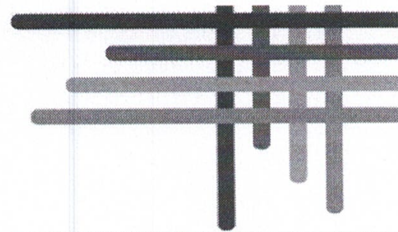


Records Release Authorization

FOR THE RELEASE OF PROTECTED MENTAL HEALTH INFORMATION

By signing this form, confidential psychological and psychiatric information can be released to and/or discussed with the people or agencies listed below unless noted by exclusions or limitations. This form is signed voluntarily and may be revoked at any time. All disclosures made pursuant to this form are valid as long as they were made before the date of revocation.

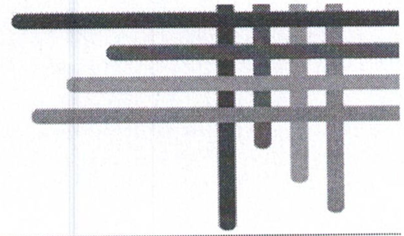
Patient's First Name:
Patient's Last Name:
Patient's Date of Birth
I authorize my provider to
Release
Receive
psychological/psychiatric mental health information to/from the Second Party as directed below:

Second Party:

Name
Address
Fax Number
Phone Number

Type Of Information To Be Disclosed:

Type Of Information To Be Disclosed
I authorize disclosure of all health information, including information relating to medical, pharmacy, mental health, substance abuse, and psychotherapy.
I authorize only the disclosure of the following information:
Please disclose only this information
My health information is being disclosed
at my request or at the request of my personal representative, or
for the following purpose:



Purpose:

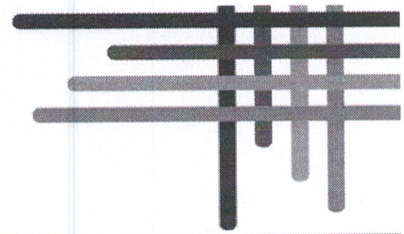
Purpose of information disclosure
Note any exclusions or limitations here
I understand that treatment, payment, enrollment in a health plan, or eligibility for benefits is not dependent on my signing this authorization. By signing below, I acknowledge that I have read and understand this document and that I have voluntarily given my provider authorization to disclose my records. I understand that I may revoke this authorization at any time by providing a written notice to my provider, however the revocation will not have an effect on any actions taken prior to the date my revocation is received. I understand that my information may be redisclosed by the authorized person/organization receiving the information, and at that point, the information may no longer be protected under the terms of this agreement. This authorization will expire one year following the date signed unless revoked in writing.

Date

Signature of Patient

Legal Guardian/Personal Representative Signature

RELIANT FAMILY
Comprehensive Psychiatry Services



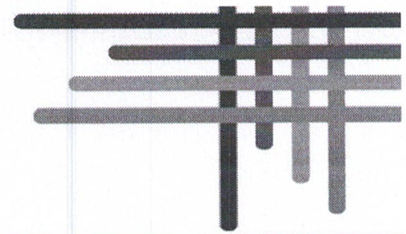
Self-Pay Agreement Form Self-Pay Agreement Form

I,__________________ the undersigned, do hereby certify and attest that I have sought evaluation, treatment, medical advice, or services from the staff at the provider's office named above. I currently have no insurance coverage, and I am not aware of any insurance coverage for the services I am seeking. I attest that if some of the treatment or services I desire are covered by a future insurance plan, but some are not, I am willing to pay for the non-covered treatment or services.

I understand and acknowledge that I will be held responsible for any amount of medical bills produced from my visits (or my minor child's visits) to this provider and it is my responsibility to make any agreed upon payments by the specified due date. I understand and acknowledge that non-compliance or defaulting on my agreed payments may result in denial of services and/or a legal claim against me for non-payment.

Signature
D.O.B
Date

contact@reliantpsychiatry.com
929 W Pioneer Pkwy, Suite A
Grand Prairie TX 75051
Phone: 972-433-0088
Fax: 972-646-8085



Informed Consent for Assessment and Treatment

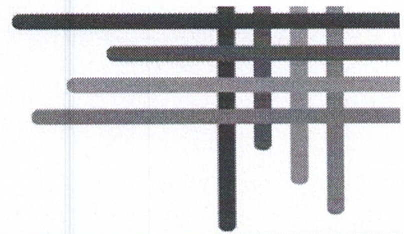
I understand that I am eligible to receive a range of services from my provider. The nature and scope of the services I receive will be determined subsequent to an initial assessment and comprehensive consultation with me. The primary objective of the assessment process is to ascertain the most appropriate treatment plan. Typically, the treatment is administered over a period of time.

I comprehend that I possess the right to pose queries throughout the course of treatment and may seek an external consultation if necessary. (I also acknowledge that my healthcare provider may furnish additional information pertaining to specific treatment aspects and methodologies on an as-needed basis during the course of treatment, and I retain the right to grant or withhold consent for such treatments.) I am aware that regular evaluations of the treatment will be conducted to assess the attainment of treatment goals. I commit to active participation in both the treatment and evaluation processes. No assurances have been provided regarding the outcomes of this treatment or any procedures employed within it. I further understand that I may stop treatment at any time but agree to discuss this decision first with my provider.

I am aware that I must authorize my provider, in writing, to release information about my treatment but that confidentiality can be broken under certain circumstances of danger to myself or others. I understand that once information is released to insurance companies or any other third party, that my provider cannot guarantee that it will remain confidential. When consent is provided for services, all information is kept confidential, except in the following circumstances:

- In the event of an imminent risk to my own safety or that of another individual, my provider is ethically obligated to take requisite measures to prevent such danger.
- If there are grounds to suspect sexual or physical abuse of a child or elder, or the potential for such abuse, my provider is legally obligated to take action to safeguard the affected individual and report to the relevant authorities.
- In cases where a valid court order is issued for the release of medical records, my provider is mandated by law to comply with such requests.

GUARANTEE OF PAYMENT



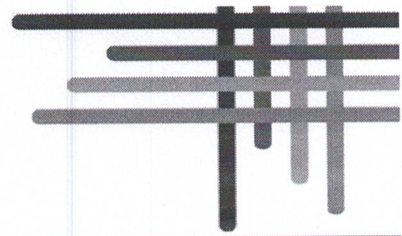
I grant my provider the authority to receive direct insurance payments for all eligible benefits associated with the care and treatment provided.

By affixing my signature below, I voluntarily request and consent to behavioral health assessment, care, treatment, or services and authorize my provider to furnish such care, treatment, or services as deemed necessary and advisable. I acknowledge that the practice of behavioral health treatment is inherently imprecise, and I affirm that no guarantees or assurances have been extended regarding the specific results I may achieve. By signing this Informed Consent to Treatment Form, I affirm that I have both read and comprehended the terms and information contained herein. Adequate opportunities have been afforded to me to seek clarification and pose any queries on aspects that remain unclear.

While this summary is designed to provide an overview of confidentiality and its limits, it is important that you read the Notice of Privacy Practices which was provided to you for more detailed explanations, and discuss with your provider any questions or concerns you may have. By my signature below, I voluntarily request and consent to behavioral health assessment, care, treatment, or services and authorize my provider to provide such care, treatment, or services as are considered necessary and advisable. I understand the practice of behavioral health treatment is not an exact science and acknowledge that no one has made guarantees or promises as to the results that I may receive.

By signing this Informed Consent to Treatment Form, I acknowledge that I have both read and understood the terms and information contained herein. Ample opportunity has been offered to me to ask questions and seek clarification of anything unclear to me.

Client Name
Signature
Date



Telehealth Services Informed Consent

Definition of Telehealth

Telehealth involves the use of electronic communications to enable professionals to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

I understand that I have the rights with respect to telehealth:

1. I understand that the laws that protect privacy and the confidentiality of medical information also applies to telehealth, and that no information obtained in the use of telehealth, which identifies me, will be disclosed to researchers or other entities without my written consent.

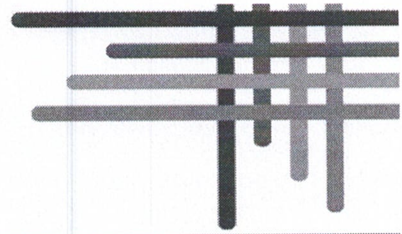
2. My health care provider has explained to me how the videoconferencing technology will be used to affect such a consultation will not b the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.

3. I understand there are potential risks to this technology including interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.

4. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

5. I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

6. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guarantee or assured.



7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.

8. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my healthcare provider and consulting healthcare provider in order to operate the video equipment. The above-mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following:

- Ask non-medical personnel to leave the telehealth examination room; and/or
- Terminate the consultation at any time

9. I agree that certain situations, including emergencies and crisis, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented healthcare facility in my immediate area.

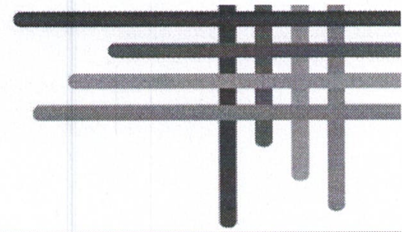
Consent to the Use of Telehealth

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me.
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

Date:

Signature:



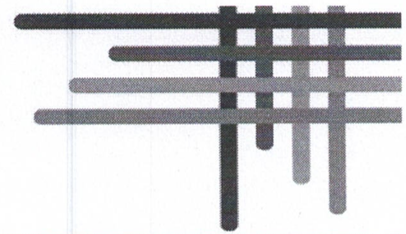
Authorization to Bill Insurance

First name
Last name
Client Address:
Date - label
Navigate forward to interact with the calendar and select a date. Press the question mark key to get the keyboard shortcuts for changing dates.
Insurance Company:
I, the undersigned, hereby certify and attest that I have sought evaluation, treatment, or medical advice from the staff at the clinic named above. I therefore authorize the medical staff and personnel to release my or my minor child's medical information to the insurance company listed above for the purpose of determining and receiving benefits for medical bills.

I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any amount of medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required.

I understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided above. Non-compliance or defaulting on payments may result in denial of service and/or legal claims against me for non-payment.

Signature:



General Anxiety Disorder (GAD- 7) Scale

Over the last two weeks, how often have you been bothered by the following problems?

Feeling nervous, anxious or on edge

Not being able to stop or control worrying

Worrying too much about different things

Trouble relaxing

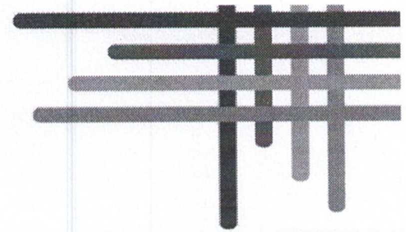
Being so restless that it is hard to sit still

Becoming easily annoyed or irritable

Feeling afraid as if something awful might

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

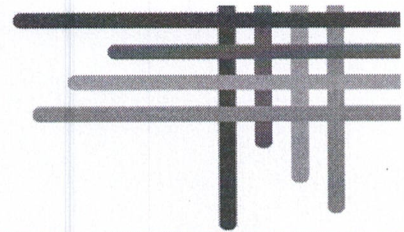
Not difficult at all
Somewhat difficult
Very difficult
Extremely difficult



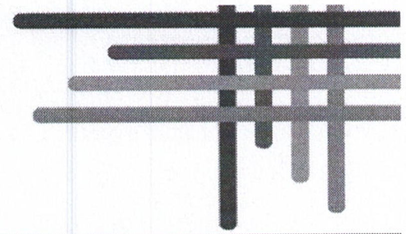
The Bipolar Spectrum Diagnostic Scale (BSDS)

Instructions: Please read through the entire passage below before selecting appropriate options

1. Some individuals notice that their mood and/or energy levels shift drastically from time to time
Yes
No
2. These individuals notice that, at times, their mood and/or energy level is very low, and at other times, very high
Yes
No
3. During their "low" phases, these individuals often feel a lack of energy; a need to stay in bed or get extra sleep; and little or no motivation to do things they need to do
Yes
No
4. They often put on weight during these periods
Yes
No
5. During their low phases, these individuals often feel "blue", sad all the time, or depressed
Yes
No
6. Sometimes, during these low phases, they feel hopeless or even suicidal
Yes
No
7. Their ability to function at work or socially is impaired
Yes
No
8. Typically, these low phases last for a few weeks, but sometimes they last only a few days
Yes
No



9. Individuals with this type of pattern may experience a period of "normal" mood in between mood swings, during which their mood and energy level feels "right" and their ability to function is not disturbed
Yes
No
10. They may then notice a marked shift or "switch" in the way they feel
Yes
No
11. Their energy increases above what is normal for them, and they often get many things done they would not ordinarily be able to do
Yes
No
12. Sometimes, during these "high" periods, these individuals feel as if they have too much energy or feel "hyper"
Yes
No
13. Some individuals, during these high periods, may feel irritable, "on edge", or aggressive
Yes
No
14. Some individuals, during these high periods, take on too many activities at once
Yes
No
15. During these high periods, some individuals may spend money in ways that cause them trouble
Yes
No
16. They may be more talkative, outgoing, or sexual during these periods
Yes
No
17. Sometimes, their behavior during these high periods seems strange or annoying to others
Yes
No
18. Sometimes, these individuals get into difficulty with co-workers or the police, during these high periods
Yes



No
19. Sometimes, they increase their alcohol or non-prescription drug use during these high periods
Yes
No
20. Now that you have read the above passage, please check one of the following four radio buttons
This story does not really describe me at all
This story fits me to some degree, but not in most respects
This story fits me fairly well
This story fits me very well, or almost perfectly

Reliant Family Psychiatry
929 West Pioneer Parkway, Ste A
Grand Prairie, TX 75051
Phone: 972-433-0088
Fax: 9727309801

Juliet Forbi

Chart ID **DOB**

Completed Date

PTSD Checklist for DSM-5 (PCL-5)

PTSD Checklist for DSM-5 (PCL-5)

Below is a list of problems that people sometimes have in response to a very stressful experience. Please read each problem carefully and then choose one of the numbers to indicate how much you have been bothered by that problem in the past month.

In the past month, how much were you bothered by::

	Responses
1. Repeated, disturbing, and unwanted memories of the stressful experience?	
2. Repeated, disturbing dreams of the stressful experience?	
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	
4. Feeling very upset when something reminded you of the stressful experience?	

	Responses
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	
8. Trouble remembering important parts of the stressful experience?	
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	
10. Blaming yourself or someone else for the stressful experience or what happened after it?	
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	
12. Loss of interest in activities that you used to enjoy?	
13. Feeling distant or cut off from other people?	

	Responses
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	
15. Irritable behavior, angry outbursts, or acting aggressively?	
16. Taking too many risks or doing things that could cause you harm?	
17. Being "super alert" or watchful or on guard?	
18. Feeling jumpy or easily startled?	
19. Having difficulty concentrating?	
20. Trouble falling or staying asleep?	

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING __0__ + ______ + ______ + ______

=Total Score: ______

If you checked off <u>any</u> problems, how <u>difficult</u> have these 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
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Name:______________________________ Date:______________________

Montgomery-Asberg Depression Scale (MADRS)

Instructions: The ratings should be based on a clinical interview moving from broadly phrased questions about symptoms to more detailed ones which allow a precise rating of severity. The rater must decide whether the rating lies on the defined scale steps (0, 2, 4, 6) or between them (1, 3, 5). It is important to remember that it is only rare occasions that a depressed patient is encountered who cannot be rated on the items in the scale. If definite answers cannot be elicited from the patients, all relevant clues as well as information from other sources should be used as a basis for the rating in line with customary clinical practice. This scale may be used for any time interval between ratings, be it weekly or otherwise, but this must be recorded.

1. ***Apparent Sadness***

Representing despondency, gloom and despair, (more than just ordinary transient low spirits) reflected in speech, facial expression, and posture. Rate on depth and inability to brighten up.

0 No sadness
1
2 Looks dispirited but does brighten up without difficulty.
3
4 Appears sad and unhappy most of the time.
5
6 Looks miserable all the time. Extremely despondent.

2. ***Reported Sadness***

Representing reports of depressed mood, regardless of whether it is reflected in appearance or not. Includes low spirits, despondency or feeling of being beyond help without hope. Rate according to intensity, duration and the extent to which the mood is reported to be influenced by events.

0 Occasional sadness in keeping with the circumstances.
1
2 Sad or low but brightens up without difficulty.
3
4 Pervasive feelings of sadness or gloominess. The mood is still influenced by external circumstances.
5
6 Continuous or unvarying sadness, misery or despondency.

3. ***Inner Tension***

Representing feelings of ill-defined discomfort, edginess, inner turmoil mounting to either panic, dread or anguish. Rate according to intensity, frequency, duration and the extent of reassurance called for.

0 Placid. Only reflecting inner tension.
1
2 Occasional feelings of edginess and ill-defined discomfort.
3
4 Continuous feelings of inner tension or intermittent panic which the patient can only master with some difficulty.
5
6 Unrelenting dread or anguish. Overwhelming panic.

4. ***Reduced Sleep***

Representing the experience of reduced duration or depth of sleep compared to the subject's own normal pattern when well.

0 Sleeps as usual.
1
2 Slight difficulty dropping off to sleep or slightly reduced light or fitful sleep.
3
4 Sleep reduced or broken by at least two hours.
5
6 Less than two or three hours sleep.

5. ***Reduced Appetite***

Representing the feeling of loss of appetite compared with when well. Rate by loss of desire for food or the need to force oneself to eat.

0 Normal or increased appetite.
1
2 Slightly reduced appetite.
3
4 No appetite. Food is tasteless.
5
6 Needs persuasion to eat.

6. ***Concentration Difficulties***

Representing difficulties in collecting one's thoughts mounting to incapacitating lack of concentration. Rate according to intensity, frequency, and degree of incapacity produced.

0 No difficulties in concentrating.
1
2 Occasional difficulties in collecting one's thoughts.
3
4 Difficulties in concentrating and sustaining thought which reduces ability to read or hold a conversation.
5
6 Unable to read or converse without great initiative.

7. ***Lassitude***

Representing a difficulty getting started or slowness initiating and performing everyday activities.

0 Hardly no difficulty in getting started. No sluggishness.
1
2 Difficulties in starting activities.
3
4 Difficulties in starting simple routine activities which are carried out with effort.
5
6 Complete lassitude. Unable to do anything without help.

8. ***Inability to Feel***

Representing the subjective experience of reduced interest in the surroundings, or activities that normally give pleasure. The ability to react with adequate emotion to circumstances or people is reduced.

0 Normal interest in the surroundings and in other people.
1
2 Reduced ability to enjoy usual interest.
3
4 Loss of interest in surroundings. Loss of feelings for friends and acquaintances.
5
6 The experience of being emotionally paralyzed, inability to feel anger, grief or pleasure and a complete or even painful failure to feel for close relatives and friends.

9. ***Pessimistic Thoughts***

Representing thoughts of guilt. Inferiority, self-reproach, sinfulness, remorse and ruin.

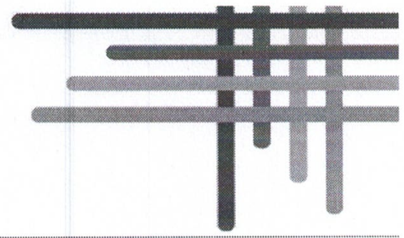
0 No pessimistic thoughts.
1
2 Fluctuating ideas of failure, self-reproach or self-depreciation.
3
4 Persistent self-accusations, or definite but still rational ideas of guilt or sin. Increasingly pessimistic about the future.
5
6 Delusions of ruin, remorse or unredeemable sin. Self-accusations which are absurd and unshakable.

10. ***Suicidal Thoughts***

Representing the feeling that life is not worth living, that a natural death would be welcome, suicidal thoughts, and the preparations for suicide. Suicidal attempts should not in themselves influence the rating.

0 Enjoys life or takes it as it comes.
1
2 Weary of life. Only fleeting suicidal thoughts.
3
4 Probably better off dead. Suicidal thoughts are common, and suicide is considered as a possible solution, but without specific plans or intention.
5
6 Explicit plans for suicide when there is an opportunity. Active preparations for suicide.

Total Score:______________



CONTROLLED SUBSTANCE AGREEMENT

I agree with the following conditions:

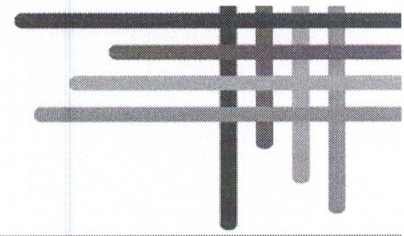
1. Medication Management:
☐ I will take medication exactly as prescribed
☐ I will not increase or change doses without consulting my provider
☐ I will not share, sell, or trade my medication
☐ I will keep medication in a secure location
☐ I will dispose of unused medication properly

2. Pharmacy and Prescriptions:
☐ I will use only one pharmacy: ________________
☐ I will not seek prescriptions from other providers
☐ I understand prescriptions will not be replaced if lost/stolen
☐ I will plan ahead for refills (minimum 3 business days)

3. Appointments and Monitoring:
☐ I will attend all scheduled appointments
☐ I will submit to random drug screening if requested
☐ I will participate in recommended monitoring (BP checks, etc.)
☐ I will inform the provider of all other medications/supplements

4. Safety Measures:
☐ I will not drive or operate machinery until effects are known
☐ I will report on concerning side effects immediately
☐ I will inform all healthcare providers about this medication
☐ Emergency contact: ________________

5. Compliance Requirements:
☐ Regular office visits (every ___ weeks/months)
☐ Random drug screens
☐ Bring medication to appointments if requested
☐ Participate in recommended therapy/treatment



CONTROLLED SUBSTANCE AGREEMENT

6. Grounds for Termination:

☐ Providing false information
☐ Non-compliance with treatment plan
☐ Evidence of medication misuse/abuse
☐ Aggressive/threatening behavior
☐ Failed drug screens

I understand that failure to comply with this agreement may result in:
☐ Discontinuation of medication
☐ Termination of care
☐ Referral to addiction services
☐ Legal reporting if required

ATTESTATION
I have read, understand, and agree to the terms above. My questions have been answered to my satisfaction.
Patient Signature: _________________ Date: _________
Provider Signature: _________________ Date: _________
Witness Signature: _________________ Date: _________

Copies provided to: □ Patient
□ Medical Record
□ Pharmacy (if requested)

Next Appointment: _______________
Pharmacy Name: ___________________
Pharmacy Phone: __________________
Emergency Contact Information:
Clinic: ________________
After Hours: ________________

Emergency: 911