Collaborative Minds LLC
New Patient Paperwork
(Please Print)

Today's Date: _____ Primary Care Physician: _____

PATIENT INFORMATION

First Name: _____ M.I: _____ Last Name: _____
Preferred Name: _____ Email: _____
Date of Birth: _____ Age: _____ SSN: _____-_____-_____
Street Address: _____
City: _____ State: _____ Zip: _____
Phone Number(home): _____ Cell phone: _____
Do we have permission to leave a voicemail? _____
Referred by whom/where: _____
Do you have any relatives seen here? _____

INSURANCE INFORMATION

Insurance Provider: _____ Member ID: _____
(Please include any PREFIXs and for ALL Medicaid patients we need your Bayou Health Plan ID number please do not give use your Medicaid number that starts with 777)
Subscriber Name: _____ DOB: _____ SSN: _____
Contact Number: _____ Address: _____
Insurance Policy: Please READ BELOW this is very important concerning your insurance:

- Patients with Insurance: If our office is contracted with your insurance company, we will file your insurance claims if you provide us with the PROPER information along with a copy of your current insurance card. If your insurance does NOT pay within 90 days, you are responsible for the remaining balance and you will be billed accordingly. This includes your insurance being denied for Coordination of Benefits, pre-existing etc. It is your responsibility to know and understand your benefits. You must coordinate with your insurance company to keep an updated file. If you do not claims can be denied at which point you will be responsible for the Self-Pay rate until the issue is resolved.
- ALL COPAYMENTS, DEDUCTIBLES OR COINSURANCE PAYMENTS ARE DUE AT THE TIME OF SERVICE. WE DO NOT BILL PATIENTS. We accept all forms of payment except for personal checks. If payment cannot be made at the time of service your appointment will be cancelled and you will have to reschedule.

PATIENTS WITH NO INSURANCE

All patients without insurance benefits or mental health coverage are also required to pay in full for the services rendered before being seen by the clinician.

- 1st appointment is $262.00
- 2nd appointment is $122.00
- All appointment thereafter are $92.00

TESTING ACCOMODATIONS

We do offer testing for ADHD/ADD through the Conner's CPT3 test. It is not billed through your insurance company. The test is $65 for patients with commercial insurance as well as noninsurance patients.
We also offer genetic testing in the office. This is also not billed through your insurance. The fee for this test is $300 for all commercial insured patients and noninsurance patients.

Name:_____ Date of Birth:_____

NOTE: WE DO NOT UNDER ANY CIRCUMSTANCE GET INVOLVED WITH ANY COURT CASE/WORK RELATED ISSUES. WE WILL NOT APPEAR IN COURT FOR ANY REASON. WE WILL NOT COMPLETE ANY PAPERWORK FOR CLEARANCE TO RETURN TO WORK OR LEAVE SUCH AS FMLA PAPERWORK ETC. IF YOU, AT ANY TIME INVOLVE OUR CLINICIANS IN ANY LEGAL MATTER, YOU WILL BE IMMEDIATELY DISCHARGED FROM OUR CLINIC.

Acknowledge and sign re: No court cases/legal matter: _____**Initial**
Acknowledge and sign re: No Disability cases/paperwork: _____**Initial**
Acknowledge and sign re: No leave of absence paperwork: _____ **Initial**

****Assignment of Benefits/Consent to Treat****

I consent to treatment at Collaborative Minds with Dr. Larry Warner M.D. and Shantell Burns, NP
I have the right to refuse treatment and medication, neither can be given unless agreed upon by my doctor and I. Listed are the following discussed; diagnoses, reason my doctor wants me to take the medication, other options to treat problems, the medication that was prescribed and any side effects it may cause. I will talk with my doctor about all medical problems and any medication I am taking. Medication will be documented in EHR. If I refuse medication treatment or general treatment it will be documented accordingly. **MANIPULATING MEDICATION WITHOUT CONSENT FROM THE TREATING PROVIDER WILL RESULT IN IMMEDIATE TERMINATION.**

Acknowledge that you agree to the terms stated above: _____**Initial**

****Disclosure of Information/Coordination of Care****

I, _____ authorize Collaborative Minds to discuss my case including medical diagnosis, appointments, medication, medical history and progress note documentations from visit with ONLY THE FOLLOWING PEOPLE. IF YOU WISH TO NOT HAVE INFORMATION RELEASED TO ANYONE LEAVE BLANK.

Name:_____Relation:_____
Name: _____ Relation:_____
Name: _____ Relation:_____
Name of School: _____
Name of Therapist: _____
Primary Care Physician_____

If there should be any additions to this list I will need to sign an additional authorization to release form.

I authorize Collaborative Minds to collaborate with my insurance company if they are to request information regarding my Coordination of Care. This may include a review of records for quality of treatment.

Acknowledgement of Release of Information for Insurance purposes:_____ **Initial**

DRUG SCREEN

All patients are required to perform drug screens. Random screening will also be performed without notice. If you refuse to comply with our policy you will not be seen at our office. These results will be sent off to the lab for conformation. Please sign below acknowledging the policy.

_____

Patient Name: _____ DOB: _____

APPOINTMENT ATTENDENCE POLICY (ALSO KNOWN AS NO SHOW POLICY)

- ALL COMMERICAL INSURANCE PATIENTS AND SELF PAYING PATIENTS are required to cancel their appointments at least 24 hours in advance by either speaking to a staff member or leaving a voicemail.

IF YOU DO NOT CANCEL YOUR APPOINTMENT AT LEAST 24 HOURS IN ADVANCE YOU WILL BE CHARGED THE 50.00 NO SHOW FEE THE DAY OF THE SCHEDULED APPOINTMENT. THIS WILL BE CHARGED TO THE CARD THAT YOU ARE REQUIRED TO HAVE ON FILE. If payment is not received, you will be responsible for this payment before you can reschedule. Patients with excessive missed appointments will be given a warning, followed by termination from care for the next missed appointment.

- Medicaid patients are only allowed 3 missed appointments per calendar year before being discharged from the clinic.

It is your responsibility to remember you appointments. Appointment cards are given and automatic reminder calls are done 2 days prior to your appointment. As a courtesy, staff will call to personally remind you of an appointment, however, this is a courtesy and may not always be done.

Signature of Acknowledgement of No Show Policy: _____

Credit Card/ Debit Card Information (This is not an option)

Your card will need to be updated when expires. Failure to update card information in a timely manner may interfere with your ability to make future appointments until updated information is received.
I, the undersigned, understand that this form will be valid for the duration of my treatment with Collaborative Minds.

Signature: _____ Date: _____

This card will only be used for missed appointments and if you forget your card at the time of your scheduled appointment.

Please Circle:	Visa	MasterCard	American Express
Patient Name:			
Card Holder Name:			
Card Number:			
Expiration Date:		CCV:	
Signature of Cardholder:			

Signature: _____ Date: _____

Patient Name: _____ DOB: _____

Please tell us a little about yourself.

1. What exactly are you wanting to be treated for?

   _____

   _____

   _____

2. What is your medication history? (Please document your current list of medications below)

   _____

   _____

   _____

3. Please list any medical problems such as heart condition, high blood pressure etc.:

   _____

   _____

   _____

   _____

4. Any medication allergies?

   _____

   _____

5. Do you smoke? _____ If so how much? _____ Any drug and/or alcohol _____ If yes please explain:

   _____

6. Have you ever received Inpatient or Outpatient Mental Health treatment before? If yes please explain:

   _____

   _____

   _____

   _____

7. Do any of your relatives suffer from mental health illness?

   _____

   _____

8. Have you ever been discharged from a doctor's care for missed appointments, noncompliance with medications or failure to pay fees?

   _____

ADHD (Inattentive Type) Adult

Answer each question with a Y or N (circle Y for Yes, N for No) for each of the following questions. A Yes response would indicate that the behavior or symptom happens frequently or most of the time.

It is important to note that these questions are related to clinical symptoms observed in over 25 years of practice. If you answer yes to five or more (observed over more than 6 months), it suggests that a consultation is advised. You may also e-mail Dr. Fisher from this website with any questions you may have regarding this questionnaire.

Y / N **1.** Do you have nervous habits like nail biting or playing with small objects in your hands?

Y / N **2.** Would you describe yourself as a "worrier"?

Y / N **3.** Do you frequently forget or lose things; like car keys, glasses, etc.?

Y / N **4.** Do you feel stressed or overwhelmed with having to remember too many things at one time?

Y / N **5.** Do you tend to pile papers in stacks; intermingling important with not so important items?

Y / N **6.** Is it hard for you to throw things out or purge at home or the office?

Y / N **7.** Do you seem to miss or be late for appointments due to being distracted and/or not using good time management?

Y / N **8.** Do you read directions or use a "hands on" approach to putting something together or learning about a new appliance?

Y / N **9.** Are standardized multiple choice tests difficult for you to take?

Y / N **10.** If yes, do you seem to misread the questions, feel overly anxious or need more time than is given for the test?

Y / N **11.** Do you often seem distracted by your own thoughts; to a point that you have a hard time focusing on conversation with someone else?

Y / N **12.** Is it hard for you to stick with a task from beginning to end?

Y / N **13.** Does it seem that you never have enough time during the day to finish the things you need to finish?

Y / N **14.** If so, do you think you underestimate the time you need to accomplish tasks?

Y / N **15.** Do you ever experience such things as right-left confusion or difficulties estimating distances?

Y / N **16.** Do you have to read something more than once to completely understand it?

Y / N **17.** Do you have sloppy or poor handwriting; to the point that others mention it?

Y / N **18.** Do you reverse numbers?

Y / N **19.** Would you describe yourself as a procrastinator?

Y / N **20.** Do you worry about your performance at work, school or home?

Y / N **21.** Were you described as inattentive as a child, easily distracted with difficulty paying attention in school?

Y / N **22.** Do you like to read?

Y / N **23.** Do you remember having trouble in school beginning at an early age? Did it seem to you that you had to work harder than your classmates to get passing grades?

Y / N **24.** Was Math hard for you?

Y / N **25.** Do you often feel tired during the day?

Y / N **26.** Are you sleeping at least seven hours a night?

Y / N **27.** Has anyone mentioned that you snore?

Y / N **28.** If yes, has it gotten progressively worse?

Y / N **29.** Do you ever feel confused or have a headache when you wake up in the morning?

Y / N **30.** Do your legs bother you when you try to get to sleep?

Y / N **31.** Are you a restless sleeper; lot's of thrashing and moving in your sleep?

Y / N **32.** Do you experience nightmares?

Y / N **33.** Do you walk, talk or eat in your sleep?

Center for Neurologic Study-Lability Scale (CNS-LS) for pseudobulbar affect (PBA)

The CNS-LS is a short (seven-item), self-administered questionnaire, designed to be completed by the patient, that provides a quantitative measure of the perceived frequency of PBA episodes. The CNS-LS can help physicians accurately diagnose PBA. A CNS-LS score of 13 or higher may suggest PBA.

Patient's name: _____

Date of assessment: _____

Using the scale below, please write the number that describes the degree to which each item applies to you *DURING THE PAST WEEK*. Write only 1 number for each item.

Applies never	Applies rarely	Applies occasionally	Applies frequently	Applies most of the time
1	2	3	4	5

Assessment questions	Answers
1. There are times when I feel fine 1 minute, and then I'll become tearful the next over something small or for no reason at all.	
2. Others have told me that I seem to become amused very easily or that I seem to become amused about things that really aren't funny.	
3. I find myself crying very easily.	
4. I find that even when I try to control my laughter, I am often unable to do so.	
5. There are times when I won't be thinking of anything happy or funny at all, but then I'll suddenly be overcome by funny or happy thoughts.	
6. I find that even when I try to control my crying, I am often unable to do so.	
7. I find that I am easily overcome by laughter.	

Total Score: _____

The CNS-LS has been validated in ALS and MS patient populations.

For more information, visit PBAinfo.org. You can also share your PBA experiences at facebook.com/PBAinfo

This form is not for use by patients or caregivers. This scale should only be used by qualified medical professionals. This questionnaire is not intended to substitute for professional medical assessment and/or advice.

Reference: Moore SR, Gresham LS, Bromberg MB, Kasarkis EJ, Smith RA. A self report measure of affective lability. *J Neurol Neurosurg Psychiatry*. 1997;63(1):89-93.

AVANIR™ pharmaceuticals

pba™ pseudobulbar affect

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?	○	○

Hamilton Anxiety Rating Scale (HAM-A)

Below is a list of phrases that describe certain feeling that people have. Rate the patients by finding the answer which best describes the extent to which he/she has these conditions. Select one of the five responses for each of the fourteen questions.

0 = Not present, 1 = Mild, 2 = Moderate, 3 = Severe, 4 = Very severe.

1 Anxious mood [0] [1] [2] [3] [4]

Worries, anticipation of the worst, fearful anticipation, irritability.

2 Tension [0] [1] [2] [3] [4]

Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax.

3 Fears [0] [1] [2] [3] [4]

Of dark, of strangers, of being left alone, of animals, of traffic, of crowds.

4 Insomnia [0] [1] [2] [3] [4]

Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors.

5 Intellectual [0] [1] [2] [3] [4]

Difficulty in concentration, poor memory.

6 Depressed mood [0] [1] [2] [3] [4]

Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.

7 Somatic (muscular) [0] [1] [2] [3] [4]

Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone.

8 Somatic (sensory) [0] [1] [2] [3] [4]

Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation.

9 Cardiovascular symptoms [0] [1] [2] [3] [4]

Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat.

10 Respiratory symptoms [0] [1] [2] [3] [4]

Pressure or constriction in chest, choking feelings, sighing, dyspnea.

11 Gastrointestinal symptoms [0] [1] [2] [3] [4]

Difficulty in swallowing, wind abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation.

12 Genitourinary symptoms [0] [1] [2] [3] [4]

Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.

13 Autonomic symptoms [0] [1] [2] [3] [4]

Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair.

14 Behavior at interview [0] [1] [2] [3] [4]

Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, etc.

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
- 0 I do not feel sad.
- 1 I feel sad
- 2 I am sad all the time and I can't snap out of it.
- 3 I am so sad and unhappy that I can't stand it.

2.
- 0 I am not particularly discouraged about the future.
- 1 I feel discouraged about the future.
- 2 I feel I have nothing to look forward to.
- 3 I feel the future is hopeless and that things cannot improve.

3.
- 0 I do not feel like a failure.
- 1 I feel I have failed more than the average person.
- 2 As I look back on my life, all I can see is a lot of failures.
- 3 I feel I am a complete failure as a person.

4.
- 0 I get as much satisfaction out of things as I used to.
- 1 I don't enjoy things the way I used to.
- 2 I don't get real satisfaction out of anything anymore.
- 3 I am dissatisfied or bored with everything.

5.
- 0 I don't feel particularly guilty
- 1 I feel guilty a good part of the time.
- 2 I feel quite guilty most of the time.
- 3 I feel guilty all of the time.

6.
- 0 I don't feel I am being punished.
- 1 I feel I may be punished.
- 2 I expect to be punished.
- 3 I feel I am being punished.

7.
- 0 I don't feel disappointed in myself.
- 1 I am disappointed in myself.
- 2 I am disgusted with myself.
- 3 I hate myself.

8.
- 0 I don't feel I am any worse than anybody else.
- 1 I am critical of myself for my weaknesses or mistakes.
- 2 I blame myself all the time for my faults.
- 3 I blame myself for everything bad that happens.

9.
- 0 I don't have any thoughts of killing myself.
- 1 I have thoughts of killing myself, but I would not carry them out.
- 2 I would like to kill myself.
- 3 I would kill myself if I had the chance.

10.
- 0 I don't cry any more than usual.
- 1 I cry more now than I used to.
- 2 I cry all the time now.
- 3 I used to be able to cry, but now I can't cry even though I want to.

11.

0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

12.

0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.

13.

0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.

14.

0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.

15.

0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16.

0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17.

0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18.

0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.

19.

0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.

0	I am no more worried about my health than usual.
1	I am worried about physical problems like aches, pains, upset stomach, or constipation.
2	I am very worried about physical problems and it's hard to think of much else.
3	I am so worried about my physical problems that I cannot think of anything else.

21.

0	I have not noticed any recent change in my interest in sex.
1	I am less interested in sex than I used to be.
2	I have almost no interest in sex.
3	I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score	Levels of Depression
1-10	These ups and downs are considered normal
11-16	Mild mood disturbance
17-20	Borderline clinical depression
21-30	Moderate depression
31-40	Severe depression
over 40	Extreme depression

No-Suicide Contract

I, _____, hereby agree that I will not harm myself in any way, attempt suicide, or die by suicide.

Furthermore, I agree that I will take the following actions if I am ever suicidal:

1) I will remind myself that I can never, under any circumstances, harm myself in any way, attempt suicide, or die by suicide.

2) I will call 911 if I believe that I am in immediate danger of harming myself.

3) I will call any or all of the following numbers if I am not in immediate danger of harming myself but have suicidal thoughts (please list names, phone numbers, addresses, and any other relevant contact information below):

1-800-SUICIDE -- 24-hour suicide prevention line that can be called from anywhere in the U.S.

4) I will continue talking on the phone with as many people as necessary for as long as necessary until the suicidal thoughts have subsided.

Signature_____ Date_____

Witness_____ Date_____