CNS
MENTAL WELLNESS

New Patient Information

Please read, complete and sign all parts of this form.

Patient Demographics:

Patient Name	
DOB	
Social Security #	
Primary Phone #	
Mailing Address	
Reason for Visit	
Next of kin	
Relationship to pt	
Phone #	
Pharmacy	Name: address:
Primary Care Dr Address Phone number	
Referral	Who referred you/how did you find us?

Meaningful Use Stage 2 requires us to provide all our patients with access to our Patient Portal. We cannot take any actions within your patient account without an e-mail address. If you do not have one, please provide the e-mail address of a relative, caregiver, etc. Our Patient portal allows us to send appointment reminders and allows you to communicate more easily with our staff.

Preferred Email: _____

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IMPORTANT PATIENT INFORMATION

- **Patient Paperwork**: MVA, FMLA, Workers Comp and other official forms, require an appointment if you have not been seen within the past three (3) months. If you have been seen within this time frame but do not wish to schedule an appointment, forms may be filled out for a fee of $50, no exceptions.
- **Insurance and Billing**: If you have authorized us to bill your insurance on your behalf, we will submit a claim within the timely filing required by your insurance. All outstanding balances will be billed to the patient. If no response or payment is received, accounts will be sent to a third-party collection agency. Please contact us as soon as you know of any changes to your insurance policy. You cannot be scheduled for an appointment until your balance is cleared or payment plan is set with a collection agency.
- **Cancellation Policy:** Please be advised that we have a 24-hour cancellation policy for all appointments. A fee will be assessed at $1/minute for the length of the appointment. (E.g. a 20-minute appointment cancellation fee would be $20.00).

*****PLEASE NOTE, WE RESERVE THE RIGHT TO FORMALLY DISCHARGE PATIENTS WITH A MINIMUM OF 3 NO SHOWS AND/OR LATE CANCELLATIONS .**

- **Interpreters (ASL):** Our office offers to schedule an ASL interpreter when needed. However, if you deny this offer, you are required to bring your own interpreter to the appointment. Appointments cannot be completed by exchanging notes as this may prevent the provider from communicating both effectively and extensively. Note: if an ASL Interpreter was scheduled for your appointment, a no-show or <24 hour cancellation will result in an office no-show fee as well as the interpreter's no-show fee being charged to your account. All other languages are required to provide their own translator.
- **Medication Refills:** Please contact our office at least one(1) week in advance to allow adequate approval and review for all medication refill requests. If your medication requires a prior-authorization, we will work to obtain this as quickly as possible, but may require additional time. For your safety, if you have not been seen in the past year, medication refill requests will not be processed without an appointment.
- **Medication Changes:** Effective 01/15/2017, medication changes **will not** be made over the phone.
- **Your Follow-up Appointment:** Please bring your photo ID, insurance cards, a medication list, and any recent labs or radiology results to every appointment. Please do not drop off CDs or films in advance of your appointment as we will not be able to hold onto these for you.
- **Labs, MRIs and other Radiology Results:** If your results are normal, you will not receive a call, and your results will be reviewed at your next appointment. If results are abnormal, our providers or medical assistants will reach out to you. Depending on the performing facility, results are received in approximately one week.
- **EMG/NCV Study:** Please do not wear any lotions, oils, or other moisturizers on your skin for this test. If you are on blood-thinners, please make sure our staff and providers are aware. Continue taking your medications as normal.
- **PAP Machines:** Please bring a recent compliance report to every appointment.
- **Botox Injections**: If you have been submitted as a candidate for Botox injections, please allow a 6-8 week turnaround-time for approval from your insurance. Injections are done on a preselected day of the month. Once approval is given from insurance and Botox is received, you will receive a call from our office to schedule your appointment on that day. On the day of injection, please do not wear excessive makeup.

I have read and understand the policies listed above: _____(**sign**)

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Financial Agreement

Thank you for choosing our practice for your patient care. We are committed to providing you with quality and affordable health care. Due to inquiries regarding patient and insurance responsibility for services rendered, we have developed this payment policy. Please read it, ask any questions you may have, and sign in the space provided below. A copy will be provided to you upon request. Our practice is committed to providing the best treatment to our patients. Our prices are representative of the usual and customary charges for our area. Thank you for understanding our payment policy. Please let us know if you have any questions or concerns.

1. **Insurance**. Our practice participates with most insurance plans, including Medicare. If you are not insured by a plan we do business with, payment in full is expected at each visit. If you are insured by a plan we do business with, but don't have an up-to-date insurance card, payment in full for each visit is required until we can verify your coverage. Knowing your insurance benefits is your responsibility, including if your plan requires a referral to be seen by our provider. Please contact your insurance company with any questions you may have regarding your coverage.

2. **Copayments and deductibles**. All copayments and deductibles must be paid at the time of service. This arrangement is part of your contract with your insurance company.

3. **Non-covered services**. Please be aware that some – and perhaps all – of the services you receive may be non-covered or not considered reasonable or necessary by Medicare or other insurers. You must pay for these services in full at the time of visit.

4. **Proof of insurance**. All patients must complete our patient information forms before seeing the doctor. We must obtain a copy of your driver's license and current valid insurance to provide proof of insurance. If you fail to provide us with the correct insurance information in a timely manner, you may be responsible for the balance of a claim. You may opt to pay our self-pay charges, which does vary depending on the level and type of service provided for your care.

5. **Claims submission**. We will submit your claims and assist you in any way we reasonably can to help get your claims paid. Your insurance company may need you to supply certain information directly. It is your responsibility to comply with their request. Please be aware that any or all balance left on your claim is your responsibility whether or not your insurance company pays your claim. Your insurance benefit is a contract between you and your insurance company. You may choose to pay our self-pay fee and file the claim at your own convenience.

6. **Coverage changes**. If your insurance changes, please notify us before your next visit so we can make the appropriate updates to help you receive your maximum benefit and obtain proper authorization for coverage. If your insurance company does not pay your claim within their contract, the balance will automatically be billed to you. If you fail to notify us of a change in coverage, it will be assumed that you are opting to be a self-pay patient and will file the claim at your own convenience.

7. **Nonpayment**. If your account is over 90 days past due, further action may be required. Partial payments will not be accepted unless otherwise negotiated. Please be aware that if a balance remains unpaid, we may refer your account to a collection agency.

8. **Missed appointments**. Our policy is to charge for missed appointments not canceled within a 24 hour period. These charges will be your responsibility and billed directly to you. Please help us to serve you better and the community by keeping your regularly scheduled appointment. Missed appointments prevent other patients from being cared for by our physicians. Please Note: if an ASL Interpreter was scheduled for your appointment, a no-show or <24 hour cancellation will result in an office no-show fee as well as the interpreter's no-show fee being charged to your account.

*****PLEASE NOTE, WE RESERVE THE RIGHT TO FORMALLY DISCHARGE PATIENTS WITH A MINIMUM OF 3 NO SHOWS.**

_____

Patient signature (sign)

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HIPAA Acknowledgement and Disclosure Form Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize Comprehensive Neurology Services, PA to use and/or disclose certain protected health information (PHI) about me to other health care providers for treatment purposes, in special situations for law enforcement or judicial purposes as described by the Health Insurance Portability Accountability Act of 1996, and to the following individuals or entities:

Name: _____Relationship:_____ Phone: _____

Name: _____Relationship:_____ Phone: _____

This authorization permits Comprehensive Neurology Services, PA to use and/or disclose the following individually identifiable health information about me, including, but not limited to, date(s) of services, type(s) of service, physicians' notes, procedural results, etc. This information will be used or disclosed if medically or lawfully necessary at the request of the patient. The practice, under normal circumstances, will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. Comprehensive Neurology Services, PA also provides a full-length description of the Health Insurance Portability and Accountability Act of 1996.

We participate in Chesapeake Regional Information System for our Patients, Inc. (CRISP), a statewide electronic health information exchange (HIE). The other CRISP participants and we share information about patients for treatment, payment, or other health care operations, as permitted by law. The purpose of CRISP is to provide better coordination of care and assist providers in making more informed treatment decisions. You may opt out and prevent CRISP participants from having the ability to search your information through HIE, however, even if you opt out, we will send your medical information to the HIE and our physicians who order diagnostic tests on you will be able to review results that the testing facility provides to CRISP. You may opt out by contacting CRISP on the internet at www.crisphealth.org or by phone at 1-877-95-CRISP.

This form and the Notice of Privacy Practices are provided so that I can make an informed decision whether to allow release of the information. I do not have to sign this authorization in order to receive treatment from Comprehensive Neurology Services, PA. I understand that I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to retraction by the patient and may no longer be protected by the federal HIPAA Privacy Rule. This authorization expires in one (1) year.

_____ _____

Patient (or Legally Authorized Representative) Signature (SEAL) Date

_____

Description of Legally Authorized Representative's Authority (POA, Guardian) (SEAL)

_____ _____

Signature of Witness Date

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Insurance Authorization and Assignment Form

All professional services rendered are charged to the patient. If we do not accept your insurance plan, the necessary forms will be completed to help expedite insurance carrier payments. However, the patient is responsible for all fees, and it is customary to pay when services are rendered unless other arrangements have been made in advance with our office. You have to pay your copayment and/or deductibles when services are rendered. It is the responsibility of the patient to secure the necessary referrals from his/her primary care physician. If you do not have the necessary referral at the time of your visit, the fee for the service rendered will be your responsibility and is expected to be paid at the time of your visit.

I hereby, authorize Dr(s) Rafiq, Strayhorn, Khan, Martins, Brosbe, Burke, Somefun, PA-C Caw, PA-C Pastrana, PA-C Afriyie, PA-C Golden, PMHNP Fair, and CRNP Ward, to diagnose, treat and manage the medical condition(s) presented at the time for the visit and to furnish all information to the insurance carriers concerning my illness and treatments. I hereby assign all my insurance payments to Comprehensive Neurology Services, PA for medical services rendered to myself or my dependents. I understand that I am responsible for any amount that is not a covered service under my insurance.

Patient name (print) Patient name (**signature**)

Patient Release of Medical Records Form

I, _____ (patient's name) request and give my permission to release my medical records to Comprehensive Neurology Services for the time period dating from_____ to _____.

The Medical Records as listed above are to be released to:

Comprehensive Neurology Services, PA

C/o Dr.(s) Shahid Rafiq, David Strayhorn, Mehrullah Khan, Albert Martins, Laura Brosbe, Sean Burke, Laura Pastrana, Ayodeji Somefun, PA-C & Jillienne Caw, PA-C, Collina Afriyie PA-C, Amanda Golden PA-C, Jatoria Fair CRNP

- ❏ 196 Thomas Johnson Drive Suite 120, Frederick, MD 21702 Fax: 240-566-3131
- ❏ 12800 Middlebrook Rd., Suite 114, Germantown, MD 20874 Fax: 240-702-0194+
- ❏ 10301 Georgia Ave., Suite 206, Silver Spring, MD, 20902 Fax: 301-363-4367
- ❏ 11110 Medical Campus Rd, Suite 227, Hagerstown MD 21740 Fax: 866-981-2695

Comments: _____

_____

_____

_____

Printed Patient Name

DOB_____ Social Security # _____

_____

Patient's **Signature** Today's Date

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Patient Name: _____ Today's Date: _____

1. Do you have any prior psychiatric diagnoses? Check all that apply

☐ Depression ☐ Generalized Anxiety Disorder ☐ Bi-polar ☐ ADHD
☐ Schizophrenia ☐ PTSD ☐ Panic Disorder ☐ OCD ☐ Social Anxiety
☐ Eating Disorder ☐ Addiction ☐ Psychosis ☐ Phobia ☐ Major Depressive Disorder
☐ Other _____

2. What are your current symptoms? Check all that apply

☐ Depressed mood ☐ Avoidance ☐ Excessive energy
☐ Racing thoughts ☐ Loss of interest ☐ Excessive guilt
☐ Excessive worry ☐ Increased libido ☐ Decreased libido
☐ Increased irritability ☐ Hallucinations ☐ Fatigue
☐ Unable to enjoy activities ☐ Crying spells ☐ Anxiety attacks
☐ Increased risky behavior ☐ Change in appetite ☐ Suspiciousness
☐ Sleep pattern disturbance ☐ Impulsivity ☐ Increased need for sleep
☐ Concentration/forgetfulness

3. Past Psychiatric Treatment

Inpatient treatment ☐ Yes ☐ No If yes please complete the following below

Reason	Date	Location/Treated by

Outpatient treatment ☐ Yes ☐ No If yes please complete the following below

Reason	Date	Location/Treated by

4. Have you ever had ECT or TMS Therapies? ☐ Yes ☐ No When? _____

5. Do you currently see a therapist? ☐ Yes ☐ No
   If yes, who is it? _____
   Therapist phone number _____

6. Do you currently see a psychiatrist? ☐ Yes ☐ No
   If yes, who is it? _____
   Psychiatrist phone number _____

7. Do you have any prior suicide attempts? ☐ Yes ☐ No when _____

8. Do you have any prior history of SI/HI? ☐ Yes ☐ No when _____

9. Do you have any self injurious behaviors? ☐ Yes ☐ No _____

10. Do you have a history of abuse? (sexual, physical, neglect) ☐ Yes ☐ No

11. Do you have a history of traumatic events? ☐ Yes ☐ No

12. If yes please describe _____
    _____

13. Do you have any access to firearms? ☐ Yes ☐ No

14. Please list your current psychiatric medications including strength and directions

Medication Name	**Strength**	**Directions**

15. To the best of your ability please complete the chart below concerning previous psychiatric medications

SSRI: Generic	Brand name	Dosage - please check	Dates	Duration	Outcome/side effects
Citalopram	Celexa	☐20 mg ☐40 mg			
Escitalopram	Lexapro	☐10 mg ☐20 mg			
Fluoxetine	Prozac	☐20 mg ☐40 mg ☐60 mg			
Fluvoxamine	Luvox	☐25mg-300mg ☐CR 100mg-300mg			
Paroxetine	Paxil	☐20 mg ☐40 mg ☐60 mg ☐80 mg			
Sertraline	Zoloft	☐50 mg ☐100 mg ☐150 mg ☐200mg			

SNRI: Generic	Brand name	Dosage - please check	Dates	Duration	Outcome/side effects
Desvenlafaxine	Pristiq	☐50 mg ☐100 mg			
Duloxetine	Cymbalta	☐20 mg ☐30 mg ☐60 mg			
Venlafaxine	Effexor	25 mg-225mg _____ XR 37.5mg-375mg _____			
Levomilnacipran	Fetzima	☐40 mg ☐80 mg ☐100 mg			
Milnacipran	Savella	12.5 mg-100 mg _____			

Tricyclic/TCA:	Brand name	Dosage - please check	Dates	Duration	Outcome/side effects
Amitriptyline	Elavil	☐50 mg ☐150 mg			
Clomipramine	Anafranil	25 mg-250 mg _____			
Desipramine	Norpramin	☐100 mg ☐200 mg			
Imipramine	Tofranil	☐50 mg ☐100 mg ☐150 mg			
Doxepin	Sinequan	150 mg - 300mg _____			
Nortriptyline	Pamelor	☐100 mg ☐150 mg			
Protriptyline	Vivadil, Vivactil	☐40 mg ☐60 mg			

NDRI: Generic	Brand name	Dosage - please check	Dates	Duration	Outcome/side effects
Bupropion	Wellbutrin	100mg - 300mg _____			
Bupropion XL	Wellbutrin XL	150 mg - 450mg _____			
Bupropion SR	Wellbutrin SR	100 mg - 400mg _____			

MAOIs: Generic	Brand name	Dosage - please check	Dates	Duration	Outcome/side effects
Phenelzine	Nardil	15mg - 90mg _____			
Tranylcypromine	Parnate	10mg - 60mg _____			
Selegiline	Emsam	6mg - 12mg patch _____			
Isocarboxazid	Marplan	20 mg - 60 mg _____			

Other: Generic	Brand name	Dosage - please add	Dates	Duration	Outcome/side effects
Nefazodone	Serzone	150mg - 600mg _____			
Desyrel	Trazodone	150 mg + Lower for sleep _____			
Vortioxetine	Trintellix	5 mg - 20 mg _____			
Mirtazapine	Remeron	15 mg - 45mg Lower for sleep _____			
Vilazodone	Viibryd	15 mg - 40 mg _____			

Augmenting Agents: Generic	Brand name	Dosage - please circle	Dates	Duration	Outcome/side effects
Aripiprazole	Abilify	2mg, 5mg, 10mg, 15mg, 20mg, 30mg			
Olanzipine	Zyprexa	5mg, 7.5mg, 10mg, 20mg			
Quetiapine	Seroquel	25mg, 50mg, 100mg, 200mg, 300mg, 400mg, 500mg, 600mg. Other for sleep:			
Brexpiprazole	Rexulti	1mg, 2mg, 3mg, 4mg			
Buspirone	Buspar	5mg - 30mg _____			
Eskalith	Lithium	600mg, 800mg, 1000mg, 1200mg, 1500mg			
L-methylfolate	Deplin, Enlyte MethylPro	7.5mg - 15mg _____			

Carbamazepine	Tegretol	600mg, 800mg, 1000mg, 1600mg, 1500mg			
Divalproex	Depakote	750mg, 1500mg			
Lamotrigine	Lamictal	25mg, 50mg, 100mg, 200mg, 300mg, 400mg, 500mg			
Lurasidone	Latuda	40mg, 60mg, 80mg			
Ziprasidone	Geodon	20mg			
Asenapine	Saphris	5mg, 10mg			
Cariprazine	Vraylar	1.5mg, 3mg, 4.5mg, 6mg			

Substance Use/Abuse

16. **Are you a smoker?** ☐ Current ☐ Former ☐ Never
    If you are a current smoker, how many cigarettes per day? _____
    If you are a current smoker, how soon after you wake up do you have your first cigarette?_____
    If you are a current smoker, are you interested in quitting? ☐ Yes ☐ No
    If you are a former smoker, how long has it been? _____
17. **Have you had any drinks containing alcohol in the past year?** ☐ Yes ☐ No
    IF YES, How often do you have a drink containing alcohol? (*check one*)
    ☐ Never ☐ Monthly ☐ Two to four times a month
    ☐ Two to three times a week ☐ Four or more times a week
    How many drinks with alcohol do you have on average? (*check one*)
    ☐ 1 or 2 ☐ 3 or 4 ☐ 5 or 6 ☐ 7 to 9 ☐ 10 or more
    IF you answered more than 5 or 6 drinks, how often do you consume 5 or 6 drinks with alcohol? (*check one*)
    ☐ Less than monthly ☐ Monthly ☐ Weekly ☐ Daily
18. Do you drink any beverages with caffeine? ☐ Yes ☐ No
    If yes, how many caffeinated beverages do you have a day? ☐ 1-2 ☐ 3-4 ☐ 5 or more
19. Have you ever used any of the following:
    Methamphetamine ☐ Yes ☐ No Cocaine/Stimulants ☐ Yes ☐ No Heroin ☐ Yes ☐ No
    LSD/Hallucinogens ☐ Yes ☐ No Marijuana ☐ Yes ☐ No Methadone ☐ Yes ☐ No
    Non-prescribed pain killers ☐ Yes ☐ No Tranquilizers/Sleeping pills ☐ Yes ☐ No
    Ecstasy ☐ Yes ☐ No Other _____ ☐ Yes ☐ No
20. Have you ever had any substance abuse treatment? ☐ Yes ☐ No When/where _____
    _____

General Medical History

21. What, if any, are your current medical issues?
    _____
    _____
    _____
    _____
    _____
    _____

22. Medical Medications

Medication Name	Strength	Directions

***** ATTACH ADDITIONAL MEDICATIONS AT THE END OF THIS FORM IF NEEDED*****

OTC Medication/Daily Vitamins	Strength	Directions

23. **Previous Medical Conditions or Diagnosis** *(What have you been **medically** diagnosed with by another physician)*

1.
2.
3.

24. **Surgical & Hospitalization History** *(Please include Date & Location if known)*

1.
2.
3.

25. Do you have a history of seizures? ____ Yes ____ No

26. Fall Risk Screening

Have you had any major falls that resulted in injury or required medical attention within the last 12 months? Check one. ____ Yes ____ No If yes, how many falls total? _____

27. **General Wellness -**

Have you had the flu shot? Please list month and year if known: _____

Have you had the Covid Vaccine? (If yes, please check which one)

☐ Moderna, ☐ Pfizer, ☐ Johnson & Johnson) Date_____

Do you have a history of any Cardiac related issues/Arrhythmias? ____ Yes ____ No

Do you have a history of LOC/head injuries? ____ Yes ____ No

Any Developmental delays? ____ Yes ____ No

Allergies *(Please include reaction to allergy if known)*

☐ Check this if there are no known allergies

1.
2.
3.

Date of your last wellness exam: _____

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28. Assigned female at birth only

What is the date of your LMP? _____

Could you be pregnant? ☐ Yes ☐ No

Form of contraception? _____

Breastfeeding? ☐ Yes ☐ No

FAMILY HISTORY

29. **Family Psych History**

(Check all that apply)

Family Member	Bi-Polar	PTSD	Depression	Anxiety	Suicide	Schizophrenia	Substance/alcohol abuse
Father							
Mother							
Siblings							
Children							
Grandparents							

30. **Family History- Medical** *(Check all that apply)*

Family Member	Alive or deceased	Diabetes	Hypertension	Heart Problems	Stroke/TIA	Mental illness	Cancer
Father							
Mother							
Siblings							
Children							
Grandparents							

For Siblings: How many brothers? _____ How many sisters? _____
(*Both alive and deceased*)

For Children: How many sons? _____ How many daughters? _____
(*Both alive and deceased*)

31. Social History

Where were you born/raised? _____

Are/were your parents ☐ married ☐ divorced

Were you raised by both parents? ☐ Yes ☐ No

Describe your childhood: _____

_____

32. Education/Employment History

What is your highest level of education?

☐ High school ☐ College-2 year ☐ College-4 year ☐ Advanced degree

Are you working right now? ☐ Yes ☐ No

If yes - Where do you work?

_____

33. Gender Identity

What is your gender identification? _____

What is your sexual orientation?_____

Are you married? ☐ Yes ☐ No

Are you sexually active? ☐ Yes ☐ No

34. What is your current living situation? _____

35. Who is your social support? _____

36. What are your hobbies/interests? _____

37. Have you ever served in the military? ☐ Yes ☐ No

38. Any current or past legal history? ☐ Yes ☐ No