PATIENT REGISTRATION

VARIETY CARE

Demographic Information

First Name | Middle Name(s) | Last Name

Date of Birth | Social Security Number | Aliases/Other Names

Phone 1 | Phone 2 | Email

Address | City, State, Zip Code

Employment Status

- ☐ Full Time
- ☐ Part Time
- ☐ Retired
- ☐ Self-Employed
- ☐ Active Military
- ☐ Unemployed and 18+

Student Status

- ☐ Not A Student
- ☐ Full Time
- ☐ Part Time
- ☐ Minor - In School

Religion: _____

Language:

- ☐ English
- ☐ Spanish
- ☐ Vietnamese
- ☐ French
- ☐ German
- ☐ American Sign Language
- ☐ Other: _____

Do you need a translator? (Circle One) ☐ YES ☐ NO

If patient is a minor, who do they live with? (Circle One)

☐ Both Parents ☐ One Parent ☐ Family/Friends ☐ Legal Guardian

☐ Other: _____

Guarantor Information (Responsible Party)

First Name | Middle Name(s) | Last Name

Date of Birth | Social Security Number | Relation to Patient

Phone 1 | Phone 2 | Email

Address | City, State, Zip Code

Employer Name | Phone Number

Address | City, State, Zip Code

Insurance Information

PRIMARY

Insurance Carrier Copay $ Co Ins%

Group No. Policy No.

Insurance Address Insurance Phone Number

Name of Policy Holder Date of Birth

Phone Number Employer SSN

Sex: ☐ Male ☐ Female

Relationship to Insured:

☐ Patient ☐ Parent ☐ Ward of the Court
☐ Spouse ☐ Stepchild ☐ Grand Child
☐ Child ☐ Foster Child ☐ Other: _____

SECONDARY

Insurance Carrier Copay $ Co Ins%

Group No. Policy No.

Insurance Address Insurance Phone Number

Name of Policy Holder Date of Birth

Phone Number Employer SSN

Sex: ☐ Male ☐ Female

Relationship to Insured:

☐ Patient ☐ Parent ☐ Ward of the Court
☐ Spouse ☐ Stepchild ☐ Grand Child
☐ Child ☐ Foster Child ☐ Other: _____

Emergency Contact

PRIMARY

Name Phone Number

Relation to Patient Zip Code

SECONDARY

Name Phone Number

Relation to Patient Zip Code

Patient Responsibility Agreement And Insurance Policy

Most insurance plans do not cover 100% of the cost of treatment. Because of this we ask our patients to pay their estimated co-pay the day service isrendered. We will estimate as closely as possible: however, we do not guarantee any estimates or actual amounts. In the case insurance does not reimburse the full amount, I understand that I am responsible for payment of services rendered and responsible for paying any co-payment and deductibles that my insurance does not cover. If after 90 days, the insurance company does not pay the claim I will be responsible for the total balance.

Signature: _____ **Date:** _____

☐ Signed by Patient ☐ Signed by Patient or Guardian ☐ Signed by Caregiver ☐ Signed by Other: _____

ADULT HISTORY QUESTIONNAIRE

Please complete all information on this form. It may seem long, but most of the questions require only a check, so it will go quickly! You may need to ask family members about the family history.

Do you give permission for ongoing regular updates to be provided to your primary care physician? ☐ No ☐ Yes

Current Therapist/Counselor: _____ Phone Number: _____

What are your treatment goals? _____

_____

_____

_____

CURRENT SYMPTOMS CHECKLIST: (check once for any symptoms present)

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

SUICIDE RISK ASSESSMENT:

Have you ever had feelings or thoughts that you didn't want to live? ..... ☐ No ☐ Yes

If yes, please answering the following. If no, please skip to the next section.

Do you **currently** feel that you don't want to live? ..... ☐ No ☐ Yes

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

_____

On a scale of 1 to 10, (ten being strongest), how strong is your desire to kill yourself currently? _____

Would anything make it better? _____

_____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

VARIETY CARE

SUICIDE RISK ASSESSMENT: (CONTINUED)

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

_____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? ☐ No ☐ Yes

If yes, please explain. _____

MEDICAL HISTORY:

Current Weight: _____ Current Height: _____

Allergies: _____

List **ALL** current prescription medications and how often you take them (if none, write "None"):

MEDICATION NAME	DOSAGE	FREQUENCY	ESTIMATED START DATE

Current over-the-counter medications, supplements, vitamins, herbs, etc.: _____

_____

Current medical problems: _____

_____

Past medical problems, non-psychiatric hospitalization or surgeries: _____

_____

Have you ever had an EKG? ☐ No ☐ Yes If yes, when: _____

Was the EKG: ☐ Normal ☐ Abnormal ☐ Unknown

For women only: Date of last menstrual period: _____

Are you currently pregnant or do you think you might be pregnant? ☐ No ☐ Yes

Are you planning to get pregnant in the near future? ☐ No ☐ Yes

Birth control method: _____

How many times have you been pregnant? _____ How many live births? _____

Do you have any concerns about your physical health that you would like to discuss with us? ☐ No ☐ Yes

Date and place of last physical exam: _____

PERSONAL AND FAMILY MEDICAL HISTORY:

Thyroid Disease	☐ You	☐ Family	Family Member: _____
Anemia	☐ You	☐ Family	Family Member: _____
Liver Disease	☐ You	☐ Family	Family Member: _____
Chronic Fatigue	☐ You	☐ Family	Family Member: _____
Kidney Disease	☐ You	☐ Family	Family Member: _____
Diabetes	☐ You	☐ Family	Family Member: _____
Asthma/Respiratory	☐ You	☐ Family	Family Member: _____
Stomach/Intestinal	☐ You	☐ Family	Family Member: _____
Cancer (type)	☐ You	☐ Family	Family Member: _____
Fibromyalgia	☐ You	☐ Family	Family Member: _____
Heart Disease	☐ You	☐ Family	Family Member: _____
Epilepsy/Seizures	☐ You	☐ Family	Family Member: _____
Chronic Pain	☐ You	☐ Family	Family Member: _____
High Cholesterol	☐ You	☐ Family	Family Member: _____
High Blood Pressure	☐ You	☐ Family	Family Member: _____
Head Trauma	☐ You	☐ Family	Family Member: _____
Liver Problems	☐ You	☐ Family	Family Member: _____
Other	☐ You	☐ Family	Family Member: _____

Is there any additional personal or family medical history? ☐ No ☐ Yes

If yes, please explain: _____

PAST PSYCHIATRIC HISTORY

Outpatient treatment? ☐ No ☐ Yes If yes, please describe when, by whom, and nature of treatment:

REASON	DATES TREATED	BY WHOM

Psychiatric Hospitalization? ☐ No ☐ Yes If yes, please describe when, by whom, and nature of treatment:

REASON	DATES HOSPITALIZED	WHERE

WHAT MEDICATIONS DO YOU TAKE?

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, and how helpful they were (if you can't remember all the details, just write what you do 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)			
Remeron (mirtazapine)			
Anafranil (clomipramine)			
Pamelor (nortrptyline)			
Tofranil (imipramine)			
Elavil (amitriptyline)			
Other			

MOOD STABILIZERS

	DATES	DOSAGE	RESPONSE/SIDE-EFFECTS
Tegretol (carbamazepine)			
Lithium			
Depakote (valproate)			
Lamictal (lamotrigine)			
Tegretol (carbamazepine)			
Topamax (topiramate)			
Other			

ANTIPSYCHOTICS/MOOD STABILIZERS

	DATES	DOSAGE	RESPONSE/SIDE-EFFECTS
Seroquel (quetiapine)			
Zyprexa (olanzepine)			
Geodon (ziprasidone)			
Abilify (aripiprazole)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Prolixin (fluphenazine)			
Risperdal (risperidone)			
Other			

SEDATIVE/HYPNOTICS

	DATES	DOSAGE	RESPONSE/SIDE-EFFECTS
Ambien (zolpidem)			
Sonata (zaleplon)			
Rozerem (ramelteon)			
Restoril (temazepam)			
Desyrel (trazodone)			
Other			

ADHD MEDICATIONS

	DATES	DOSAGE	RESPONSE/SIDE-EFFECTS
Adderall (amphetamine)			
Concerta (methylphenidate)			
Ritalin (methylphenidate)			
Strattera (atomoxetine)			
Other			

ANTI-ANXIETY MEDICATIONS

	DATES	DOSAGE	RESPONSE/SIDE-EFFECTS
Xanax (alprazolam)			
Ativan (lorazepam)			
Klonopin (clonazepam)			
Valium (diazepam)			
Busbar (buspirone)			

YOUR EXERCISE LEVEL:

Do you exercise regularly? ☐ No ☐ Yes

How many days a week do you get exercise? _____

How much time each day do you exercise? _____

What kind of exercise do you do? _____

FAMILY PSYCHIATRIC HISTORY:

Has anyone in your family been diagnosed with or treated for:

☐ Bipolar Disorder ☐ Schizophrenia ☐ Depression ☐ Violence

☐ Post-Traumatic Stress ☐ Anxiety ☐ Alcohol Abuse ☐ Other

☐ Anger ☐ Other Substance Abuse ☐ Suicide

If yes, who had each problem? _____

_____

Has any family member been treated with psychiatric medication? ☐ No ☐ Yes

If yes, who was treated, what medications did they take, and how effective was the treatment? _____

_____

SUBSTANCE USE:

Have you ever been treated for alcohol or drug use or abuse?..... ☐ No ☐ Yes

If yes, for which substances? _____

If yes, where were you treated and when? _____

_____

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you should cut down on your drinking or drug use? _____

Have people annoyed you by criticizing your drinking or drug use?..... ☐ No ☐ Yes

Have you ever felt bad or guilty about your drinking or drug use?..... ☐ No ☐ Yes

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?..... ☐ No ☐ Yes

Do you think you may have a problem with alcohol or drug use?..... ☐ No ☐ Yes

Have you used any street drugs in the past 3 months?..... ☐ No ☐ Yes

If yes, which ones? _____

Have you ever abused prescription medication?..... ☐ No ☐ Yes

If yes, which ones and for how long? _____

HAVE YOU EVER TRIED THE FOLLOWING:

Methamphetamine	☐ No ☐ Yes	If yes, how long and when did you last use? _____
Cocaine	☐ No ☐ Yes	If yes, how long and when did you last use? _____
Stimulants (pills)	☐ No ☐ Yes	If yes, how long and when did you last use? _____
Heroin	☐ No ☐ Yes	If yes, how long and when did you last use? _____
LSD/Hallucinogens	☐ No ☐ Yes	If yes, how long and when did you last use? _____
Marijuana	☐ No ☐ Yes	If yes, how long and when did you last use? _____
Pain Killers (not as prescribed)	☐ No ☐ Yes	If yes, how long and when did you last use? _____
Methadone	☐ No ☐ Yes	If yes, how long and when did you last use? _____
Tranquilizer/	☐ No ☐ Yes	If yes, how long and when did you last use? _____
Sleeping Alcohol	☐ No ☐ Yes	If yes, how long and when did you last use? _____
Ecstasy	☐ No ☐ Yes	If yes, how long and when did you last use? _____
Other _____	☐ No ☐ Yes	If yes, how long and when did you last use? _____

Do you currently hold a Medical Marijuana License? ☐ No ☐ Yes

How many caffeinated beverages do you drink a day? Coffee _____ Sodas _____ Tea _____

TOBACCO HISTORY:

Have you ever smoked cigarettes? ☐ No ☐ Yes

Currently? ☐ No ☐ Yes How many packs per day?_____ How many years? _____

In the past? ☐ No ☐ Yes How many years? _____ When did you quit?_____

Do you use chewing tobacco? ☐ No ☐ Yes How often per day? _____ How many years? _____

FAMILY BACKGROUND AND CHILDHOOD HISTORY:

Were you adopted? ☐ No ☐ Yes Where did you grow up? _____

List your siblings and their ages: _____

What was your father's occupation? _____

What was your mother's occupation? _____

Did your parents divorce? ☐ No ☐ Yes If so, how old were you when they divorced? _____

If your parents divorced, who did you live with? _____

Describe your father and your relationship with him: _____

_____

Describe your mother and your relationship with her: _____

_____

How old were you when you left home? _____

Has anyone in your immediate family died? ☐ No ☐ Yes

Who and when? _____

TRAUMA HISTORY:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ☐ No ☐ Yes

Please describe when, where and by whom: _____

_____

EDUCATIONAL HISTORY:

Highest grade completed? _____ Where? _____

Did you attend college? ☐ No ☐ Yes Where? _____

What is your highest educational level or degree attained? _____

OCCUPATIONAL HISTORY:

Are you currently: ☐ Working ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

Have you ever served in the military? ☐ No ☐ Yes If so, what branch and when? _____

Honorable discharge? ☐ No ☐ Yes Other discharge type: _____

RELATIONSHIP HISTORY AND CURRENT FAMILY:

Are you currently: ☐ Married ☐ Partnered ☐ Divorced ☐ Single ☐ Widowed

How long? _____

If not married, are you currently in a relationship? ☐ No ☐ Yes Yes If yes, how long? _____

Are you sexually active? ☐ No ☐ Yes

What is your sexual orientation? _____

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other: _____

_____

Have you had any prior marriages? ☐ No ☐ Yes If so, how many? _____ How long? _____

Do you have children? ☐ No ☐ Yes If yes, list ages and sex (as assigned at birth): _____

Describe your relationship with your children: _____

_____

List everyone who currently lives with you: _____

_____

_____

LEGAL HISTORY:

Have you ever been arrested? ☐ No ☐ Yes

Do you have any pending legal problems: ☐ No ☐ Yes

Is there anything else that you would like us to know? _____

_____

_____

_____

_____ _____ _____

Printed Name of Patient Signature Date

New Patient Forms

Treatment Consent, Disclosure and Personal Representative

Patient Name:_____ **DOB:** _____ **Date:**_____

Name of person giving consent (if not patient): _____

Relationship to Patient: ☐ Parent ☐ Guardian ☐ Primary Caregiver ☐ Other: _____

PERMISSION FOR DISCLOSURE OF INFORMATION AND APPOINTMENT OF PERSONAL REPRESENTATIVE

Person's Name (Print): _____ Relationship: _____

Person's Name (Print): _____ Relationship: _____

Person's Name (Print): _____ Relationship: _____

I give Variety Care permission to share my information and/or coordinate with the persons listed as provided above. I understand that I may revoke my permission at any time by notifying Variety Care in writing.

I give the following permissions (check all that apply):

☐ General information: To make, confirm or cancel appointments, be told I am a patient, and that I am in my appointment

☐ To obtain copies of my medical records as my personal representative under HIPAA

☐ To relay messages to my (or my child/wards') provider/staff

☐ To receive information regarding my medications

☐ To receive information regarding my diagnosis and treatment

☐ To receive information about test or lab results

☐ To bring my child/ward to appointments and consent for treatment

OR ☐ **All the rights and permissions listed above**

OR ☐ **I *do not want* my information given to *anyone.***

Signature: _____ Date: _____

CONSENT FOR TREATMENT

I consent to treatment by Variety Care providers and staff. There are risks and dangers with any type treatment. I give my consent assuming those risks. I know my provider will discuss with me any risks of treatments and alternatives and that I may ask any questions or refuse treatment if I choose. I understand this consent will be effective until I revoke it or I am required to give consent due to a change in circumstances.

I consent for Variety Care to submit for payment of authorized benefits for my insurance and release any information required for payment. I know I am responsible for all deductibles and/or copayments. I also understand that I am responsible for any charges or amounts that are not paid by my insurance. I know that some lab work or other tests, such as x-rays, are not included in my regular medical visit and may require me to go to an outside provider. I know that I may receive a separate bill for those services.

Signature: _____ Date: _____

Patient Release
Medical Information

(One form per patient)

Patient Name: _____

Date of Birth: _____ **SS#:** _____ **Phone:** _____

I hereby authorize Variety Care, Inc. to release the records for the above named person consisting of (check box):

☐ Other: (Be specific, like "Vaccine Record" or "Medical Summary")

_____

☐ Medical Records ☐ Vision Records ☐ Pharmacy Records ☐ Dental Records

☐ Behavioral Health Records ☐ X-ray records ☐ Billing Records

☐ Appointment Records only ☐ Letter from Provider Only (BH)

☐ **All records, regardless of type ($0.30 - max charge $200)**

I authorize the release of these records to:

☐ Myself, Or ☐ Another person or entity - Name: _____

Please release records by:

☐ Mail: _____

☐ Fax: _____

☐ eMail: _____

☐ Pick up in person: 6800 Broadway Extension, Oklahoma City, OK 73116

Reason for disclosure:

☐ At my request ☐ For my healthcare / treatment ☐ For legal purposes ☐ For payment / insurance purposes

☐ Other: _____

This Authorization will expire: (choose one)

☐ 12 months from the date signed ☐ Other (insert date or event): _____

I understand I may change or revoke this authorization at any time by providing written notice to Variety Care at: Variety Care, Attn: Medical Records, 6800 Broadway Extension, Oklahoma City, OK 73116. I understand I cannot restrict information that may have already been shared based on this authorization by a revocation or change.

By signing this request, the patient or representative acknowledges the following:

- I understand I have free access to my records via the Patient Portal and chose to request records via above stated method.
- I understand that if I provide a phone, fax or email and request that my records be released by that medium that those means of communication are not always secure and Variety Care cannot guarantee the confidentiality of my information when transmitted by those means. I understand that if I do not make a selection, that Variety Care will release my records as paper records through the mail.

Patient Release

Medical Information

- I understand that there are fees associated with the release of Medical Records from Variety Care and that I am responsible for paying those fees in accordance with the law. Variety Care may impose a fee of $0.50 for each page to cover the cost of labor and copying, plus postage for the requested information. $0.30 for each page in digital copy.
- I understand that Variety Care has up to thirty (30) days from receipt of my request to process my request and confirm that it is appropriate for the release of records.
- I understand that I may request my records in format other than paper (electronically or on CD) by providing that preference to Variety Care. Variety Care will produce my records in the format I request if it is possible. If I do not make a request for a specific alternative format, Variety Care will release my records as paper records.
- I understand that this release may contain records that may indicate the presence of a communicable/non-communicable or venereal disease, which may include but is not limited to diseases such as Hepatitis, Syphilis, Gonorrhea, Human Papilloma Virus (HPV), Chlamydia, Herpes Simplex Virus, or the Human Immunodeficiency Virus (HIV), also known as Acquired Immunodeficiency Syndrome (AIDS).
- I understand that if I have requested all of my records or my behavioral health records be released, that the information included in that release may contain information relating to my treatment for psychological, psychiatric, alcohol or substance abuse conditions.
    - I understand that if the patient is a minor, release of any information regard alcohol/substance abuse treatment requires their direct permission and they must sign this form under 42 C.F.R §2.14 even if I am their parent or guardian.
- I understand that Variety Care is not responsible for the protection of my information that has been released under this request. I specifically release Variety Care and its agents and employees from any liability for release of information connected with this request. I understand that my information may no longer be protected when it is released.
- I understand that I may inspect or obtain a copy of the protected health information shared under this authorization by sending written request to the address listed.
- I understand that I may request a copy of this request for records from Variety Care but will not be given a copy unless I request it.
- Unless the purpose of this authorization is to determine payment of a claim for benefits, the requesting entity will not condition the provision of treatment or payment for my care on my signing this authorization.
- I am making this request voluntarily. I understand that my treatment will not be impacted whether I sign this request or not.

Signature of Patient (Patient Only) **Date**

<u>If you are not the Patient but you are signing on behalf of a patient, please complete this section</u>

I, _____, am the (check which applies):

- ☐ Parent with Parental Rights (not sufficient for substance abuse records)
- ☐ Registered Kinship Care Relative (not sufficient for substance abuse records)
- ☐ Court Appointed Guardian (not sufficient for substance abuse records)
- ☐ Legally Appointed Healthcare Agent (not sufficient for substance abuse records)
- ☐ Medical Power of Attorney (not sufficient for substance abuse records)
- ☐ Power of Attorney with Right to See Medical Records (not sufficient for substance abuse records)
- ☐ Court Appointed Personal Representative of Deceased Representative's

Signature: _____ Date: _____/_____/_____

<u>You MUST attach proof of your authority to act on behalf of the patient as checked above (other than parent).</u>

Notice of Privacy Practices

Effective Date: 8/1/2022

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW THIS NOTICE CAREFULLY.

Who We Are:

This Notice describes the privacy practices of **Variety Care, (all locations)** and the privacy practices of:

- all of our doctors, nurses, and other health care professionals authorized to enter information about you into your medical chart.
- all of our departments, including, *e.g.*, our medical records and billing departments.
- all of our Variety Care sites.
- all of our employees, staff, volunteers and other personnel who work for us or on our behalf.

Our Pledge: We understand that health information about you and the health care you receive is personal. We are committed to protecting your personal health information. When you receive treatment and other health care services from us, we create a record of the services that you received. We need this record to provide you with quality care and to comply with legal requirements. This notice applies to all of our records about your care, whether made by our health care professionals or others working in this office, and tells you about the ways in which we may use and disclose your personal health information. This notice also describes your rights with respect to the health information that we keep about you and the obligations that we have when we use and disclose your health information. Variety Care is part of an organized health care arrangement including participants in OCHIN. A current list of OCHIN participants is available at www.ochin.org. As a business associate of Variety Care, OCHIN supplies information technology and related services to Variety Care and other OCHIN Participants. OCHIN also engages in quality assessment and improvement activities on behalf of its participants. For example, OCHIN coordinates clinical review activities on behalf of participating organizations to establish best practices standards and access clinical benefits that may be derived from the use of electronic health record systems. OCHIN also helps participants work collaboratively to improve the management of internal and external patient referrals. Your health information may be shared by Variety Care with OCHIN participants when necessary for health care operation purposes of the organized health care arrangement.

For More Information, Contact Us:

Privacy Officer
Variety Care
3000 N. Grand Blvd
Oklahoma City, OK 73107
405-632-6688

We are required by law to:

- make sure that health information that identifies you is kept private in accordance with relevant law.
- give you this notice of our legal duties and privacy practices with respect to your personal health information.
- follow the terms of the notice that is currently in effect for all of your personal health information.

How We May Use and Disclose Your Health Information:

We may use and disclose your personal health information for these purposes:

For Treatment. We may use health information about you to provide you with health care treatment or services. We may disclose health information about you to the doctors, nurses, technicians, medical students and others who are involved in your care. They may work at Variety Care, at the hospital if you are hospitalized under our supervision, or at another doctor's office, lab, pharmacy or other health care provider to whom we may refer you for treatment, consultation, x-rays, lab tests, prescriptions or other health care service. They may also include doctors and other health care professionals who work at Variety Care, or elsewhere, whom we consult about your care. For example, we may consult with a specialist who lends his/her services to Variety Care about your care or disclose to an emergency room doctor who is treating you for a broken leg that you have diabetes, because diabetes may affect your body's healing process.

For Payment. We may use and disclose health information about you to bill and collect payment from you, your insurance company, including Medicaid and Medicare, or other third party that may be available to reimburse us for some or all of your health care. We may also disclose health information about you to other health care providers or to your health plan so that they can arrange for payment relating to your care. For example, if you have health insurance, we may need to share information about your office visit with your health plan in order for your health plan to pay us or reimburse you for the visit. We may also tell your health plan about treatment that you need to obtain your health plan's prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. We may use and disclose health information about you for our day-to-day operations, and may disclose information about you to other health care providers involved in your care or to your health plan for use in their day-to-day operations. These uses and disclosures are necessary to run Variety Care and to make sure that all of our patients receive quality care, and to assist other providers and health plans in doing so as well. For example, we may use health information to review the services that we provide and to evaluate the performance of our staff in caring for you. We may also combine health information about our patients with health information from other health care providers to decide what additional services Variety Care should offer, what services are not needed, whether new treatments are effective or to compare how we are doing with others and to see where we can make improvements. We may remove information that identifies you from this set of health information so others may use it to study health care delivery without learning who our patients are.

Appointment Reminders. We may use and disclose health information about you to contact you as a reminder that you have an appointment at Variety Care.

Health-Related Services and Treatment Alternatives. We may use and disclose health information to tell you about health-related services or recommend treatment options or alternatives that may be of interest to you. Please let us know if you do not wish us to contact you with this information, or if you wish to have us use a different address when sending this information to you.

Fundraising Activities. We may use health information about you to contact you in an effort to raise money for our not-for-profit operations. We may disclose health information about you to a foundation related to Variety Care so that the foundation may contact you in raising money for Variety Care. We will only release contact information, such as your name, address and phone number and the dates you received treatment or services from us. Please let us know if you do not want us to contact you for fundraising efforts.

Individuals Involved in Your Care or Payment for Your Care. We may release

health information about you to a friend or family member who is involved in your health care or the person who helps pay for your care.

Research. Under certain circumstances, we may use and disclose health information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another for the same condition. All research projects, however, are subject to a special approval process. This process evaluates a proposed research project and its use of health information, trying to balance the research needs with a patient's need for privacy. Before we use or disclose health information for research, the project will have been approved through this special approval process, although we may disclose health information about you to people preparing to conduct a research project. For example, we may help potential researchers look for patients with specific health needs, so long as the health information they review does not leave our facility. We will almost always ask for your specific permission if the researcher will have access to your name, address, or other information that reveals who you are or will be involved in your care.

Organ and Tissue Donation. If you are an organ donor, we may disclose health information about you to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

As Required By Law. We will disclose health information about you when required to do so by federal, state or local law.

To Avert a Serious Threat to Health or Safety. We may use and disclose health information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Military and Veterans. If you are a member of the armed forces or separated/ discharged from military services, we may release health information about you as required by military command authorities or the Department of Veterans Affairs as may be applicable. We may also release health information about foreign military personnel to the appropriate foreign military authorities.

Workers' Compensation. We may release health information about you for workers' compensation or similar programs. These programs provide benefits for work-related injuries or illness.

Public Health Activities. We may disclose health information about you for public health activities. These activities generally include the following:

- to prevent or control disease, injury or disability.
- to report births and deaths.
- to report child abuse or neglect.
- to report reactions to medications or problems with products.
- to notify people of recalls of products.
- to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Health Oversight Activities. We may disclose health information about you to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections and licensure. These activities are necessary for the government to monitor the health care system, government programs and compliance with civil rights laws.

Lawsuits and Disputes. We may disclose health information about you in response to a court or administrative order. We may also disclose health information about you in response to a subpoena, discovery request or other lawful process that is not accompanied by a court or administrative order, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.

Law Enforcement. We may release health information about you if asked to do so by a law enforcement official:

- in response to a court order, subpoena, warrant, summons or similar process.
- to identify or locate a suspect, fugitive, material witness or missing person.
- under certain limited circumstances, about the victim of a crime.
- about a death we believe may be the result of criminal conduct.
- about criminal conduct at the Variety Care
- in emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.

Coroners, Health Examiners and Funeral Directors. We may release health information about our patients to a coroner or health examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. We may also release health information to funeral directors as may be necessary for them to carry out their duties.

National Security and Intelligence Activities. We may release health information about you to authorized federal officials for intelligence, counterintelligence and other national security activities authorized by law.

Protective Services for the President and Others. We may disclose health information about you to authorized federal officials so they may provide protection to the President, other authorized persons or foreign heads of state or conduct special investigations.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release health information about you to the corrections institution or law enforcement official. This release would be necessary (1) for the institution to provide you with health care, (2) to protect your health and safety or the health and safety of others, or (3) for the safety and security of the correctional institution.

YOUR RIGHTS

You have certain rights with respect to your personal health information. This section of our notice describes your rights and how to exercise them:

Right to Inspect and Copy: You have the right to inspect and copy the personal health information in your medical and billing records, or in any other group of records that we maintain and use to make health care decisions about you. This right does not include the right to inspect and copy psychotherapy notes, although we may, at your request and on payment of the applicable fee, provide you with a summary of these notes.

To inspect and copy your personal health information, you must submit your request in writing to our privacy contact person identified on the first page of this notice. If you request a copy of the information, we may charge a fee for the copying and mailing costs, and for any other costs associated with your request.

We may deny your request to inspect and copy in certain very limited circumstances. If your request is denied, you may request that the denial be reviewed. We will designate a licensed health care professional to review our decision to deny your request. The person conducting the review will not be the

same person who denied your request. We will comply with the outcome of this review. Certain denials, such as those relating to psychotherapy notes, however, will not be reviewed.

Right to Amend: If you feel that the health information we maintain about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for any information that we maintain about you. To request an amendment, your request must be made in writing, submitted to our privacy contact person identified on the first page of this notice, and must be contained on one piece of paper legibly handwritten or typed. In addition, you must provide a reason that supports your request for an amendment.

We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or organization that created the information is no longer available to make the amendment,
- is not part of the health information kept by or for the Variety Care
- is not part of the information which you would be permitted to inspect and copy, or
- is accurate and complete.

Any amendment we make to your health information will be disclosed to the health care professionals involved in your care and to others to carry out payment and health care operations, as previously described in this notice.

Right to Receive an Accounting of Disclosures. You have the right to receive an accounting of certain disclosures of your health information that we have made. Any accounting will not include all disclosures that we make. For example, an accounting will not include disclosures:

- to carry out treatment, payment and health care operations as previously described in this notice.
- pursuant to your written authorization.
- to a family member, other relative, or personal friend involved in your care or payment for your care when you have given us permission to do so.
- to law enforcement officials.

To request an accounting of disclosures, you must submit your request in writing to our privacy contact person identified on the first page of this notice. Your request must state a time period which may not be more than six (6) years and may not include dates before April 14, 2003. The first list you request within a 12 month period will be free. For additional lists, we may charge you for the costs of providing the list. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred. We will mail you a list of disclosures in paper form within 30 days of your request, or notify you if we are unable to supply the list within that time period and by what date we can supply the list; this date will not exceed 60 days from the date you made the request.

Right to Request Restrictions. You have the right to request a restriction or limitation on the health information we use or disclose about you for treatment, payment or health care operations. You also have the right to request a limit on the health information we disclose about you to someone who is involved in your care or the payment for your care, such as a family member or friend. For example, you may request that we not disclose information about you to a certain doctor or other health care professional, or that we not disclose information to your spouse about certain care that you received.

We are not required to agree to your request for restrictions if it is not feasible for us to comply with your request or if we believe that it will negatively impact our ability to care for you. If we do agree, however, we will comply with your request unless the information is needed to provide emergency treatment. To request a restriction, you must make your request in writing to our privacy contact person identified on the first page of this notice. In your request, you must tell us what information you want to limit and to whom you want the limits to apply.

Right to Confidential Communications. You have the right to request that we communicate with you about health matters in a certain way. For example, you can ask that we only contact you at work or by mail to a specified address. To request that we communicate with you in a certain way, you must make your request in writing to our privacy contact person identified on the first page of this notice. We will not ask you the reason for your request. Your request must specify how or where you wish to be contacted. We will accommodate all reasonable requests.

Right to a Paper Copy of this Notice. You have the right to receive a paper copy of this notice at any time. To receive a copy, please request it from our privacy contact person identified on the first page of this notice. You may also obtain a copy of this notice at our website, at www.varietycare.org

Complaints or Questions:

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. You may file a complaint by mailing or e-mailing us a written description of your complaint or by telling us about your complaint in person or over the telephone:

Privacy Officer
Variety Care
3000 N. Grand Blvd

Please describe what happened and give us the dates and names of anyone involved. Please also let us know how to contact you so that we can respond to your complaint. You will not be penalized for filing a complaint.

If you **are not satisfied** with the manner in which this office handles a complaint, you may submit a complaint to:

Department, Health & Human Services
Office of Civil Rights
Herbert H. Humphrey Building
Room 509F
200 Independence Avenue, SW
Washington, D.D. 20201

You will not be penalized for filing a complaint.

Other Uses and Disclosures of Your Protected Health Information:

Other uses and disclosures of personal health information not covered by this notice or applicable law will be made only with your written authorization. If you give us your written authorization to use or disclose your personal health information, you may revoke your authorization, in writing, at any time. If you revoke your authorization, we will no longer use or disclose your personal health information for the reasons covered by your written authorization. You understand that we are unable to take back any uses and disclosures that we have already made with your authorization, and that we are required to retain our records of the care that we have provided to you.

Changes to this Notice:

We reserve the right to change this notice and to make the changed notice effective for all of the health information that we maintain about you, whether it is information that we previously received about you or information we may receive about you in the future. We will post a copy of our current notice in our facility Our notice will indicate the effective date on the first page, in the top right-hand corner. We will also give you a copy of our current notice upon request.

About Our Notice of Privacy Practices

We are committed to protecting your personal health information in compliance with the law. The attached Notice of Privacy Practices states:

- our obligations under the law with respect to your personal health information.
- how we may use and disclose the health information that we keep about you.
- your rights relating to your personal health information.
- our rights to change our Notice of Privacy Practices.
- how to file a complaint if you believe your privacy rights have been violated.
- the conditions that apply to uses and disclosures not described in this Notice.
- the person to contact for further information about our privacy practices.

I have recieved a copy of the Notice of Privacy Practices.

Signature: _____

Date: _____

VARIETY CARE

NOTICE OF PRIVACY PRACTICES

For Variety Care Health Center Locations

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

Medication Use Agreement

I, (patient name)_____, agree:

- Controlled Substance
  - My medication: _____is a controlled substance.
  - The medication will be prescribed only by my provider: _____
  - I will take the medication only as directed.
  - I will not take any other controlled substances without approval from my provider.
- Purpose
  - The controlled substance is necessary for treating my medical condition.
  - This medication is to help me to be able to do my daily activities.
  - My provider talked with me about goals for treatment.
  - My provider talked with me about other options for treatment.
- Risks
  - My provider talked with me about the risks of this medication.
  - This medication can lead to addiction.
  - There is a risk of overdose and death.
  - I will tell my provider if I have misused alcohol or drugs in the past.
  - For my safety, I will tell my provider if I take:
    - herbal remedies
    - over-the-counter medication
    - other prescribed medication
    - alcohol
- Clinic Visits
  - My provider has told me how often I must have clinic visits.
  - My provider has told me how often I can get refills.
  - I will not ask for an early refill.
  - I will keep my appointments.
  - If I miss my appointment, I may not get refills.
- Pharmacy
  - My provider will only send electronic refills.
  - I will not use more than one pharmacy.
  - My provider will not send refills to a pharmacy in another state.
  - My provider checks PDMP (Prescription Drug Monitoring Program). My PDMP report will show if I get other controlled medications.
- Safety
  - I will keep the medication safe.

    - I will keep the medication out of reach of children.
    - Lost or stolen medication will not be refilled for any reason.
- Pill Counts
    - My provider may ask for a pill count at any time.
    - If I do not bring my medication for the pill count, I may not get refills.
    - If the pill count does not match with records, I may not get refills.
- Drug Tests
    - My provider may ask for drug tests at any time.
    - Drug tests may be urine or blood.
    - I will cooperate with drug tests.
    - If I refuse to do the drug tests, I may not get refills.
    - If the drug test shows a controlled substance not approved by my provider, I may not get refills.
- Specialists
    - My provider may require a specialist to check my medical condition.
    - If so, I will keep appointments with the specialist.
    - My provider will share my health records with the specialist. A copy of this agreement may be sent the specialist.
- Provider Rights
    - My provider is not required to prescribe the medication for me.
    - My provider has the right to stop prescribing the medication if:
        - I ask for any other controlled substance from anyone other than my provider.
        - I get any other controlled substance from anyone other than my provider.
        - I give my medication to any other person.
        - I sell my medication to any other person.
        - I share my medication with any other person.
        - I try to forge a prescription in any way.
        - I try to alter a prescription in any way.
    - My provider will stop prescribing the medication if my provider decides:
        - Taking this medication is not safe for me.
        - This medication is not helping my medical condition.
- My provider answered all my questions about the medication.

Patient Signature_____ Date _____

Telemedicine Informed Consent

Patient Name: _____ DOB: _____

Telemedicine services involve the use of secure audio and video connections that allow your providers and care team to deliver health care services to patients when located at different sites to help you access care how and when you would like it.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I agree that the Variety Care Patient Rights and Responsibilities also apply to telehealth. I agree that:
    a. I will be in a private, set location during my visit;
    b. I will be properly dressed during my visit;
    c. I will follow all rules of conduct required and be respectful during my visit as required by Variety Care; and
    d. I understand that if I do not follow the rules for my visit that my provider may warn me or end my visit and I will still be billed.
4. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my health care provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
5. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting Variety Care at 405-632-6688.
    b. I agree that this consent will continue until I revoke it.
6. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services and Variety Care's privacy practices regarding my protected health information (PHI) will still apply. I know that I may get a copy of the notice of privacy practices upon request from Variety Care.
7. I understand that this document will become a part of my medical record.
8. I understand that I am responsible for any payment required for my telemedicine, including the copay or visit cost if I am not covered by insurance. I understand that the Variety Care sliding fee discount will be applied to telehealth visits if I have provided all the documentation required for that program.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Oklahoma and will be in Oklahoma during my telemedicine visit(s).

_____ _____

Patient/Parent/Guardian Signature Date

Patient Form Discounted Fee Application

☐ **I decline to apply for the Sliding fee scale program. I understand that I am responsible for the full cost of the services provided, with no discounts applied. If I am unable to pay in full, I acknowledge that I can arrange a payment plan or reschedule non-emergency appointments.**

- ✓ Variety Care offers patients a sliding fee discount on guarantor balances, after all other payers' sources (if applicable), and if they qualify for our sliding fee scale. The discount percentage is based on the **GROSS income of all adult members of the household** and the **number of dependents** in the household.

- ✓ The required documentation **must be renewed each year** unless there is a financial change or household member change prior to the annual renewal, in which case must notify Variety Care at the time of service at the next visit and complete a new Sliding Fee Application and provide proof of the financial change if applicable.

- ✓ **Proof of Income must be verified within 30 days from the date of service to submit to qualify for the Sliding Fee Scale** and will be required to pay the sliding fee discount prices at the time services are rendered. Failure to provide all the required documentation will result in being responsible for the full amount of all charges without discount.

Proof of Income (Employed)
- Current 1040, W-2 or other tax return
- Recent Pay stub (last 30 days)
- Written and Signed document from
- Employer – form available.

Proof of Income (Unemployed)
- Public Assistance statement of benefits
- Proof of Social Security, Disability, or Pension
- Letter from Non-Profit Org. (e.g., Church)
- Other approved by Billing.

- ✓ If any information provided proves to be fraudulent, the Sliding Fee Scale status will be canceled, and it will be billed for all previous visits.

All Head Household and Dependent's Name:	**Date of Birth:**	**Monthly Income**	**Annual Income**
Self (Guarantor)			
Spouse and/or Partner			
Child			
Child			
Child			
Child			
Child			
Child			
Relatives (explain relationship)			
Relatives (explain relationship)			

Office Use Only > Total Calculated Annual Income:$ 0.00

Total number of family members living in household:_____

A MINIMUM NOMINAL FEE OF $35.00 WILL BE COLLECTED BEFORE YOUR PRIMARY MEDICAL OFFICE VISIT.
A MINIMUM NOMINAL FEE OF $40.00 WILL BE COLLECTED FOR PRIMARY DENTAL; $30.00 FOR PERIODIC VISITS.
ANY LAB, X-RAYS, MEDICAL PROCEDURE, OR INJECTIONS MAY BE AN ADDITIONAL FEE. ALL FEES ARE BASED ON INCOME.

NO DISCOUNT WILL BE APPLIED IF PROOF OF INCOME IS NOT RETURNED WITHIN 30 DAYS

Patient or Parent/Guardian Signature:_____ **Date:** _____

PHQ-9 Screening

Name: _____ DOB:_____ Date:_____

Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things:	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless:	☐	☐	☐	☐
3. Trouble falling asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating:	☐	☐	☐	☐
6. Feeling bad about yourself- or that you are a failure or have let yourself or your family down:	☐	☐	☐	☐
7. Trouble concentrating on things like school, work, reading, or watching TV?	☐	☐	☐	☐
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:	☐	☐	☐	☐
9. Thoughts you would be better off dead or hurting yourself in some way:	☐	☐	☐	☐

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?			
Not difficult at all difficult	Somewhat difficult	Very difficult	Extremely
☐	☐	☐	☐

GAD-7 Screening

Name:_____ **DOB:**_____

Over the last two weeks, how often have you been bothered by the following problems?	**Not at all**	**Several days**	**More than half the days**	**Nearly everyday**
1. Feeling nervous, anxious, or on edge:	0☐	1☐	2☐	3☐
2. Not being able to stop or control worrying:	0☐	1☐	2☐	3☐
3. Worrying too much about different things:	0☐	1☐	2☐	3☐
4. Trouble relaxing	0☐	1☐	2☐	3☐
5. Being so restless that it is hard to sit still:	0☐	1☐	2☐	3☐
6. Becoming easily annoyed or irritable:	0☐	1☐	2☐	3☐
7. Feeling afraid, as if something awful might happen:	0☐	1☐	2☐	3☐

Column totals _____ + _____ + _____ + _____

= Total score 0

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?			
Not difficult at all ☐	Somewhat difficult ☐	Very difficult ☐	Extremely difficult ☐

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

	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 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 in 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? *Please check 1 response only.*	○	○
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ○ No problem ○ Minor problem ○ Moderate problem ○ Serious problem		
4. Have any of your blood relatives (ie, 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?	○	○

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist Instructions

The questions on the back page are designed to stimulate dialogue between you and your patients and to help confirm if they may be suffering from the symptoms of attention-deficit/hyperactivity disorder (ADHD).

Description: The Symptom Checklist is an instrument consisting of the eighteen DSM-IV-TR criteria. Six of the eighteen questions were found to be the most predictive of symptoms consistent with ADHD. These six questions are the basis for the ASRS v1.1 Screener and are also Part A of the Symptom Checklist. Part B of the Symptom Checklist contains the remaining twelve questions.

Instructions:

Symptoms

1. Ask the patient to complete both Part A and Part B of the Symptom Checklist by marking an X in the box that most closely represents the frequency of occurrence of each of the symptoms.

2. Score Part A. If four or more marks appear in the darkly shaded boxes within Part A then the patient has symptoms highly consistent with ADHD in adults and further investigation is warranted.

3. The frequency scores on Part B provide additional cues and can serve as further probes into the patient's symptoms. Pay particular attention to marks appearing in the dark shaded boxes. The frequency-based response is more sensitive with certain questions. No total score or diagnostic likelihood is utilized for the twelve questions. It has been found that the six questions in Part A are the most predictive of the disorder and are best for use as a screening instrument.

Impairments

1. Review the entire Symptom Checklist with your patients and evaluate the level of impairment associated with the symptom.

2. Consider work/school, social and family settings.

3. Symptom frequency is often associated with symptom severity, therefore the Symptom Checklist may also aid in the assessment of impairments. If your patients have frequent symptoms, you may want to ask them to describe how these problems have affected the ability to work, take care of things at home, or get along with other people such as their spouse/significant other.

History

1. Assess the presence of these symptoms or similar symptoms in childhood. Adults who have ADHD need not have been formally diagnosed in childhood. In evaluating a patient's history, look for evidence of early-appearing and long-standing problems with attention or self-control. Some significant symptoms should have been present in childhood, but full symptomology is not necessary.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	☐	☐	☐	☐	☐
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?	☐	☐	☐	☐	☐
3. How often do you have problems remembering appointments or obligations?	☐	☐	☐	☐	☐
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	☐	☐	☐	☐	☐
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	☐	☐	☐	☐	☐
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?	☐	☐	☐	☐	☐

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?	☐	☐	☐	☐	☐
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	☐	☐	☐	☐	☐
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	☐	☐	☐	☐	☐
10. How often do you misplace or have difficulty finding things at home or at work?	☐	☐	☐	☐	☐
11. How often are you distracted by activity or noise around you?	☐	☐	☐	☐	☐
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	☐	☐	☐	☐	☐
13. How often do you feel restless or fidgety?	☐	☐	☐	☐	☐
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?	☐	☐	☐	☐	☐
15. How often do you find yourself talking too much when you are in social situations?	☐	☐	☐	☐	☐
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	☐	☐	☐	☐	☐
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	☐	☐	☐	☐	☐
18. How often do you interrupt others when they are busy?	☐	☐	☐	☐	☐

Part B

PCL-5

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then select one of the numbers to the right to indicate how much you have been bothered by that problem in the past month.

Your worst event: _____

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
2. Repeated, disturbing dreams of the stressful experience?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
4. Feeling very upset when something reminded you of the stressful experience?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
8. Trouble remembering important parts of the stressful experience?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
10. Blaming yourself or someone else for the stressful experience or what happened after it?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
12. Loss of interest in activities that you used to enjoy?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
13. Feeling distant or cut off from other people?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
15. Irritable behavior, angry outbursts, or acting aggressively?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
16. Taking too many risks or doing things that could cause you harm?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
17. Being "superalert" or watchful or on guard?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
18. Feeling jumpy or easily startled?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
19. Having difficulty concentrating?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯
20. Trouble falling or staying asleep?	0 ◯	1 ◯	2 ◯	3 ◯	4 ◯

COLUMBIA-SUICIDE SEVERITY RATING SCALE

Screen Version - Recent

SUICIDE IDEATION DEFINITIONS AND PROMPTS	**Past month**	
Ask questions that are bolded and underlined.	**YES**	**NO**
Ask Questions 1 and 2		
1) ***Have you wished you were dead or wished you could go to sleep and not wake up?***	☐	☐
2) ***Have you actually had any thoughts of killing yourself?***	☐	☐
If YES to 2, ask questions 3, 4, 5, and 6. If NO to 2, go directly to question 6.		
3) ***Have you been thinking about how you might do this?*** E.g. "*I thought about taking an overdose but I never made a specific plan as to when where or how I would actually do it….and I would never go through with it.*"	☐	☐
4) ***Have you had these thoughts and had some intention of acting on them?*** As opposed to "*I have the thoughts but I definitely will not do anything about them.*"	☐	☐
5) ***Have you started to work out or worked out the details of how to kill yourself? Do you intend to carry out this plan?***	☐	☐

6) ***Have you ever done anything, started to do anything, or prepared to do anything to end your life?*** Examples: Collected pills, obtained a gun, gave away valuables, wrote a will or suicide note, took out pills but didn't swallow any, held a gun but changed your mind or it was grabbed from your hand, went to the roof but didn't jump; or actually took pills, tried to shoot yourself, cut yourself, tried to hang yourself, etc. **If YES, ask:** ***Was this within the past three months?***	**YES**	**NO**
	☐	☐
	☐	☐

☐ Low Risk
☐ Moderate Risk
☐ High Risk

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Edinburgh Postnatal Depression Scale[1] (EPDS)

Name: _____ Address: _____

Your Date of Birth: _____ _____

Baby's Date of Birth: _____ Phone: _____

As you are pregnant or have recently had a baby, we would like to know how you are feeling. Please check the answer that comes closest to how you have felt **IN THE PAST 7 DAYS**, not just how you feel today.

Here is an example, already completed.

I have felt happy:
- ☐ Yes, all the time
- ☒ Yes, most of the time
- ☐ No, not very often
- ☐ No, not at all

This would mean: "I have felt happy most of the time" during the past week. Please complete the other questions in the same way.

In the past 7 days:

1. I have been able to laugh and see the funny side of things
   - ☐ As much as I always could
   - ☐ Not quite so much now
   - ☐ Definitely not so much now
   - ☐ Not at all

2. I have looked forward with enjoyment to things
   - ☐ As much as I ever did
   - ☐ Rather less than I used to
   - ☐ Definitely less than I used to
   - ☐ Hardly at all

*3. I have blamed myself unnecessarily when things went wrong
   - ☐ Yes, most of the time
   - ☐ Yes, some of the time
   - ☐ Not very often
   - ☐ No, never

4. I have been anxious or worried for no good reason
   - ☐ No, not at all
   - ☐ Hardly ever
   - ☐ Yes, sometimes
   - ☐ Yes, very often

*5 I have felt scared or panicky for no very good reason
   - ☐ Yes, quite a lot
   - ☐ Yes, sometimes
   - ☐ No, not much
   - ☐ No, not at all

*6. Things have been getting on top of me
   - ☐ Yes, most of the time I haven't been able to cope at all
   - ☐ Yes, sometimes I haven't been coping as well as usual
   - ☐ No, most of the time I have coped quite well
   - ☐ No, I have been coping as well as ever

*7 I have been so unhappy that I have had difficulty sleeping
   - ☐ Yes, most of the time
   - ☐ Yes, sometimes
   - ☐ Not very often
   - ☐ No, not at all

*8 I have felt sad or miserable
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Not very often
   - ☐ No, not at all

*9 I have been so unhappy that I have been crying
   - ☐ Yes, most of the time
   - ☐ Yes, quite often
   - ☐ Only occasionally
   - ☐ No, never

*10 The thought of harming myself has occurred to me
   - ☐ Yes, quite often
   - ☐ Sometimes
   - ☐ Hardly ever
   - ☐ Never

Administered/Reviewed by _____ Date _____

[1]Source: Cox, J.L., Holden, J.M., and Sagovsky, R. 1987. Detection of postnatal depression: Development of the 10-item Edinburgh Postnatal Depression Scale. *British Journal of Psychiatry* 150:782-786 .

[2]Source: K. L. Wisner, B. L. Parry, C. M. Piontek, Postpartum Depression N Engl J Med vol. 347, No 3, July 18, 2002, 194-199