Eastern Panhandle Psychiatry
51 Street of Dreams
Martinsburg, WV 25403
(P)304-264-1442 (F)304-264-4317

Registration Information Sheet
Patient Information

Date:_____

Patient Name:_____
Date of Birth:_____ Age:_____
Home #_____Cell#_____
Social Security Number_____
Sex: Male Female Legal Status: Single Married Divorced Widowed
Race:_____ Religion (if any) _____

Emergency Contact Name: _____
Relationship to patient:_____phone:_____

Physical Address: _____
City:_____State: WV VA MD Zip Code:_____

Email Address:_____
Would you like email appointment reminders: YES NO

Preferred Pharmacy: _____Number:_____
Address:_____City:_____

Subscribers Name:_____
Relationship: _____DOB :_____

For Minors:
Parent/Legal Guardian Present:_____
Relationship to minor: _____

Eastern Panhandle Psychiatry
51 Street of Dreams
Martinsburg, WV 25403
Phone 304-264-1442
Fax 304-264-4317

REQUEST FOR MEDICAL RECORDS

Hospital/Institution:

_____

_____

_____

TO WHOM IT MAY CONCERN:

The patient below is now being treated in our office. We have been informed that he/she was treated at your facility on or about_____.

Patient Name:_____

Social Security Number:_____

Date of Birth:_____

Please send us the following information on this patient at your earliest convenience.

_____Discharge Summary

_____Admitting History & Physical

_____Operative Report & Pathology Report

_____Doctor's Orders and Progress Notes

_____Consultation Notes

_____Radiology,Labs,EKG,EEG,ECHO reports

_____Nurses Notes

_____Entire Chart

I understand that the information to be released includes information concerning my physical and mental status, as well as results of any diagnostic tests. Including HIV and/or drug screens if applicable, along with all diagnostic information.

I understand that this authorization is valid for a period of 90 days from the date of signature. I hereby give my permission to release my medical records to Eastern Panhandle Psychiatry.

Parent/Legal Guardian:_____Patient:_____Date:_____

Eastern Panhandle Psychiatry
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(P)304-264-1442 (F)304-264-4317

Primary Care Physician:

Fax:

Phone:

Please call your Doctor's office and provide us with this information:

Eastern Panhandle Psychiatry Inc.
51 Street of Dreams
Martinsburg, WV 25403
Phone 304-264-1442
Fax 304-264-4317

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION

I, _____ authorize Eastern Panhandle Psychiatry Inc to exchange my personal health information and treatment to the following:

_____ Date:_____

Relationship to patient:_____

_____Date:_____

Relationship to patient:_____

I understand that this authorization may be revoked and updated by myself at any time except the information that has already been released under this or previous authorizations. I hereby release Eastern Panhandle Psychiatry Inc from all liabilities that may arise from the release of the information requested. I understand that all my records are protected under federal regulations governing. Confidentiality of alcohol and drug abuse, patient records, 42 CFT Part 2, cannot be disclosed without my written consent unless otherwise provided for in the regulations.

Date:_____

Patient Signature:_____Date of Birth:_____

Signature of Parent, Guardian or Authorized Representative:_____

Witness:_____

Patient Financial Responsibilities and Insurance Policies

Individual's Financial Responsibility

__I understand that I am financially responsible for my health insurance deductible, coinsurance and any non covered service.

__Co payments are due at the time of service.

__If my plan requires a referral, I must obtain it prior to my visit.

__In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided.

__If I am uninsured, I agree to pay for the Mental Health services rendered to me at the time of service.

__If my insurance changes, it is my responsibility to provide updated information in a timely manner per my insurance companies guidelines. Failure to do so in a timely manner may result in my having pay at a self-pay rate due to my insurance company's policies.

__Missed appointments, I understand that keeping appointments is expected as part of effective mental health treatment. Cancellations less than **24 hours** of my scheduled appointment will result in a $75 No Show fee to be paid **before** my next appointment.

__Medication prescriptions are to be given at a scheduled visit, otherwise there is a $25.00 fee per medication requests which could have been addressed during a scheduled follow up appointment.

__There is a $30.00 service fee for all returned checks.

_I verify that all insurance given is accurate and I have no other insurance including Medicaid.

_I consent to see my provider through virtual telehealth communications.

Insurance Authorization for Assignment of Benefit

__I hereby authorize and direct payment of my Mental Health Benefits to Eastern Panhandle Psychiatry PC on my behalf for any services furnished to me by the provider.

_____
Printed Name of Patient/Responsible Party

_____ _____
Signature of Patient or Responsible Party Date

_____
Relationship to patient (if other than patient)

HIPAA
PATIENT CONSENT FORM

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information about you. The Notice contains a Patients' Rights section describing your rights under the law. You have the right to review our Notice before signing this Consent. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how protected health information about you is used or disclosed for treatments, payment, or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you consent to our use and disclosure of protected health information about you for treatment, payment and health care operations. You have the right to revoke this Consent in writing, signed by you. However, such revocation shall not affect any disclosures we have already made in reliance on your prior Consent. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

Protected health information may be disclosed or used for treatment, payment or health care operations.
The Practice has Notice of Privacy Practices and that the patient has the opportunity to review this Notice.
The Practice reserves the right to change the Notice of Privacy Practices.
The Patient has the right to restrict the uses of their information, but the Practice does not have to agree to those restrictions.
The Patient may revoke this Consent in writing at any time and all future disclosures will then cease.
The Practice may condition receipt of treatment upon the execution of this Consent.

This Consent was signed by:

_____
Printed Name-Patient or Responsible Party

_____
Patient Signature or Responsible Party Date

_____
Relationship to patient (if other than)

_____
Printed Name-Practice Representative (witness)

_____
Signature of Witness Date

Eastern Panhandle Virginia Mental Health Hagerstown Psychiatry

Date of authorizing charge:_____

Patient Name:_____

Credit Card Number:_____

Expiration Date:_____ Security Code:_____

Amount to be charged:_____ How Often:_____

Card Holder Name:_____

Billing Address:_____

City:_____ State:_____ Zip Code:_____

Email for receipts:_____

Printed name of Card Holder:_____

Signature of Card Holder:_____ Date:_____

Permission for Telehealth Visits

What is telehealth?

Telehealth is a way to visit with healthcare providers, such as your doctor, nurse practitioner, counselor or therapist.

You can talk to your provider from any place, including your home. You don't go to a clinic or hospital.

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet, using video so you and your provider can see each other.

How does telehealth help me?

- You don't have to go to a clinic or hospital to see your provider.
- You won't risk getting sick from other people.

Can telehealth be bad for me?

- You and your provider won't be in the same room, so it may feel different than an office visit.
- Your provider may make a mistake because they cannot examine you as closely as at an office visit. (We don't know if mistakes are more common with telehealth visits.)
- Your provider may decide you still need an office visit.
- Technical problems may interrupt or stop your visit before you are done.

Will my telehealth visit be private?

- We will not record visits with your provider.
- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- Your provider will tell you if someone else from their office can hear or see you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.
- There is a very small chance that someone could use technology to hear or see your telehealth visit.

What if I try telehealth and don't like it?

- You can stop using telehealth any time, even during a telehealth visit.
- You may be able to get an office visit if you no longer want a telehealth visit. But not all providers are available in person so you may have to switch providers or experience longer wait times, if your provider is no longer seeing in office patients or has limited their in person apointments.
- If you decide you do not want to use telehealth again, call 304-264-1442 and say you want to stop.

How much does a telehealth visit cost?

- What you pay depends on your insurance.
- A telehealth visit will not cost any more than an office visit.
- If your provider decides you need an office visit in addition to your telehealth visit, you may have to pay for both visits.

Do I have to sign this document?

Almost all of our providers use telehealth to treat patients. In order to be seen through telehealth, we require that this form be signed. Please know that the providers who are seeing patients in person are very limited.

What does it mean if I sign this document?

If you sign this document, you agree that:

- We talked about the information in this document.
- We answered all your questions.
- You want a telehealth visit.

Your name (please print) Date

Your signature Date

INTAKE FORM/SELF ASSESSMENT

DATE:

Patient Full Name: _____ Age: _____ M / F

Person Completing this form: Patient Parent/Guardian: _____ Other: _____

How did you find this practice? Family/Friend Internet Insurance Physician Hospital

Describe the purpose of today's appointment: _____ Medication _____ Therapy

_____

_____

_____

Check Symptoms:	Circle Severity Ratings: low-high	History (specify how long)
Depressed Mood	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Mood Swings	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Irritable/Grumpy	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Tearfulness	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Racing Thoughts	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Do not feel joy	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Hopelessness (whats the use)	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Helplessness (beyond change)	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Worthlessness (feel guilty)	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Low Self-Esteem	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Low Energy/Fatigued	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Increased Energy/Hyperactive	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Difficulty with decisions	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Poor Concentration	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Memory difficulties, forgetful	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Inconsistent Motivation	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Procrastination/Poor Planning	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Not completing Tasks	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Trouble with follow-through	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Impulsive: Verbal/behavior	0 1 2 3 4 5 6	____ weeks ____ months ____ years

Check Symptoms:	Circle Severity Ratings: low-high	History (specify how long)
Poor Judgment/Choices	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Self doubt/ Self critical	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Confusion / Disoriented	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Easily Overwhelmed	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Disorganized	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Negative Focus / Attitude	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Problems with Daily Hygiene	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Problems at School / Work	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Relationship Difficulties	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Sexual Concerns / No Interest	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Excessive Unusual purchases	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Exaggerated Self-Confidence	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Pressure to Speak Fast, on-going	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Reckless / Risky Behavior	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Increased Sex Drive	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Self Injurious Behavior	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Threatening/Assaultive/Violent	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Argumentative/Defiant Behavior	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Running away/Staying away	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Destructive to Objects	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Lying, Hiding, Making excuses	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Blaming, Defensiveness	0 1 2 3 4 5 6	____ weeks ____ months ____ years

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Sleep Quantity: enough too much too little ___weeks _____months ____ years

Average sleep a night _____(over past 4 weeks) circle: nightmares sleep apnea

Describe sleep routine: _____

Quality of sleep: _____

Appetit changes: Increase Decrease How Long: ____weeks _____months ____years

Weight Changes: intentional / not intentional Related to Medications? Yes No

How much of a weight change? Increase Decrease _____pounds over _____time

Check Symptoms:	Circle Severity Ratings: low-high	History (specify how long)
Anxiety (general)	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Cannot Control Worry	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Fears of: _____	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Obsessions: _____	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Perfectionist	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Preoccupations/Rituals	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Binging/Purging Food	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Compulsive Behaviors	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Hoarding/Collecting	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Avoiding places/people	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Social Withdrawal	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Intrusive, distracting thoughts	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Intrusive, negative thoughts	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Restlessness, feel keyed up	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Panic Episodes	0 1 2 3 4 5 6	____ weeks ____ months ____ years

Age of first panic episode: _____ Where: _____

Any previous Hospitalizations: Yes No If so: When: _____ Where: _____

Most Recent Panic Episode: _____ Total number of panic episodes in lifetime: _____

Check Symptoms:	Circle Severity Ratings: low-high	History (specify how long)
Muscle Tension	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Palpitations	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Sweating (without exertion)	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Trembling/Shaking	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Shortness of Breath	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Chest Pain	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Nausea	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Fear of Dying	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Fear of Losing Control	0 1 2 3 4 5 6	____ weeks ____ months ____ years
Tingling in arms/legs/head	0 1 2 3 4 5 6	____ weeks ____ months ____ years

History of Self-harmful Thoughts, Plans or Behaviors: Current? Yes / No Past? Yes / No

Explain:_____

History of Suicidal Thoughts, Plans or Behaviors: Current? Yes / No Past? Yes / No

Explain:_____

History of Hurtful / Homicidal Thoughts, Plans or Behaviors: Current? Yes / No Past? Yes / No

Explain: _____

Medical History: (list general issues and approximate year / age, of onset or occurrence)

Physical Medical Conditions: _____

Major Injuries:_____

Surgeries: _____

_____

History of Head Injury No / Yes _____ History of Seizures No / Yes _____

Describe Injuries of any Motor Vehicle (or other severe) Accident: _____

_____

Current Medications: (if you have a list, it can be photo copied for convenience) _____

_____

Allergies to ANY Medications: _____Seasonal: _____

_____

Primary Care Physician: _____ Location: _____

Other Physicians / Focus: _____

Past Psychiatric Care: (give general dates and name of previous providers, if possible, and results)

In Patient: _____

Out Patient: _____

Past Psychiatric Medications and Results: _____

History of Traumatic Stress: abuse / neglect / violation / witness of threat or harm to others: *(For persons under the age of 18, medical professionals are legally mandated to report a current concern of safety or a history of child abuse to the Department of Social Services, when such information has NOT been previously reported. If information provided in detail indicates a need to make a report, this requirement and process will be discussed for further assessment and options, and relevance to treatment).*

Family of Origin / Other Significant Experiences (circle): chaotic crisis-oriented repeated relocations

Emotional Abuse Emotional Neglect Verbal Abuse Physical Abuse Sexual Abuse

To what degree was this history addressed in previous therapy (or otherwise)?_____

Do you believe this history has relevance to your mental health at this time? Yes No Uncertain

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Family History: check what applies; use DX=diagnosed TX=treated UD=undiagnosed UT=untreated

Who applies (include siblings)	Mother's Side	Father's Side
_____ Major Depression		
_____ Bipolar (manic) Disorder		
_____ Anxiety Disorder		
_____ Panic Disorder		
_____ Obsessive-Compulsive Disorder		
_____ Eating Disorder		
_____ Alcohol abuse / Dependence		
_____ Drug abuse / Dependence		
_____ Gambling		
_____ Attention Deficit/Hyperactivity		
_____ Autism Spectrum Disorders		
_____ Schizophrenia		
_____ Mental Retardation		
_____ Dementia		
_____ Alzheimer's		
_____ Physical / Sexual abuse		
_____ Legal problems		

Where were you born: _____ Raised: _____

Education: highest level completed _____ Degree_____ Where:_____

Describe school experiences: Academic/Learning:_____

Social: _____ Grades: _____

Were You ever held back for academic reasons? _____

Substance Use: Past or Present problems with alcohol or drugs? Yes / No if Yes circle letter for each

Issue: **A** to cope **B** for recreation **C** increased use **D** cause of concern **E** recent **F** long term

__Use of Alcohol **A B C D E F** __My Prescriptions mis-used **A B C D E F**

__Illegal Drugs / Meds **A B C D E F** __ Gambling Problems **A B C D E F**

Does stopping alcohol / drugs cause physical or psychological difficulties? Yes No

Money Spent on alcohol/drugs $_____day / $ _____week Causes financial problems Yes No

Do you need to cut down on alcohol / drug use? Yes No

Do you feel guilty about your alcohol / drug use? Yes No

Do you feel angry when someone talks about your use? Yes No

Do you need alcohol / drugs to get you going for the day? Yes No

Alcohol Use: Present No / Yes Past No / Yes ___years ago Beer Wine Liquor ____per day

Drug Use: Present No / Yes Past No / Yes _____ years ago _____

Cannabis Cocaine Ecstasy LSD Amphetamines Barbiturates Benzodiazepines Heroin Opioids

In-patient Treatment: No Yes _____ 12 Step/Support Group: No Yes

Tobacco: No Yes _____ In past _____ Type: _____ per day _____

Caffeine: use per day Soda ___per day Coffee ___per day Energy drinks ____per day

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EMPLOYMENT: Current:_____ Past: _____

(please describe) Types of work / focus: _____

Financial Stress: Current None Some A Lot On-going Past _____

__Insufficient / Unpredictable Income __Poor Judgement __Unforeseen Circumstances / Hardship

__Under-employment / lay-off / injury / illness _____

Current Recreation / Interests / Hobbies: _____

Current Community affiliations / religious organizations: _____

LEGAL History / Issues: Current No Yes Past No Yes _____

Living Arrangements: __rent __mortgage __own __other How long at current residence? _____

How do you feel about your current living arrangements? (setting, people, neighborhood, situation)

_____

Please list others who reside with you Quality of relationship at this time

Name	Age	Relationship to You	(supportive,stable,tense,mixed,distant,uncertain)

How long did you live at the residence prior to your current home? _____ Location:_____

Extended Family (if applicable,siblings,parents,grandparents,etc) Quality of relationship at this time

Name	Age	Relationship to You	(supportive,stable,tense,mixed,distant,uncertain)

Goals of Treatment: What do you hope the outcome to be as a result of participating in treatment?

Goal No 1 _____

Goal No 2_____

I would be interested in learning about the following options for treatment, support and education:

____Individual Counseling ____Group Counseling / Support ___Special Topic Workshop

Additional Comments / Questions: _____

_____

_____

_____

_____

_____

Child / Adolescent Development

(this page, if applicable, for patients under age 18, or for self-reference of childhood)

Were medications taken during pregnancy?

NO YES UNKNOWN Please Specify: _____

Did the Birth mother consume alcohol or abuse drugs during pregnancy?

NO YES UNKNOWN Please Specify: _____

Did the Birth mother experience any physical or emotional problems during pregnancy?

NO YES UNKNOWN Please Specify: _____

What was child's birth weight? ____pounds ____ounces

Was delivery normal? NO YES UNKNOWN Please Specify: _____

Did the child experience any problems immediately after birth?

NO YES UNKNOWN Please Specify: _____

At what age did the child do the following? *Please check approximate range or make corrections*

_____	Held head up (3-4 months)	_____	Walked by self (12 months)
_____	Smiled (6 months)	_____	Talked in single words (18-24 months)
_____	Rolled over (6 months)	_____	Fed self (2 years)
_____	Sat alone (6-10 months)	_____	Talked in sentences (30-36 months)
_____	Pulled self up (6-10 months)	_____	Toilet trained (2 1/2-4 years)
_____	Crawled (6-10 months)	_____	Rode a bike (6 years)

Is there any history of physical, sexual or emotional abuse?

NO YES UNKNOWN Please Specify: _____

How would you describe the child's approach to new situations?

__Positive, jumps right in ___Withdrawn, tends not to participate __Slow to warm up, cautious

How would you describe the child's overall mood?

__Positive (happy, laughing, upbeat, hopeful) ___Negative (depressed, cranky, angry, hostile)

__Mixed but more positive than negative ___Mixed but more negative than positive