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)

<u>On the patient referenced below:</u>

Patient Name: ____________________________________

Date of Birth: For Dates From: ____________ to ____________

<u>For the purpose of: (please check one)</u>

☐ 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.**

ST. CHARLES
PSYCHIATRIC ASSOCIATES
IMPROVING MENTAL HEALTH CONDITIONS

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.

*____

ST. CHARLES
PSYCHIATRIC ASSOCIATES
IMPROVING MENTAL HEALTH CONDITIONS

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.

*______________________________

Child / Adolescent Confidential Questionnaire

Today's Date: _____________ Patient Name ______________________________ DOB: __________________

Grade: _____________ Siblings: ____________________

1. Please describe your child/adolescent's problem.

____

____

____

____

2. When did the problem start?

____

____

____

____

3. Were your child's pregnancy & delivery normal?

____

____

____

____

4. Were there any delays in development (walking, talking, etc)?

____

____

____

____

5. Has your child previously seen a psychiatrist or counselor? ☐ Yes ☐ No

Was a diagnosis given?

____

____

____

____

6. Has your child ever taken psychiatric medication? ☐ Yes ☐ No

Please list:

____

____

____

____

7. Any psychiatric hospitalizations?

List dates:

____

____

____

____

8. Please check any problems that apply to your child:

☐ Low mood ☐ Temper tantrums ☐ Sleep problems (increased / decreased)

☐ Oppositional behavior ☐ Appetite problems (increased / decreased)

☐ Truancy / school refusal ☐ Crying ☐ Fighting ☐ Energy level ☐ Hyperactivity

☐ Motivation problems ☐ Compulsive thoughts, obsessive behaviors

☐ Social adjustment problems ☐ Attention problems ☐ Anxiety or unusual fears

☐ Impulsivity ☐ Eating disorders (binging / purging, laxative abuse)

9. Has your child ever talked about or attempted suicide?

10. Any problems at school? Please Describe:

11. Please list average grades during this past school year.

12. Any drug or alcohol use? Please Describe:

13. Has your child ever had legal problems? Please Describe:

14. Any history of emotional, physical, or sexual abuse?

15. Is there any family history of psychiatric problems? Please List:

____

____

____

____

Medical History

Family Physician: ______________________ Current Medications: ____________________________________

Surgeries: ____ Hospitalizations: ___________________________

Medical Problems: ___________________________________

Check all that apply:

☐ Head Injury ☐ Loss of Consciousness ☐ Meningitis ☐ Tics (unusual face or body movements)

16. Any medication allergies? Please List:

____

____

____

____

ST. CHARLES PSYCHIATRIC ASSOCIATES
IMPROVING MENTAL HEALTH CONDITIONS

Child Behavior Screening

Today's Date: ______________ Patient Name ________________________________ DOB: ___________________

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
1. Fails to give close attention to details or makes careless mistakes in schoolwork.	0	1	2	3
2. Fidgets with hands or feet or squirms in seat.	0	1	2	3
3. Has difficulty sustaining attention in tasks or play activities.	0	1	2	3
4. Leaves seat in classroom or in other situations in which remaining seated is expected.	0	1	2	3
5. Does not seem to listen when spoken to directly.	0	1	2	3
6. Runs about or climbs excessively in situations in which it is inappropriate.	0	1	2	3
7. Does not follow through on instructions and fails to finish work.	0	1	2	3

Posttraumatic Stress - Child

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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ST. CHARLES
PSYCHIATRIC ASSOCIATES
IMPROVING MENTAL HEALTH CONDITIONS

Child ADHD Rating Scale-IV: Home Version

Today's Date: ____________ Patient Name ____________________________ DOB: _________________

Completed By: ____________________________

Circle the number that best describes your child's home behavior over the past 6 months.

	Never/ Rarely 0	Sometimes 1	Often 2	Very Often 3
1. Fails to give close attention to details or makes careless mistakes in schoolwork.	0	1	2	3
2. Fidgets with hands or feet or squirms in seat	0	1	2	3
3. Has difficulty sustaining attention in tasks or play activities.	0	1	2	3
4. Leaves seat in classroom or in other situations in which remaining seated is expected	0	1	2	3
5. Does not seem to listen when spoken to directly.	0	1	2	3
6. Runs about or climbs excessively in situations in which it is inappropriate.	0	1	2	3
7. Does not follow through on instructions and fails to finish work	0	1	2	3
8. Has difficulty playing or engaging in leisure activities quietly	0	1	2	3
9. Has difficulty organizing tasks and activities	0	1	2	3
10. Is “on the go” or acts as if “driven by a motor.”	0	1	2	3
11. Avoids tasks (eg, schoolwork, homework) that require sustained mental effort.	0	1	2	3
12. Talks excessively.	0	1	2	3
13. Loses things necessary for tasks or activities	0	1	2	3
14. Blurts out answers before questions have been completed	0	1	2	3
15. Is easily distracted.	0	1	2	3
16. Has difficulty awaiting turn.	0	1	2	3
17. Is forgetful in daily activities.	0	1	2	3
18. Interrupts or intrudes on others.	0	1	2	3

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 somthing awfull might happen

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

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

ST. CHARLES
PSYCHIATRIC ASSOCIATES
IMPROVING MENTAL HEALTH CONDITIONS

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

ST. CHARLES
PSYCHIATRIC ASSOCIATES
IMPROVING MENTAL HEALTH CONDITIONS

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

Item					
1. Depressed Mood *A person may report feeling "sad" or "empty" or may cry frequently.*	1	2	3	4	5
2. Decreased Interest or Pleasure *A person may show markedly diminished interest or pleasure in all, or almost all, daily activities.*	1	2	3	4	5
3. Weight Changes *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.*	1	2	3	4	5
4. Sleep Disturbances *Insomnia or sleeping too much may be a symptom of depression.*	1	2	3	4	5
5. Psychomotor Agitation or Retardation *The person may be observed to be either agitated and restless or physically slowed down in their movements.*	1	2	3	4	5
6. Fatigue *Deep fatigue or a loss of energy is a symptom of depression.*	1	2	3	4	5
7. Feelings of Worthlessness or Guilt *A depressed person may feel that they have no value or they may feel inappropriately guilty about things they have no control over.*	1	2	3	4	5
8. "Brain Fog" *A depressed person may have a diminished ability to think, concentrate or make decisions*	1	2	3	4	5
9. Thoughts of Death *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.*	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: [ ]