Perspectives Therapy Services

Psychiatric Program

2200 Genoa Business Park Drive, Suite 100
Brighton, MI 48114
(810) 494-7180, ext. 107

Welcome.

We are honored that you have chosen *Perspectives Therapy Services* to accompany you on your personal journey of healing and wellness.

Before your first psychiatry appointment, please take some time to complete the attached intake packet. It is preferred that you bring these completed forms to our office in advance. Nonetheless, **all forms must be submitted by the time of your appointment**.

In addition to your forms, please also bring the following to your initial appointment:

- Complete list of ALL current prescription medications, supplements, and/or herbs you take, including dosages, frequencies, and reasons for taking them
- Copy of your latest blood work and/or laboratory results if any have been done within the past 12 months
- Copy of your health insurance card and state-issued ID

If you have any questions, please contact our psychiatric team at 810-494-7180, ext 107.

Mental Health Intake Pt. I **Name:** _____

Date of Appointment: _____ **D.O.B.** _____ **Age:** _____

Females:
Pregnant? Yes: ___ No: _____ Taking any birth control? Yes:____No:____

Menopause? Yes: _____ No: _____
If not pregnant and not past menopause, please indicate date of last period: _____

Current Medication List: _____

Medication or Environmental Allergies: Include names of medications and types of reactions (i.e. hives, difficulty breathing, etc.)

Current Medical Issues: (i.e. back pain, diabetes, thyroid, etc.)

Current Symptoms: Please place a checkmark (✓) to indicate any present symptoms, and a double checkmark (✓✓) for your **major** symptoms

( ) Depressed mood
( ) Unable to enjoy activities
( ) Sleep pattern disturbance
( ) Loss of interest
( ) Concentration/Forgetfulness
( ) Change in appetite
( ) Excessive guilt
( ) Fatigue
( ) Decreased libido
( ) Suicidal thoughts
( ) Thoughts of harming someone else
( ) Racing thoughts
( ) Impulsivity
( ) Increased risky behavior
( ) Decreased need for sleep
( ) Excessive energy
( ) Increased irritability
( ) Crying spells
( ) Self-harm
( ) Thoughts of worthlessness
( ) Thoughts of hopelessness
( ) Sadness
( ) Distressing dreams or nightmares
( ) Repetitive actions (i.e. hand washing, checking doors, etc.)
( ) Excessive nervous habits (i.e. skin picking, hair pulling, etc.)
( ) Increased libido
( ) Restricting food and/or vomiting to lose weight
( ) Paranoia
( ) Mood fluctuations
( ) Hearing or seeing things that are not there
( ) Excessive worry
( ) Anxiety attacks
( ) Avoidance
( ) Hallucinations
( ) Suspiciousness
( ) _____
( ) _____

Additional comments/explanations on above checked or additional symptoms not listed:

Past hospitalizations and/or outpatient/inpatient treatment for **mental health** reasons:

Previous mental health diagnosis:

Past hospitalizations for medical issues or surgeries:

When your mother was pregnant with you, were there any complications during the pregnancy or birth AND/OR any delays in development or issues in childhood (i.e. born prematurely, learning difficulties in school, etc.)?
Yes: _____ No: _____ If yes, explain:

Have you ever had a major head trauma where you lost consciousness or didn't know where you were at?
Yes: _____ No: _____ If yes, explain:

Exercise: Do you exercise regularly?
Yes: _____ No: _____ If yes, explain type, intensity, how long per session, and how many sessions per week:

Caffeine: How much caffeine do you consume in a typical day (including sodas, energy drinks, etc.)?

Tobacco:
Have you ever smoked cigarettes? Yes: _____ No: _____
Do you currently smoke cigarettes? Yes: _____ No: _____
If yes, how many packs per day, on average? _____How long have you smoked? _____
If you used to smoke regularly, but have since quit, when did you quit? _____
Do you use non-cigarette nicotine or tobacco products (vaping, pipes, cigars, chewing tobacco, etc.)?
Yes: _____ No: _____ If yes, clarify: _____

Substance Use: Have you ever been treated for alcohol or drug abuse? Yes: _____ No: _____
If yes, for which substance(s)? _____
Where were you treated, and when? _____

Family Psychiatric History: Have **you** or **anyone in your family** ever been diagnosed with the following (If yes, indicate who)

- Bipolar Disorder _____
- Schizophrenia _____
- Depression _____
- Post-traumatic Stress _____
- Anxiety _____
- Obsessive-Compulsive Disorder _____
- Anger _____
- Alcohol Abuse _____
- Other substance abuse _____
- Suicide _____
- Violence _____

Has any family member been treated with a psychiatric medication? Yes: _____ No: _____
If yes, who was treated, what medications did they take, and how effective was treatment?

Family Background and Childhood History
Were you adopted? Yes: _____ No: _____
Where did you grow up? _____
List your siblings and their ages _____
_____

What were your parents' occupations?
_____
_____

Did your parents divorce? Yes: _____ No: _____
If yes, how old were you when they divorced? _____
Who did you live with? _____

Describe your parents and your relationships to them:

How old were you when you left home? _____
Has anyone in your immediate family died? Yes: _____ No: _____

If yes, who and when? _____

How would you describe your childhood (i.e. loving, chaotic, difficult, traumatic, etc.)? Please explain:

Trauma History: Do you have a history of being abused emotionally, sexually, physically, or by neglect?
Yes: _____ No: _____ If yes, **when, where, and by who**?

Education History: What is your highest education level? (If applicable, please specify institution and degree)

Occupational History: Are you currently
Working: _____ Student: _____ Unemployed: _____ Disabled: _____ Retired: _____
If applicable,
What is/was your occupation? _____
Where do you work? _____
How long have you been at your present position? _____
Full time: _____ Part time: _____

Relationship History and Current Family: Are you currently
Married: _____ Partnered: _____ Divorced: _____ Single: _____ Widowed: _____

How long? _____
If not married or partnered, are you currently in a relationship?
Yes: _____ No: _____ If yes, for how long? _____
What is your significant other's occupation? _____
Describe your relationship_____
_____

Have you had any prior marriages?
Yes: _____ No: _____ If yes, how long were you married? _____

Do you have any children?
Yes: _____ No: _____ If yes, how many? _____ List ages and genders: _____
_____

Describe your relationship with your children:

List everyone who currently lives with you:

Legal History: Have you ever been arrested? Yes: _____ No: _____
Do you have any pending legal problems? Yes: _____ No: _____

Spirituality: Do you belong to a religion or spiritual group?

ANY ADDITIONAL INFORMATION:

Patient Name: _____ Signature: _____ Date: _____

Past Psychiatric Medications

If you have ever taken any of the following medications, please indicate the dates, dosages, and how helpful they were. If you can't remember all the details, just write in what you can remember.

Antidepressants Dates Dosage Response/Side Effects

Prozac (fluoxetine) _____
Zoloft (sertraline) _____
Luvox (fluvoxamine) _____
Paxil (paroxetine) _____
Celexa (citalopram) _____
Lexapro (escitalopram) _____
Effexor (venlafaxine) _____
Cymbalta (duloxetine) _____
Wellbutrin (bupropion) _____
Trintellix (vortioxetine) _____
Remeron (mirtazapine) _____
Anafranil (clomipramine) _____
Pamelor (nortriptyline) _____
Tofranil (imipramine) _____
Elavil (amitriptyline) _____
Other: _____

Mood Stabilizers

Tegretol (carbamazepine) _____
Lithium _____
Depakote (valproate) _____
Lamictal (lamotrigine) _____
Tegretol (carbamazepine) _____
Topamax (topiramate) _____
Other: _____

Antipsychotics

Seroquel (quetiapine) _____
Zyprexa (olanzapine) _____
Geodon (ziprasidone) _____
Abilify (aripiprazole)_____
Clozaril (clozapine) _____
Haldol (haloperidol)_____
Risperdal (risperidone) _____
Other: _____

Sleep Aids

Melatonin _____
Over-the-counter meds (Tylenol PM, Zzz-Quil, etc.) _____
Ambien (zolpidem)_____
Sonata (zaleplon) _____
Rozerem (ramelteon)_____
Restoril (temazepam) _____
Desyrel (trazodone) _____
Other: _____

ADHD Medications

Adderall (amphetamine) _____
Concerta (methylphenidate)_____
Ritalin (methylphenidate)_____
Vyvanse (lisdexamphetamine) _____
Strattera (atomoxetine) _____

Antianxiety Medications

Xanax (alprazolam) _____
Ativan (lorazepam) _____
Klonopin (clonazepam) _____
Valium (diazepam) _____
Tranxene (clorazepate) _____
Buspar (buspirone) _____
Other: _____

Perspectives Therapy Services LLC

Disclosure Statement and Consent to Psychiatric Treatment

Provider Training and Credentials

Thank you for choosing *Perspectives Therapy Services* LLC (PTS) for your emotional, mental, relationship, and psychiatric needs. Your Perspectives provider has received an advanced degree in one or more of the following fields: marriage, family therapy, social work, professional counseling, or psychiatry. S/he is licensed through the state of Michigan. If s/he holds a limited license, or it is required by the particular insurance company, s/he will be supervised by a fully licensed clinician.

Therapeutically, our staff is trained to work with individuals, couples, and families. We comprise a group practice of independent private practitioners and are not affiliated with any medical center or hospital. **We are not available for emergency services** and advise that, in these cases, you contact your local Community Mental Health agency or your nearest medical center/hospital.

Psychiatry Specifics

The initial assessment meeting is charged at $250. A follow-up medication review is charged at $175. Obligation for payment is understood not to be dependent upon the patient's receiving third-party reimbursement from insurance coverage. While the practice certainly supports and encourages patients to pursue the maximum amount of financial reimbursement from third-party payers—such as health insurance agencies—it is ultimately the patient's responsibility to ensure that s/he receives all third-party payments for which s/he may be eligible. PTS will submit all insurance billing for health insurance companies with which we are networked. All co-payments are due at the time of service. There is a returned check fee of $20.00. It is our practice's policy to keep a credit card on file for all clients and patients in the practice. You may still choose to pay for your balances using another form of payment.

Session fees cover the following professional services:

- Psychiatric services
- Initial and ongoing assessments
- Treatment planning
- Time spent in consultation with other professionals

Phone contact—other than to schedule appointments or request prescription refills—is considered a consultation and may be billed at $50 per 15 minutes. Report-writing is charged at a rate of $200 per hour.
The providers at PTS do not provide custody evaluations or appear in court. Additionally, evaluations for disability applications are also not completed.

Patient Rights and Responsibilities

Although you may choose to end treatment at any time, you are responsible for attending any scheduled sessions. Unless a session is cancelled at least 24 hours prior to the time of the scheduled appointment, you will be responsible to remit payment of $150.00 for a missed psychiatric evaluation session and $90.00 for a missed medication review session. This is a strict policy with no exceptions. Please remember that if you are using insurance, charges cannot be submitted for missed sessions, and you will be held responsible for the charges as specified above. In cases of excessive absences, it will be at your provider's discretion to terminate services at PTS and possibly refer your care elsewhere. If a patient owes on their account, payment is expected during each visit in order to continue scheduling. If a balance exists whereby no payments have been made in 30 days, PTS will attempt to contact you. If no payments are made after these attempts, PTS contracts with an external collections service that will then pursue settling the amount due.

Information disclosed in session will be kept confidential and not revealed to any other person or agency without your written consent. However, there are exceptional circumstances that may require your therapist to share information obtained in a session without your permission. These exceptional situations include: (1) If you threaten serious bodily harm to yourself or another person, your provider is required by law to inform the intended victim and/or the appropriate law enforcement agency; (2) If your provider is subpoenaed by a court of law to provide specific information, s/he is obligated to comply; and (3) If you reveal information to your provider about child abuse and/or neglect, s/he is required by law to report this information to the appropriate authority.

After you have carefully read this information and have received satisfactory answers to any relevant questions, please sign this contract below. Anyone over the age of 18 years must sign this form in order to be treated through PTS. Parents or legal guardians must sign for persons under 18 years old.

I have read and understand the information provided in this document and agree to the outlined procedures and conditions. I understand that I may terminate treatment at any time and will be financially responsible for those sessions already completed.

Patient name (Print) _____ Date: _____

Patient signature (Parent signature for minor patients) _____ Date: _____

Provider signature _____Date: _____

At times, there are persons who join the therapy process who are not identified as the "patient", but are important to treatment. By signing below, you acknowledge this is a health care setting. The protections in place through our practice's HIPAA policies protect you to the same degree as the primary patient. If a minor is joining the therapy process, the parent or legal guardian must consent to this participation by signing below:

Signature: _____ Date: _____

_____ Initial here to acknowledge that you have read the Notice of Privacy Practices and that a copy of the Notice has been provided to you upon your request.

Expectations of Patients Receiving Psychiatric Care

Perspectives Therapy Services LLC (PTS) makes every effort to meet your mental health and medication needs. Please read the following expectations that our practice has of its psychiatric patients:

1. It is important that the patient keeps and attends all scheduled appointments with the provider. Consistent attendance and regular medical monitoring are imperative to comprehensive treatment.
2. It is essential that you take any prescribed medications as directed by your psychiatric care provider.
3. Women of childbearing age should avoid pregnancy while taking psychotropic medications. Women of childbearing age should notify their provider immediately if they intend to become pregnant or if there is a possibility, they may be pregnant.
4. It is our policy to coordinate care amongst the patient's healthcare providers. This is especially true when medications are involved as they need to be monitored and assured that they can be safely used together. Once you sign a Release of Information form to permit inter-provider communication, we will coordinate with them on your behalf.
5. It is expected that you obtain any laboratory tests as requested by your psychiatric provider.
6. If you see a psychiatric care provider at PTS, it is expected that you will also be regularly seeing a therapist (preferably within the practice as well).
7. If, at any time, you and your provider decide to discontinue treatment, a 30-day supply of your medication can be prescribed to you. After that time, you are expected to contact your family physician for continuation of your medication regimen.
8. Patients who are seeing a psychiatric care provider because of disability are expected to bring disability forms to their scheduled appointments. In order to have your disability forms completed, you must keep all scheduled appointments.

If you have any questions about the psychiatric services you are receiving through PTS, please contact our psychiatric team at 810-494-7180, ext 107.

Patient signature (Parent signature for minor patients) _____ Date: _____

Insurance Consent

By signing below, I give PTS permission to release all required information to my insurance company to attain payment for services rendered. I understand that if my insurance company does not cover these services, I am responsible for the balance.

Signature of Insured _____ Date: _____

Cell Phone Communication Consent

The patient and/or legal guardian of the patient has the privilege of contacting their provider via cell phone. This communication includes both phone calls as well as text messages. Know that this ability can be revoked if the provider deems the patient to be abusing this privilege. This definition of abuse is left to the discretion of the individual provider and may include, but is not limited to, excessive calls and texts from the patient and/or legal guardian despite the provider addressing the concern.

Please know that just because you call or text a provider does not mean you will receive an immediate response, or even a response at all. Some concerns brought up in a text message, for example, may be better addressed during a clinical session. Please note that the intention of receiving the provider's phone number is primarily for scheduling purposes and to increase communicative efficiency. Please respect normal business hours when calling or texting your provider.

Providing this number **in no way** indicates 24-hour daily access to a provider's services, nor should it be considered an emergency resource. If you or someone you know is in a mental health crisis, you are still instructed to contact your local Community Mental Health agency, call 911, or go to your local emergency room.

HIPAA Privacy Disclosure Regarding Cell Phone Communication

Please be advised that communication via cell phone is not secure. While all efforts will be made to maintain your privacy, the confidentiality of cell phone calls or text messages cannot be guaranteed.

By signing below, you are indicating that you understand and accept the above conditions. Failure to sign this section of the form will not change your care at PTS. It is completely optional.

Patient signature (Parent signature for minor patients) _____ Date: _____

REGISTRATION AND INTAKE FORM

CLIENT CONTACT INFORMATION

_____ _____ _____
Last Name First Name Social Security #

Address_____ City_____ State_____ Zip_____

Please check below if a message can be left at the following numbers
_____ Home phone: (_____)_____ _____ Work phone: (_____)_____
_____ Cell phone: (_____)_____ Cell phone carrier: _____
Email address:_____

APPOINTMENT REMINDERS

Appointment information is considered to be "Protected Health Information" under HIPAA. By my signature, I am waiving my right to keep this information completely private and requesting that it be handled as I have requested below. Missed appointment fees will still apply if the reminder message is not received.

Where would you like to receive an appointment reminder? (check one)
___ Via text message on my cell phone (normal text message rates will apply according to your contract)
___ Via email message to the address listed above
___ Via automated telephone message to my home phone
___ None of the above. I'll remember my appointments on my own

Signature:_____ Date:_____

CLIENT PROFILE INFORMATION

Date of Birth_____ Male____ Female____ Marital Status: Single___ Married____ Other____

Household Member Name Date of birth Relationship to you

_____
_____
_____
_____

Emergency contact:_____
Name Phone number Relationship

BILLING INFORMATION

Responsible Party Name (who pays the bill):_____ SSN:_____

Responsible Party Address: _____
Street City State Zip Code

Primary Insurance Company Name:_____

Subscriber/Member ID #:_____ Group #:_____

Patient relation to insured: Self_____ Spouse_____ Child_____ Other_____

Subscriber name:_____ Subscriber birthdate:_____

Secondary Insurance Company Name:_____

Subscriber/Member ID #:_____ Group #:_____

Patient relation to insured: Self_____ Spouse_____ Child_____ Other_____

Subscriber name:_____ Subscriber birthdate:_____

REFERRAL INFORMATION

How did you find out about Perspectives Therapy Services? Check appropriate box

□ Friend(s)/Neighbors □ Family Member □ Physician/Family Doctor □ Web Search/Internet
□ Social Service Agency □ Court System □ School System □ Yellow Pages
□ Other (please specify)_____

May we send a general thank-you to this referring source? □ Yes □ No
If yes, where should this be sent? _____

PREVIOUS THERAPY EXPERIENCE

Have you received mental health services (counseling/therapy) in the past? _____Yes _____No
If yes,……..When?_____Where or with whom?_____
For what reason?_____

What was *most* helpful about this therapy experience?_____
_____

What was *least* helpful about this previous therapy experience?_____
_____

MEDICAL BACKGROUND

Primary Care Physician_____ Phone Number_____

Address_____ City_____ State_____ Zip_____

Please list any medications you are taking at this time.

Medication	Dosage/Frequency	Reason for taking
Medication	Dosage/Frequency	Reason for taking
Medication	Dosage/Frequency	Reason for taking

Have you ever been hospitalized for reasons relevant to your attending therapy? □ Yes □ No
If yes, please describe_____

PROBLEM SPECIFICATION

Briefly describe what brings you to therapy at this time_____
_____
What would you like to see happen as a result of therapy? _____
_____

Office Use Only

Therapist initials:_____ Location: B L Hi F Diagnosis:_____ Supervisor:_____
USERNAME: PASSWORD:

Thank you for providing the information requested on this form. This is considered confidential information and will not be shared with anyone other than your therapist unless permission is granted through written consent.

Credit Card Authorization

Perspectives Therapy Services LLC uses an integrated electronic medical record-keeping system for client charts and billing. This form serves as an authorization to input your credit card information into our secure system and charge it when a balance on your account exists.

The following are examples of charges that will be charged to the credit card on file: co-payments, deductibles, document preparation/report-writing fees, costs for attendance at collaboration meetings, late cancel and no-show fees, and returned check fees.

Type of Card (check one): ☐ MASTERCARD ☐ VISA ☐ AMERICAN EXPRESS ☐ DISCOVER

Type of Card (circle one): CREDIT HSA/FSA DEBIT

Name of Cardholder:_____

Card No._____

Expiration date:_____ CVV2 (security code):_____

Client address:_____
Street City State Zip Code

Authorizing signature:_____ Date:_____

Client name (printed):_____

*This card will be used for any and all providers with whom a client receives services from through Perspectives Therapy Services. It is the client's responsibility to update credit card information with our practice as changes occur.

For Office Use Only:

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, 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 any problems, how difficult 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**
☐	☐	☐	☐

THE MOOD DISORDER QUESTIONNAIRE

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

	YES	NO
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?	○	○
...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?	○	○

Beck Anxiety Inventory

Below is a list of common symptoms of anxiety. Please carefully read each item in the list. Indicate how much you have been bothered by that symptom during the past month, including today, by circling the number in the corresponding space in the column next to each symptom.

	Not At All	Mildly but it didn't bother me much	Moderately - it wasn't pleasant at times	Severely – it bothered me a lot
Numbness or tingling	0	1	2	3
Feeling hot	0	1	2	3
Wobbliness in legs	0	1	2	3
Unable to relax	0	1	2	3
Fear of worst happening	0	1	2	3
Dizzy or lightheaded	0	1	2	3
Heart pounding/racing	0	1	2	3
Unsteady	0	1	2	3
Terrified or afraid	0	1	2	3
Nervous	0	1	2	3
Feeling of choking	0	1	2	3
Hands trembling	0	1	2	3
Shaky / unsteady	0	1	2	3
Fear of losing control	0	1	2	3
Difficulty in breathing	0	1	2	3
Fear of dying	0	1	2	3
Scared	0	1	2	3
Indigestion	0	1	2	3
Faint / lightheaded	0	1	2	3
Face flushed	0	1	2	3
Hot/cold sweats	0	1	2	3
Column Sum				

Scoring - Sum each column. Then sum the column totals to achieve a grand score. Write that score here _____ .