Adult Intake Form

Legal Name: _____ Preferred Name: _____ Date: _____

Date of birth: _____ Age:_____ Pronouns (i.e. she/her, he/him, they/their):_____

Phone number: _____Email: _____

Address: _____ City:_____ Zip:_____

Referred by:_____

Reason for visit: _____

_____

_____

What are your goals for treatment? _____

_____

_____

Medical History

Food Allergies: _____ Medication Allergies: _____

Primary Care Physician: _____

Medical Problems (i.e. diabetes, asthma):

_____

_____

_____

_____

_____

Do you have a history of seizures or serious head injury? _____

Do you have a history of any heart problems? _____

Please list all current medications:

Medication Name:	Dosage:	When started?	Benefits?	Side effects?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Psychiatric History

What are some of your strengths? _____

What are some of your weaknesses? _____

What significant life changes or stressful events have you experienced lately? _____

_____

Have you ever experienced any traumatic events? _____

Have you ever had talk therapy before? Yes No

Name of therapist _____ Length of therapy _____

Have you ever seen a psychiatrist before? Yes No

Name of psychiatrist _____ Length of treatment _____

Do you have a history of any of the following?

Suicide attempt _____ Cutting _____ Psychiatric Hospitalization _____

Physical Abuse _____ Sexual Abuse _____ Substance abuse _____

Please list all psychiatric medication that you have taken in the past:

Special Note: If you have difficulty remembering the names and dosages of past medication, you can request a print out from your pharmacy of your prescription history to bring with you to your appointment.

Medication Name:	Dosage:	When started?	Benefits?	Side effects?
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Family History

Please list any members in your family who have experienced any psychiatric disorders such as anxiety, OCD, depression, ADHD, schizophrenia, autism, bipolar disorder, eating disorders, learning disabilities, and substance abuse.

_____

_____

_____

Please list any medications that have been helpful to family members with psychiatric disorders and how they have helped.

_____

_____

Please list any medical problems that run in your family (diabetes, asthma, thyroid problems, seizures, heart problems).

_____

_____

Has anyone in your family had heart problems at a young age (prior to age 40) or suddenly died at a young age for unknown reason? Yes No

Insurance Information:

Subscriber: _____ Date of birth: _____

Member ID: _____ Group #: _____

Stacy Greeter, MD

Board Certified in Child, Adolescent, and Adult Psychiatry

2415 University Pkwy, Suite 219
Sarasota, FL 34243

phone: (941) 413-0834
fax: (941) 761-5547

Authorization for the Release of Confidential Information

I, _____ DOB: _____, authorize Stacy Greeter, MD
(patient name)
to ____ (send) and ____ (receive) information to and from the following agencies or people:

(Name)	(Address)	(Phone)	(Fax)
(Name)	(Address)	(Phone)	(Fax)
(Name)	(Address)	(Phone)	(Fax)
(Name)	(Address)	(Phone)	(Fax)

The type of information to be disclosed can include (check as needed):

Evaluation ____	Psychological/Medical Test Results ____	Medical History ____
Diagnosis ____	Psychological/Psychiatric Reports ____	Social History ____
Treatment Plan ____	Alcohol and Substance Use History ____	**Entire Record ____**

The above information will be disclosed for the purpose of (check as needed):

Planning Appropriate Treatment ____
Continuing Appropriate Treatment ____
Collaboration Between Treatment Providers ____

Exceptions: _____

I understand that I may revoke this consent at any time providing written notice, and after one year this consent automatically expires. I have been informed what information will be given, its purpose, and who will receive the information. I understand that this authorization does not extend to the release of HIV/AIDS information unless I have placed my initials here ___. I understand that this authorization does not extend to the release of substance abuse information unless I have placed my initials here ___.

Signature of Patient _____ Date _____

Signature of Parent _____ Date _____

Signature of Witness _____ Date _____
(If patient is unable to sign.)

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Authorization for Family, Friends, or Advisors To Receive Information About Your Appointments or The Status of Your Bill

I authorize only the following individual(s) to receive written and/or oral communications about my appointments and the status of my bill.

Authorized Individual(s). Please print name(s)

_____ _____

_____ _____

_____ _____

_____ _____

_____

Signature

_____ _____

Print Name Date

Stacy Greeter MD, PLLC
Board Certified in Child, Adolescent, and Adult Psychiatry

2415 University Pkwy, Suite 219
Bradenton, FL 34243

ph: (941) 413-0834
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Prescription Renewal Policy

It is our office policy to renew prescriptions only during regularly scheduled appointments. At an appointment, our providers can provide up to 90 days of medication, and will always give you enough to last until your next appointment.

If you miss an appointment, only up to 30 days of medication can be dispensed outside of a regularly scheduled appointment. If you cancel an appointment, please reschedule within 30 days.

It is important to Dr. Greeter and her PAs that patients do not suddenly discontinue their medications, which can put their mental health at risk. Thus, in certain urgent situations, your psychiatric provider will renew prescriptions outside of regularly scheduled appointments. Patients must call at least three (3) business days in advance when needing a prescription refilled. The office requires three (3) business days to refill a prescription.

The office does not respond to refill requests from pharmacies. If you need a prescription renewed, you must leave a message with our office that includes your full name, the name of your medication, your dosage, how you take the medication, your date of birth, your phone number, and the phone number of your pharmacy. Alternatively, you may attend an appointment with one of our providers to request a refill. Under certain circumstances, our providers may require that you attend an appointment in order to obtain a refill.

Prescriptions for controlled substances will not be replaced if there is a pattern of more than two lost prescriptions.

If a Prior Authorization is needed for a medication, please allow the office one (1) week to process it.

_____
Print Patient/Guardian Name

_____ _____
Signature Date

Outstanding Balances

Payment is due at the time of your appointment. We require all patients to keep their credit card information on file. You are responsible for updating this information if your card changes.

Credit Card # _____

Exp date: _____ CVV code: _____

Billing Address: _____

Please note that you must pay your outstanding balance prior to scheduling future appointments. If you do not make payment at the time of your appointment, the office reserves the right to cancel all upcoming appointments. Patients who do not respond to a good faith effort on the behalf of the practice to pay their balance due within 30 days are subject to discharge from the practice. Thank you.

_____
Print Patient/Guardian Name

_____ _____
Signature Date

Contacting Dr. Greeter's Office Outside of Appointments

Please make every effort to address your questions/concerns to Dr. Greeter and her PAs during regularly scheduled appointments.

Questions that cannot wait for the next available appointment can be left on our providers' voicemails. To reach our providers' voicemails, please call 941-413-0834 and press the extension given for your provider. Voicemails left on our office lines will be returned by the following business day free of charge.

Please be aware that any phone calls with Dr. Greeter or her PAs lasting longer than 10 minutes will be charged an appointment fee.

Phone Calls After Hours

If your question/concern cannot wait until the next business day, you can reach our providers by calling 941-413-0834 and pressing the extension give for your provider's after-hours line. You can also reach them this way on weekends and holidays. Leave a message and the provider will return your call as soon as they are able.

Patients who call our providers' after-hours lines will automatically be charged $45 per call for this convenience. Our providers make themselves available after hours for urgent questions about medication side effects, lost medication, and other **urgent medication issues** as a service to patients. These calls should be under 10 minutes in length, and otherwise your concern will need to be addressed during a regularly scheduled appointment.

Please note that our providers do not return calls immediately and their cell phones are turned off while they are sleeping at night, so if it is an emergency, call 911 or go directly to the emergency room. Please utilize the emergency room or call 911 for safety concerns, such as suicidal ideation/self-injurious behavior. You can also call the 24-hour suicide prevention hotline at 1-800-273-TALK (8255).

Our providers are not available to return phone calls while out of town or on vacation. The office voicemail message will provide information on how to reach the covering physician/psychiatric PA in this instance.

Our providers do not respond to email messages or text messages. Please do NOT attempt to text the office as your message will not be received.

_____

Print Patient/Guardian Name

_____ _____

Signature Date

Medical Resident and Medical Student Observers

Dr. Greeter is involved with teaching various medical students, medical residents and PA students who will on occasion be observing them in the office to learn about psychiatry.

These students have signed a confidentiality agreement and will only be observing. Students do not provide treatment and are not involved in any clinical decision-making, but may ask questions to aid in their learning. They may assist in basic tasks such as checking blood pressure and weight or collecting paper work.

At any time, you have the right to decline having a student observer present at your appointment.

Please select your preference regarding student observers below:

I agree to have a student observer present at my appointment. I understand that I can change my mind at any time and ask that the student observer leave. _____

I do not want a student observer present at my appointment. _____

_____
Print Patient/Guardian Name

_____ _____
Signature Date

Appointment Scheduling and Missed/Late Appointments

In an effort to make sure that everyone is seen at their regularly scheduled appointment time without a wait and to decrease the waitlist for new clients, Dr. Greeter has instituted the below policy for missed appointments and late cancellations:

All appointments must be cancelled or rescheduled by communicating with the office at least 48 business hours before the scheduled appointment. Missed appointments and appointments that are cancelled with less than **48 business hours notice** will automatically be charged a $150 no show/late cancellation fee for 15 minute and 30 minute appointments. The full appointment fee will be charged for 60 minute appointments that are cancelled with less than 48 business hours notice.

Patients are encouraged to arrive early for appointments. Patients who arrive 15 minutes or more after their scheduled appointment time will NOT be seen, will be charged a $150 missed appointment fee, and their appointment must be rescheduled if needed. Any patient who arrives five (5) minutes or more late for a 15-minute appointment will likewise not be seen by a provider, will be charged their full appointment fee, and their appointment must be rescheduled if needed.

Patients who have three (3) missed appointments or late cancellations within a 6-month period may be subject to discharge from the practice. If their provider discharges them, they will be given up to 30 days of medication upon discharge. This is, of course, subject to the patient's individual situation and our providers' discretion.

It is our office policy that patients who are prescribed a controlled substance must meet with their provider for an in-person office appointment at least once per year.

Certain crisis situations may occur that may put Dr. Greeter or her PAs behind schedule. If your provider is running behind schedule, they will still give you your full appointment time. If your provider is running behind schedule, you may choose to decrease the length of your appointment if you need to be somewhere and we will reimburse you for the un-used time.

Appointments can be scheduled/re-scheduled by calling 941-413-0834 (extension 2) any time during business hours.

By signing this form, you agree to receive messaging and reminders related to scheduled appointments.

_____

Print Patient/Guardian Name

_____ _____

Signature Date

Telehealth Consent

Patients at this practice may choose to hold their medical appointments via telehealth. Telehealth (also called telemedicine) refers to the delivery of mental health services using interactive audio, video, or other electronic communications. The purpose of telehealth is to enable you to access psychiatric care when an in-person visit is not feasible.

If you choose to participate in telehealth, you agree that sessions may include:
-Live two-way audio and video conferencing
-Use of a secure, HIPAA-compliant platform to protect your privacy
-Self-reporting of basic health data (e.g., weight, blood pressure) when requested

Before beginning a telehealth appointment, you must ensure that you are in a private space, and that your internet connection is sufficient and secure.

The services you receive via telehealth will be medical services. If you receive telehealth services from a physician assistant, they are providing the services under the delegated authority of Dr. Stacy Greeter. Upon request, Dr. Greeter is available to provide consultation, evaluation, treatment, follow-up care, and/or referrals in relation to the delegated medical services, during a regularly scheduled appointment with Dr. Greeter.

You may be asked to report basic health metrics (weight, blood pressure, pulse, etc.). By signing below, you acknowledge understanding that these self-reported data may be less accurate than those obtained by trained healthcare professionals and that this may affect your care plan.

All communications are protected under HIPAA; no recordings will be made without your written permission. Telehealth sessions are conducted via a secure, encrypted platform.

Telehealth is not appropriate for psychiatric emergencies (e.g., suicidal or homicidal ideation). If you experience an emergency, call 911 or go to your nearest emergency department.

Participation in telehealth is voluntary. You may withdraw consent at any time without affecting your right to future care. If you refuse telehealth at any time, there will be no penalty, confidentiality protections will continue to apply, and you will continue to have full access to all medical records from your telemedicine care.

By signing below, I certify that:
-I have read and understand this Consent to Telehealth Services.
-I consent to receive psychiatric care via telehealth. (This consent is required even if you do not plan to utilize telehealth.)
-I have had the opportunity to ask questions, and all have been answered to my satisfaction.
-I understand the limitations of self-reported measurements and the possible impact on my care.
-I agree to abide by the guidelines and responsibilities described above.

_____
Print Patient/Guardian Name

_____ _____
Signature Date

Past Medications

Name: _____ Date of Birth: _____ Today's Date: _____

Please mark the medications below that you have taken in the past. Trade names are in parentheses.

First-line Antidepressants + Anxiolytics:

Fluoxetine (Prozac) ☐	Venlafaxine (Effexor) ☐	Bupropion (Wellbutrin) ☐
Paroxetine (Paxil) ☐	Duloxetine (Cymbalta) ☐	Mirtazapine (Remeron) ☐
Sertraline (Zoloft) ☐	Desvenlafaxine (Pristiq) ☐	Amitriptyline (Elavil) ☐
Citalopram (Celexa) ☐	Vilazodone (Viibryd) ☐	Nortriptyline (Pamelor) ☐
Escitalopram (Lexapro) ☐	Vortioxetine (Trintellix) ☐	

Benzodiazepines:

Alprazolam (Xanax) ☐	Clonazepam (Klonopin) ☐	Lorazepam (Ativan) ☐
Chlordiazepoxide (Librium) ☐	Diazepam (Valium) ☐	Temazepam (Restoril) ☐

Other sleep (hypnotic) or anxiolytics:

Buspirone (Buspar) ☐	Gabapentin (Neurotin) ☐	Zaleplon (Sonata) ☐
Doxepin (Silenor) ☐	Prazosin (Minipress) ☐	Zolpidem (Ambien) ☐
Hydroxyzine (Vistaril) ☐	Pregabalin (Lyrica) ☐	
Eszopiclone (Lunestra) ☐	Trazodone (Desyrel) ☐	

Antipsychotics / Mood stabilizers:

Haloperidol (Haldol) ☐	Quetiapine (Seroquel) ☐	Lithium (Lithobid/Eskalith) ☐
Risperidone (Risperdal) ☐	Aripiprazole (Abilify) ☐	Divalproex/Valproate (Depakote) ☐
Olanzapine (Zyprexa) ☐	Lurasidone (Latuda) ☐	Lamotrigine (Lamictal) ☐

ADHD medications:

Methylphenidate (Ritalin/Concerta/Metadate CD) ☐	Dexmethylphenidate (Focalin) ☐	Atomoxetine (Strattera) ☐
Dextroamphetamine + amphetamine (Adderall) ☐	Dextroamphetamine (Dexedrine) ☐	Clonidine (Catapres/Kapvay) ☐
☐	Lisdexamfetamine (Vyvanse) ☐	Guanfacine (Tenex/Intuniv) ☐

Other psychotropic medications not listed above:

_____

Over-the-counter, herbal, & dietary supplements (vitamins/minerals):

_____

If you checked any of the above and/or are currently taking psychotropic medications now, please complete the next page. Otherwise, leave the next page blank.

Name: _____ Today's Date: _____

EFFECTIVE Medications	**Effects:** How was it helpful?	**Dose:** At what dose?	**Duration:** When and how long did you take it for?	**Current med:** Are you still taking it now? If not, why was it stopped?	**Adverse effects:** Do/did you have any side effects on it? If yes, please list them.

INEFFECTIVE Medications	**Indication:** Why did your physician prescribe this medication for you?	**Effective Dose:** What was the highest dose that you tried?	**Duration:** When and how long did you take it for?	**Current med:** Are you still taking it now?	**Adverse effects:** Do/ did you have any side effects on it? If yes, please list them.

Notice of Privacy Practices

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

PLEASE READ IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a Federal program that requests that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally are kept properly confidential. This Act gives you, the patient, the right to understand and control how your personal health information ("PHI") is used. HIPAA provides penalties for covered entities that misuse personal health information.

As required by HIPAA, we prepared this explanation of how we are to maintain the privacy of your health information and how we may disclose your personal information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operation.

- Treatment means providing, coordinating, or managing health care and related services by one or more healthcare providers. An example of this is a primary care doctor referring you to a specialist doctor.

- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilization review. An example of this would include sending your insurance company a bill for your visit and/or verifying coverage prior to a surgery.

- Health Care Operations include business aspects of running our practice, such as conducting quality assessments and improving activities, auditing functions, cost management analysis, and customer service. An example of this would be new patient survey cards.

- The practice may also be required or permitted to disclose your PHI for law enforcement and other legitimate reasons. In all situations, we shall do our best to assure its continued confidentiality to the extent possible.

We may also create and distribute de-identified health information by removing all reference to individually identifiable information.

We may contact you, by phone or in writing, to provide appointment reminders or information about treatment alternatives or other health-related benefits and services.

The following use and disclosures of PHI will only be made pursuant to us receiving a written authorization from you:

- Most uses and disclosure of psychotherapy notes;

- Uses and disclosure of your PHI for marketing purposes, including subsidized treatment and health care operations;
- Disclosures that constitute a sale of PHI under HIPAA; and
- Other uses and disclosures not described in this notice.

You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your prior authorization.

You may have the following rights with respect to your PHI.

- The right to request restrictions on certain uses and disclosures of PHI, including those related to disclosures of family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to honor a request restriction except in limited circumstances which we shall explain if you ask. If we do agree to the restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of Protected Health Information by alternative means or at alternative locations.
- The right to inspect and copy your PHI.
- The right to amend your PHI.
- The right to receive an accounting of disclosures of your PHI.
- The right to obtain a paper copy of this notice from us upon request.
- The right to be advised if your unprotected PHI is intentionally or unintentionally disclosed.

If you have paid for services "out of pocket", in full and in advance, and you request that we not disclose PHI related solely to those services to a health plan, we will accommodate your request, except where we are required by law to make a disclosure.

We are required by law to maintain the privacy of your Protected Health Information and to provide you the notice of our legal duties and our privacy practice with respect to PHI.

This notice is effective as of May 14, 2017 and it is our intention to abide by the terms of the Notice of Privacy Practices and HIPAA Regulations currently in effect. We reserve the right to change the terms of our Notice of Privacy Practice and to make the new notice provision effective for all PHI that we maintain. We will post and you may request a written copy of the revised Notice of Privacy Practice from our office.

You have recourse if you feel that your protections have been violated by our office. You have the right to file a formal, written complaint with office and with the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

Feel free to contact Dr. Greeter for more information, in person or in writing.

Receipt of Notice

Stacy Greeter, MD, PLLC
Practice Name

I am a patient of Dr. Stacy Greeter. I hereby acknowledge receipt of Stacy Greeter, MD, PLLC's Notice of Privacy Practices.

Name [please print]: _____

Signature: _____ Date: _____

OR

I am a parent or legal guardian of _____ [patient name]. I hereby acknowledge receipt of Stacy Greeter, MD, PLLCS's Notice of Privacy Practices with respect to the patient.

Name [please print]: _____

Relationship to Patient: _____ Parent_____ Legal Guardian

Signature: _____ Date: _____