Demographics

PLEASE COMPLETE *AT LEAST 24 HOURS BEFORE* APPOINTMENT TO AVOID RESCHEDULING.

IF YOU HAVE ANY ISSUES FILLING OUT THE FORMS, PLEASE CALL THE OFFICE: 910-343-8424.

Date

Patient First Name | **Patient Middle Name** | **Patient Last Name** | **Preferred Name**

Date of Birth | **Age** | **Sex** ☐ Male ☐ Female ☐ Other | **Social Security Number**

Explain

Email Address | **Home Phone** | **Cell Phone** | **Okay to leave message?** ☐ Yes ☐ No

Address | **City, State** | **Zip** | **Okay to send mail?** ☐ Yes ☐ No

Other family seen here? ☐ Yes ☐ No | **Student Status:** ☐ FT ☐ PT ☐ N/A | **Employer** | **Occupation**

Name(s)

Pharmacy Name | **Pharmacy Phone** | **Pharmacy Address**

Primary Care Physician | **Phone** | **Insurance Provider**

Emergency Contact Name | **Emergency Contact Phone** | **Relationship**

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I authorize Trinity Wellness Center or insurance company to release any information required to process claims.

Patient First Name | **Patient Last Name** | **Patient Signature**

Psychiatric Intake

Patient First Name | **Patient Middle Name** | **Patient Last Name** | **Date of Birth**

Are you dealing with any legal/custody issues that will be brought up in session?

☐ Yes ☐ No

Are you on short/long-term disability requiring forms to be filled out by our office? (NOTE: We do not evaluate disability claims.)

☐ Yes ☐ No

Psychiatric Intake

What are your main concerns for wanting to be seen? How long have you had this issue? Were you referred by PCP, therapist, or someone else? (NOTE: We do not prescribe benzodiazepines for sleep).

Past Psychiatric History

Previous psychiatric diagnoses | **Current psychiatric medications** | **Previous psychiatric medications**

Previous Psychiatrist or Therapist | **Previous psychiatric hospitalization** | **Previous pharmacogenetic test**

☐ Yes ☐ No

Past Medical History

Current medical problems: | **Current medications and supplements:** | **Drug allergies and reactions:**

Traumatic brain injury or Seizures: | **Surgeries/Hospitalizations:** | **Recent labs in the last 12 months:**

Do you see a specialist (GI, Endo...)? | **Height** | **Weight** | **Blood Pressure**

Social History

Spiritual/religious? | **Living situation** | **General sleeping habits**

Your support system? | **Current Occupation** | **General eating habits**

Trauma/Military history | **Level of Education** | **Hobbies? Exercise?**

Substance Use History

Personal history: Alcohol use | **Personal history: Tobacco use** | **Personal history: Substance use**

Family History

Family history: Psychiatric diagnoses | **Family history: Suicide** | **Family history: Substance abuse**

Notes:

Pharmacy	Address
PHQ-9	
MDQ	
GAD-7	
ASRS	

PHQ-9

Patient First Name | **Patient Middle Name** | **Patient Last Name** | **Date of Birth**

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	○	○	○	○
2. Feeling down, depressed or hopeless	○	○	○	○
3. Trouble falling or staying 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 (reading, watching tv,…)	○	○	○	○
8. Moving or speaking so slowly that other people notice	○	○	○	○
9. Thoughts that you would be better off dead, or of hurting yourself	○	○	○	○

Total

10. If you checked off any problems, how difficult have these problems 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

Please briefly elaborate

Please briefly elaborate

Patient First Name | **Patient Last Name** | **Patient Signature**

MDQ

Patient First Name | **Patient Middle Name** | **Patient Last Name** | **Date of Birth**

1. Has there ever been a period of time when you were not your usual self and...

	Yes	No
...you felt so good or hyper that other people thought you were not your normal self or 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 to feel rested or found you didn't really miss it or need it?	○	○
...you were much more talkative or felt a pressure to talk constantly?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted, had trouble concentrating, or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were more much active than usual (e.g., took on more work or projects)?	○	○
...you were much more social or outgoing than usual (e.g., call friends in the middle of the night)?	○	○
...you were more sexually active than usual?	○	○
...you did things that were unusual for you or that others thought were excessive, foolish, or risky (e.g., driving recklessly)?	○	○
...spending money got you or your family into trouble (e.g., shopping sprees)?	○	○

Total

2. If you checked YES more than once, have several of these ever happened during the same period of time?

▢ Yes ▢ No

How long (hours, days, weeks, or months) do these periods typically last?

3. How much of a problem did this episode cause in work, school, or relationships (e.g., being unable to work, having family, money, or legal troubles, getting into fights, etc)?

▢ No Problem ▢ Minor Problem ▢ Moderate Problem ▢ Severe Problem

Briefly described what happened

Briefly described what happened

4. Any blood relatives (i.e., children, siblings, parents, etc.) have manic-depressive or bipolar disorder?

▢ Yes ▢ No

Please list family members

5. Has a health professional ever told you that you have manic-depressive or bipolar disorder?

▢ Yes ▢ No

Please briefly elaborate

Patient First Name | **Patient Last Name**

Patient Signature

GAD-7

Patient First Name | **Patient Middle Name** | **Patient Last Name** | **Date of Birth**

Over the last 2 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. Feeling nervous, anxious or on edge?	○	○	○	○
2. Not being able to stop or control worrying?	○	○	○	○
3. Worrying too much about different things?	○	○	○	○
4. Trouble relaxing?	○	○	○	○
5. Being so restless that it is hard to sit still?	○	○	○	○
6. Becoming easily annoyed or irritable?	○	○	○	○
7. Feeling afraid as if something awful might happen?	○	○	○	○

Total

8. If you checked off any problems, how difficult have these problems 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

Please briefly elaborate

Please briefly elaborate

Patient First Name | **Patient Last Name** | **Patient Signature**

ASRS

Patient First Name | **Patient Middle Name** | **Patient Last Name** | **Date of Birth**

Total

Please select which best describes how you have felt and conducted yourself over the past 6 months.

	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?	○	○	○	○	○
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're 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/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?	○	○	○	○	○

Patient First Name | **Patient Last Name** | **Patient Signature**

Photo Upload

Insurance Information

Do you have insurance? ☐ Yes ☐ No

Upload Insurance

Subscriber's Name:

Subscriber's Relationship to Patient:

Subscriber's Date of Birth

Do you have secondary insurance? ☐ Yes ☐ No

Upload Secondary Insurance

Subscriber's Name:

Subscriber's Relationship to Patient:

Subscriber's Date of Birth

Photo ID

Upload Photo ID

HIPAA

CONSENT FOR EXCHANGE OF INFORMATION

ANYONE NOT LISTED BELOW WILL NOT BE PROVIDED WITH ANY PATIENT INFORMATION

I, , give permission for Trinity Wellness Center to exchange, release, obtain information with the following people (family, spouse, or friends):

Name		☐ **Billing, Appointments, Medications Only**	☐ **Whole Chart/Records**
Name		☐ **Billing, Appointments, Medications Only**	☐ **Whole Chart/Records**
Name		☐ **Billing, Appointments, Medications Only**	☐ **Whole Chart/Records**

I authorize Trinity Wellness Center to exchange, obtain, or release information to my insurance provider for the purpose of billing. I understand that this practice has multiple providers. I authorize all staff of Trinity Wellness Center to exchange, obtain, and release information for the purpose of coordinating my care at this facility. This consent is fully understood and made voluntarily on my behalf. I understand that I may withdraw this consent at any time. This consent is valid for one year, unless otherwise stated below:

Patient First Name	**Patient Last Name**	**Patient Signature**

PHI

Authorization for Use and Disclosure of Protected Health Information

Patient First Name | **Patient Middle Name** | **Patient Last Name** | **Date of Birth**

Who is our client asking us to get records from? | **Who would our client like records sent to?**

I, , authorize Trinity Wellness Center to communicate with and disclose to one another the following information for the purpose of coordinating substance abuse, medical and/or psychiatric care:

- ☐ **Medical and Substance Abuse History/Notes**
- ☐ **Substance Abuse, Medical & Psychiatric Diagnoses and/or Impressions**
- ☐ **Medication and Medical Orders**
- ☐ **All Records**
- ☐ **Laboratory and X-Ray Results & Examination Findings**
- ☐ **Treatment Program Status, Progress, Recommendations**
- ☐ **Identifying Health Information (e.g., date of birth)**

Records Date Range:

I understand that my records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of1996 (HIPAA),45 CFR Parts 160 and 164 and state confidentiality law governing substance abuse services (G.S. 122 C) cannot be disclosed without my written consent unless otherwise provided for in the regulations.

I understand that the information to be released may include information regarding alcohol abuse, drug abuse, HIV infection, AIDS, and AIDS related conditions, psychological, psychiatric, or physical impairments.

I also understand that I may revoke this consent in writing at anytime except to the extent that action has been taken in reliance on it , and that in any event this consent expires automatically as follows:

This consent shall expire

☐ in one (1) year from the date executed. ☐ on the date provided below:

Date

I understand that generally, Trinity Wellness Center, may not condition my treatment on whether I sign an authorization form, but that in certain limited circumstance I may be denied treatment if I do not sign and authorization form. I certify that this authorization is made freely, voluntarily and without coercion.

Patient First Name | **Patient Last Name** | **Date of Birth** | **Patient Signature**

Office Policies

PLEASE READ CAREFULLY AND SIGN

By signing, you agree to the policies and take responsibility for being informed of the policies.

****OUR OFFICE DOES NOT COMPLETE ANY DISABILITY FORMS****

Our office does not write ESA letters. Should you need a form or other accommodation letter, these are written and filled out by providers at their discretion, and returned within one week. Same-day letters/forms will not be provided to clients, unless done in an appointment. There is a $50 fee per letter/form. This fee and all balances for services rendered must be paid in full before the letter/form is provided to the client. Providers may decline to provide any letter or form at their discretion.

COPAY / DEDUCTIBLES

Fees associated with insurance are due **prior** to being seen by your provider. It is the patient's responsibility to be informed of their insurance policies. If a patient arrives for that day's appointment and cannot produce their insurance information, the patient will be responsible for the self-pay amount for that appointment and any future appointments until insurance information is provided to the office. **If your insurance changes**, you are advised to call prior to your appointment to verify that your provider accepts your new insurance.

****WE DO NOT ACCEPT MEDICAID and do not offer self-pay rates to those with Medicaid****

NO-SHOW / LATE-CANCELLATION FEES

Each provider has set their own individual missed appointment fee. This fee is $60 and will be collected at the next appointment time unless paid beforehand. The fee will also apply to any appointment that you cancel within a 24-hour window of the scheduled appointment time. We have a voicemail set up on the weekends to allow patients to cancel any Monday appointments. When leaving a voicemail, please include: NAME, DATE OF BIRTH, PHONE NUMBER AND REASON FOR YOUR CALL. Emergencies will be handled on a case-by-case basis at the provider's discretion.

Failure to receive appointment reminders does not excuse a missed appointment nor waive the missed appointment fee.

If a patient is 10 minutes late to an appointment, the office reserves the right to ask the patient to reschedule the appointment, and the patient will be responsible for the missed appointment fee.

CONSENT FOR TREATMENT

I understand that I have chosen to receive psychiatric services from Trinity Wellness Center. This includes Dr. R. Thomas Mathew, M.D. and his associates affiliated with the practice. I understand that my choice to seek services within this office was done voluntarily and I may terminate treatment at any time. Trinity Wellness Center reserves the right to terminate treatment at any time after giving a thirty-day written notice to the last address on record.

I understand that my participation in the recommended treatment includes attending all scheduled appointments. I understand that any recommendations will be explained to me, and it is then my responsibility to ask questions if I do not fully understand. I agree to hold

Trinity Wellness Center and its associates harmless if I fail to understand or follow the recommended treatment plan. I have the right to accept or reject any treatment recommendations at any time. I understand that there is no assurance or guarantee that my medical or psychiatric illnesses will respond to treatment by any provider. I understand that Trinity Wellness Center is limited to outpatient services, and I am responsible for securing an inpatient facility if the need for one should arise. I understand that in the event of an emergency, I am responsible for seeking emergency treatment at a local emergency room or inpatient psychiatric facility.

I understand that I have a responsibility to procure, maintain, and properly care for the storage and security of all medications prescribed. I understand that it is my responsibility to assure that the medication is not lost, stolen, or destroyed. I am also aware that it is illegal to share my prescription medication with another person without a prescription.

NOTE: I hereby grant my explicit consent for the healthcare provider to retrieve and review my prescription history when scheduling appointments or ordering medications in the Electronic Health Record (EHR) system. I understand that this information will be used solely for the purpose of ensuring the accuracy and safety of my healthcare, allowing for the reconciliation of medications, and improving the quality of my medical care.

I acknowledge that some of our clinicians use an AI program called Freed or Doximity Scribe to record and transcribe sessions for the purpose of documenting the clinical encounter and simplifying record-keeping.

We have found that this improves your patient experience as the provider can then focus on gathering information from you without having to enter that data manually into their computer. These recordings and transcriptions will be used solely for medical record-keeping and will be handled in accordance with all applicable privacy and confidentiality laws, including HIPAA. Audio recordings are temporarily saved in a secure manner until note summaries and quality checks are complete, and then they are automatically deleted.

I acknowledge that I have the right to withdraw this consent at any time, and I understand that doing so may affect the healthcare provider's ability to provide optimal care. My consent will remain valid until explicitly revoked by me in writing or through a formal request.

I have been provided with an explanation of the potential benefits and risks of sharing my prescription history, and I consent to its retrieval as described.

By signing below, I acknowledge that I have read the practice information and consent to treatment/notice of the privacy practices and agree to abide by the terms. I also acknowledge that I have a clear understanding of my (and/or my child's) responsibilities according to the office/financial policies. I agree to abide by these policies, and I consent to receive treatment at Trinity Wellness Center, as well as consent to providers in the facility to consult about my health care with other providers who practice within this facility.

Patient First Name | **Patient Last Name** | **Patient Signature**

Telemedicine

Patient Consent To The Use of Telehealth: Telehealth involves the use of electronic communications to enable providers at different locations to share individual client information for the purpose of improving client care. Providers may include primary care providers, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow-up and/or education.

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Expected Benefits:

- Improved access to care by enabling a patient to remain in his/her provider's office (or at a remote site) while the providers obtains test results and consults from practitioners at distant/other sites.
- More efficient patient evaluation and management.
- Obtaining expertise of a distant specialist.

Possible Risks:

- There are potential risks associated with the use of telehealth. These risks include, but may not be limited to:
- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate decision making by the providers and consultant(s);
- Delays in evaluation and treatment could occur due to deficiencies or failures of the equipment;
- In very rare instances, security protocols could fail, causing a breach of privacy of personal health information;
- In rare cases, a lack of access to complete health records may result in interactions or allergic reactions or other judgment errors;

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of health information also apply to telehealth, and that no information obtained in the use of telehealth which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telehealth interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of health care may be available to me, and that I may choose one or more of these at any time. My provider has explained the alternatives to my satisfaction.
5. I understand that telehealth may involve electronic communication of my personal health information to other practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform my provider of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telehealth in my care, but that no results can be guaranteed or assured.
8. I understand my PHYSICAL LOCATION must be in North Carolina for telehealth.

I, , have read and understand the information provided above regarding telehealth, have discussed it with my provider or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telehealth in my care.

Patient First Name	**Patient Last Name**	**Patient Signature**

Medication List

Antidepressants

- [ ] Auvelity
- [ ] Celexa
- [ ] Cymbalta
- [ ] Effexor XR
- [ ] Fetzima
- [ ] Lexapro
- [ ] Paxil
- [ ] Pristiq
- [ ] Prozac
- [ ] Trintellix
- [ ] Viibryd
- [ ] Wellbutrin
- [ ] Zoloft
- [ ] TCA
- [ ] MAOI

Antipsychotics

- [ ] Abilify
- [ ] Caplyta
- [ ] Geodon
- [ ] Latuda
- [ ] Rexulti
- [ ] Risperdal
- [ ] Saphris
- [ ] Seroquel
- [ ] Vraylar
- [ ] Zyprexa

Anticonvulsants

- [ ] Depakote
- [ ] Gabapentin
- [ ] Gabatril
- [ ] Tegetrol
- [ ] Lamictal
- [ ] Trileptal
- [ ] Topamax

Other

- [ ] Buspar
- [ ] Litihium
- [ ] Stimulants
- [ ] Straterra
- [ ] Provigil
- [ ] Cytomel
- [ ] Nuvigil
- [ ] IV Ketamine
- [ ] ECT
- [ ] TMS

Text