



**ST. CHARLES
PSYCHIATRIC ASSOCIATES**
IMPROVING MENTAL HEALTH CONDITIONS

Demographic Form

Patient Information:

Title:___ First Name * _____ Middle Name _____ Last Name* _____

Preferred Name _____

Street Address _____ Apt/Suite # _____

City* _____ State* _____ Zip Code* _____

Email* _____

Cell/Other Phone* _____ Home Phone _____

Work Phone _____ Preferred Phone* _____

Date of Birth* _____ Sex Assigned at Birth* _____ Marital Status _____

Gender Identity _____ Sexual Orientation _____ Language _____

Ethnicity _____ Race _____

Responsible Party:

Name _____
(Last) (First) (M.I.)

Street Address _____

City, State, ZIP _____

Home Phone _____ Work Phone _____ Cell Phone _____

Relationship to Patient _____ Employer _____

Primary Insurance:

Policy Holder _____

Insurance Company _____

Insurance ID _____

Policy/Group# _____

Effective Date _____

Policy Holder's DOB _____

Policy Holder's SSN _____

Employer _____

Secondary Insurance:

Policy Holder _____

Insurance Company _____

Insurance ID _____

Policy/Group# _____

Effective Date _____

Policy Holder's DOB _____

Policy Holder's SSN _____

Employer _____

Signature of Patient or Legal Guardian

Signature of Insurance Policy Holder

Date

St. Charles Psychiatric Associates

4801 Weldon Spring Parkway, Suite 300

Saint Charles, MO 63304

(636) 949-5760 Phone (866) 440-9231 Fax

AUTHORIZATION FOR RELEASE OF PROTECTED PATIENT HEALTH INFORMATION

I hereby authorize **St. Charles Psychiatric Associates** and/or its affiliates to

Obtain patient records from:

Name: _____

Address: _____

Phone #: _____

Fax Number: _____

-OR-

Release patient records to:

Name: _____

Address: _____

Phone #: _____

Fax Number: _____

(Please provide name, address, phone number, and fax number of person that we are releasing or obtaining from)

On the patient referenced below:

Patient Name: _____

Date of Birth: For Dates From: _____ to _____

For the purpose of: (please check one)

Continuation of Care Legal Purposes Insurance/Disability Purposes

Employer Requirement Other: _____

I would like to give the above healthcare organization permission to disclose: (please check as appropriate)

- Complete health record Diagnoses Lab test results Treatment Genetic Information
- Communicable diseases including, but not limited to, HIV and Aids - **Initial here**
- Mental health records - **Initial here**
- Alcohol/drug abuse treatment records - **Initial here**
- All records listed above. - **If releasing all records above please initial here.**

By signing below, I authorize that a photocopy of this authorization form will be fully acceptable as an original. I also understand that I may revoke this authorization at any time with a written request, with the exception that action had already been taken on the original request. This authorization to release protected health information is voluntary, and I understand that the disclosure of this information carries a potential for unauthorized re-disclosure and the information may not be protected by Federal confidentiality rules.

Patient

-OR-

Parent/Legal Guardian

Relationship to Patient: _____

Signature: _____ Date: _____

PROHIBITION OF REDISCLOSURE: Except as provided under Federal Law 45 CFR 164.524, this information has been disclosed from records whose confidentiality is protected by Federal Law 42 CFR Part 2. The recipient of this information is prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical information is not sufficient for this purpose.



HIPAA, Consent for Treatment Billing Authorization

Today's Date: _____ Patient Name _____ DOB: _____

Services Rendered:

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.

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 REGARD TO ANY AND ALL TREATMENT.

**FAILURE TO CANCEL APPOINTMENT WITHOUT 24 HOUR NOTICE WILL RESULT IN A FEE OF \$45.00 FOR M.D./N.P. AND/OR \$90.00 FOR THERAPIST.

* _____

Stimulant Fee Policy

I understand that all patients that are on a stimulant medication, or maybe prescribe a stimulant medication, agrees to pay our stimulant fee of \$50.00 every 6 months.

* _____

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.

St. Charles Psychiatric Associates reserves the right to deny appointments and/or medication refills for accounts with outstanding balances if payments cannot be made in a timely manner. Copays, coinsurance portions, and self-pay rates are due at the time of service. At no point in time do we want this policy to be considered abandonment of care, so we ask patients to maintain timely payments or work with office staff to initiate payment plans to ensure continuation of care.

* _____

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.

*

Consent for Treatment:

I hereby give my consent for necessary medical evaluations and treatments.

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.

I hereby give my consent for telehealth visits as scheduled with the MD/NP and/or therapist.

*



Privacy Practices

Today's Date: _____ Patient Name _____ DOB: _____

Notice of Privacy Practice

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

While 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 your 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.

- *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.
- *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.
- *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
4801 Weldon Spring Parkway, Suite 300
St. Charles, MO 63304
(636) 949-5760

Acknowledgement of Receipt of Notice of Privacy Practices:

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

*



Adult Confidential Questionnaire

Today's Date: _____ Patient Name _____ DOB: _____

OCCUPATION: _____ MARITAL 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 Information

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 Information

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?



Adult ADHD Self-Report Scale (ASRS-V1.1)

Today's Date: _____ Patient Name _____ DOB: _____

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, indicate the number that best describes how you have felt and conducted yourself over the past 6 months.

1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

2. How often do you have difficulty getting things in order when you have to do a task that requires organization?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

3. How often do you have problems remembering appointments or obligations?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

6. How often do you feel overly active and compelled to do things, like you were driven by a motor?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

7. How often do you make careless mistakes when you have to work on a boring or difficult project?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

10. How often do you misplace or have difficulty finding things at home or at work?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

11. How often are you distracted by activity or noise around you?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

13. How often do you feel restless or fidgety?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

14. How often do you have difficulty unwinding and relaxing when you have time to yourself?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

15. How often do you find yourself talking too much when you are in social situations?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

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?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

17. How often do you have difficulty waiting your turn in situations when turn taking is required?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

18. How often do you interrupt others when they are busy?

_____ 1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time



PHQ - 9 Patient Health Questionnaire

Today's Date: _____ Patient Name _____ DOB: _____

Please answer all ten questions listed below. While you are reading each question ask yourself,
Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things.

___ Not at All ___ Several Days ___ More Than Half the Days ___ Nearly Every Day

2. Feeling down, depressed, or hopeless.

___ Not at All ___ Several Days ___ More Than Half the Days ___ Nearly Every Day

3. Trouble falling or staying asleep, or sleeping too much.

___ Not at All ___ Several Days ___ More Than Half the Days ___ Nearly Every Day

4. Feeling tired or having little energy.

___ Not at All ___ Several Days ___ More Than Half the Days ___ Nearly Every Day

5. Poor appetite or overeating.

___ Not at All ___ Several Days ___ More Than Half the Days ___ Nearly Every Day

6. Feeling bad about yourself or that you are a failure or have let yourself or your family down.

___ Not at All ___ Several Days ___ More Than Half the Days ___ Nearly Every Day

7. Trouble concentrating on things, such as reading the newspaper or watching television.

___ Not at All ___ Several Days ___ More Than Half the Days ___ Nearly Every Day

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.

___ Not at All ___ Several Days ___ More Than Half the Days ___ Nearly Every Day

9. Thoughts that you would be better off dead or of hurting yourself in some way.

___ Not at All ___ Several Days ___ More Than Half the Days ___ Nearly Every Day

10. If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?

- Not Difficult at All
- Somewhat Difficult
- Very Difficult
- Extremely Difficult



GAD-7

Today's Date: _____ Patient Name _____ DOB: _____

Over the last 2 weeks, how often have you been bothered by the following problems?
Please mark the answer that corresponds.

1. Feeling Nervous, anxious or on edge.

___ Not at All ___ Several Days ___ More Than Half the Days ___ Nearly Every Day

2. Not being able to stop or control worrying.

___ Not at All ___ Several Days ___ More Than Half the Days ___ Nearly Every Day

3. Worrying too much about different things.

___ Not at All ___ Several Days ___ More Than Half the Days ___ Nearly Every Day

4. Trouble relaxing.

___ Not at All ___ Several Days ___ More Than Half the Days ___ Nearly Every Day

5. Being so restless that it is hard to sit still.

___ Not at All ___ Several Days ___ More Than Half the Days ___ Nearly Every Day

6. Becoming easily annoyed or irritable.

___ Not at All ___ Several Days ___ More Than Half the Days ___ Nearly Every Day

7. Feeling afraid as if something awful might happen

___ Not at All ___ Several Days ___ More Than Half the Days ___ Nearly Every Day

(For office coding: Total Score T____ = ____ + ____ + ____)



Adult Recent Behavior Survey

Today's Date: _____ Patient Name _____ DOB: _____

Completed By: _____

Please indicate the number next to each item that best describes your behavior
DURING THE PAST 2 WEEKS.

1=Never 2 = Occasionally 3 = Sometimes 4 = Most of the Time 5 = All The Time

- | | | | | | |
|---|---|---|---|---|---|
| 1. Depressed Mood
<i>A person may report feeling "sad" or "empty" or may cry frequently.</i> | 1 | 2 | 3 | 4 | 5 |
| 2. Decreased Interest or Pleasure
<i>A person may show markedly diminished interest or pleasure in all, or almost all, daily activities.</i> | 1 | 2 | 3 | 4 | 5 |
| 3. Weight Changes
<i>Significant changes in weight when not attempting to gain or lose (a gain or loss of 5% or more in a month) may be indicative of depression.</i> | 1 | 2 | 3 | 4 | 5 |
| 4. Sleep Disturbances
<i>Insomnia or sleeping too much may be a symptom of depression.</i> | 1 | 2 | 3 | 4 | 5 |
| 5. Psychomotor Agitation or Retardation
<i>The person may be observed to be either agitated and restless or physically slowed down in their movements.</i> | 1 | 2 | 3 | 4 | 5 |
| 6. Fatigue
<i>Deep fatigue or a loss of energy is a symptom of depression.</i> | 1 | 2 | 3 | 4 | 5 |
| 7. Feelings of Worthlessness or Guilt
<i>A depressed person may feel that they have no value or they may feel inappropriately guilty about things they have no control over.</i> | 1 | 2 | 3 | 4 | 5 |
| 8. "Brain Fog"
<i>A depressed person may have a diminished ability to think, concentrate or make decisions</i> | 1 | 2 | 3 | 4 | 5 |
| 9. Thoughts of Death
<i>A depressed person may have frequent thoughts of death and suicide, although they may or may not have an actual plan for carrying it out.</i> | 1 | 2 | 3 | 4 | 5 |

Visual Analogue Scale

Indicate the numeric value (0-100) corresponds to how you have mostly felt the past week including today:

0 = Not Depressed 100 = Completely Depressed

Numeric Value:



The Mood Disorder Questionnaire

Today's Date: _____ Patient Name _____ DOB: _____

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

...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?

Yes No

...you were so irritable that you shouted at people or started fights or arguments?

Yes No

...you felt much more self-confident than usual?

Yes No

...you got much less sleep than usual and found you didn't really miss it?

Yes No

...you were much more talkative or spoke much faster than usual?

Yes No

...thoughts raced through your head or you couldn't slow your mind down?

Yes No

...you were so easily distracted by things around you that you had trouble concentrating or staying on track?

Yes No

...you had much more energy than usual?

Yes No

...you were much more active or did many more things than usual?

Yes No

...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?

Yes No

...you were much more interested in sex than usual?

Yes No

...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?

Yes No

...spending money got you or your family into trouble?

Yes No

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?

- Yes No

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?

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?

- Yes No

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?

- Yes No



Posttraumatic Stress - Adult

Today's Date: _____ Patient Name _____ DOB: _____

Who filled out this form?

Self Mother Father Grandparent Guardian Other

People sometimes have problems after extremely stressful events or experiences. How much have you been bothered by each of the following problems that occurred or became worse after an extremely stressful event/experience?

Please list the traumatic event you experienced:

Date of the traumatic event: _____

Over the last 7 days, how often have you experienced any of the following? Be sure to answer ALL the questions.

1. Having "flashbacks," that is, you suddenly acted or felt as if a stressful experience from the past was happening all over again (for example, you reexperienced parts of a stressful experience by seeing, hearing, smelling, or physically feeling parts of the experience)?

Not at all A little bit Moderately Quite a bit Extremely

2. Feeling very emotionally upset when something reminded you of a stressful experience?

Not at all A little bit Moderately Quite a bit Extremely

3. Trying to avoid thoughts, feelings, or physical sensations that reminded you of a stressful experience?

Not at all A little bit Moderately Quite a bit Extremely

4. Thinking that a stressful event happened because you or someone else (who didn't directly harm you) did something wrong or didn't do everything possible to prevent it, or because of something about you?

___ Not at all ___ A little bit ___ Moderately ___ Quite a bit ___ Extremely

5. Having a very negative emotional state (for example, you were experiencing lots of fear, anger, guilt, shame, or horror) after a stressful experience?

___ Not at all ___ A little bit ___ Moderately ___ Quite a bit ___ Extremely

6. Losing interest in activities you used to enjoy before having a stressful experience?

___ Not at all ___ A little bit ___ Moderately ___ Quite a bit ___ Extremely

7. Being "super alert," on guard, or constantly on the lookout for danger?

___ Not at all ___ A little bit ___ Moderately ___ Quite a bit ___ Extremely

8. Feeling jumpy or easily startled when you hear an unexpected noise?

___ Not at all ___ A little bit ___ Moderately ___ Quite a bit ___ Extremely

9. Being extremely irritable or angry to the point where you yelled at other people, got into fights, or destroyed things?

___ Not at all ___ A little bit ___ Moderately ___ Quite a bit ___ Extremely

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