person receiving the data will not release it further, unless you give permission.

If we receive a subpoena or similar legal process demanding release of any information about you, we will attempt to notify you (unless we are prohibited from doing so). Except as required by law or as described above, we do not share information with other parties, including government agencies.

The Practice does not share any customer information with third-party marketers who offer their products and services to our patients.

Count on our commitment to your privacy

You can count on us to keep you informed about how we protect your privacy and limit the sharing of information you provide to us - whether it's at our office, over the phone, or through the Internet.

St. Charles Psychiatric Associates
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