Thank you for choosing Stanbro Healthcare Group!

Our detailed intake process that is designed to improve efficiency and provide the best service possible. In order to set up your appointment, we ask that you carefully fill out all of the enclosed forms as completely as possible and return them via email, fax or US mail to the address provided below. Once we receive your packet, you will be contacted by one of our placement team members as soon as an appointment date becomes available.

Methods for returning your completed packet:

- Fax: 405.341.2672
- Email: Info@StanbroHealthcareGroup.com
- US Mail: 2000 East 15th Street, Suite 400A, Edmond, OK 73013

Again, thank you for choosing Stanbro Healthcare Group. We are honored to serve you.

Sincerely,

The SHG Team

NEW PATIENT CHECKLIST

WE ARE UNABLE TO SCHEDULE YOUR APPOINTMENT UNTIL ALL DOCUMENTATION IS COMPLETE AND RECEIVED

- ☐ **COPY OF FRONT AND BACK OF INSURANCE CARD (WE DO NOT ACCEPT MEDICARE)**
- ☐ **COPY OF PHOTO ID**
- ☐ **SIGNATURES/DATES**
  Pages 10-16 require signatures and dates.
- ☐ **SCREENING TOOLS**
  (Pages 17-19)
- ☐ **MOST RECENT PSYCHIATRIC RECORDS**
  The release of information on page 11 must be completed if you are unable to produce these records.
- ☐ **CONTROLLED SUBSTANCE AGREEMENT**
- ☐ **LEGAL GUARDIANSHIP DOCUMENTS**
  If applicable.

INFORMATION YOU SHOULD KNOW ABOUT
MENTAL HEALTH INSURANCE COVERAGE

Stanbro Healthcare Group provides in-network services for a wide variety of insurance providers. We also provide documentation of billing and services if you prefer out-of-network coverage. We are not contracted with and **do not accept Medicare**. We do accept Medicaid/Soonercare.

Please note that mental health coverage is frequently very different from medical coverage. Also benefits allowed by your insurance provider are frequently subject to change beyond our control. We strongly encourage you to contact your insurance provider or benefits administrator to verify the specific mental health services allowed by your insurance plan.

- **Verification of mental health benefits and preauthorization for services:** As a courtesy to you, we obtain information regarding your mental health benefits and preauthorization before your first visit. You will be provided with the information we are given by your health plan and we encourage you to refer to your policy manual or call your plan to confirm the information provided to us.

- **Co-payments:** Costs are often a percentage of the charges incurred instead of a fixed dollar amount. Information about co-payments for mental health services is rarely listed on the insurance card and is obtained by calling the plan.

- **Deductibles:** Mental health services are often separate and in addition to the medical deductible outlined by your insurance plan. If the deductible required by your plan has not been reached, we may need to collect the full amount for services at the time of your appointment.

- **Referrals:** If you are covered by a managed care insurance plan which requires referrals, you must obtain referral forms from your primary care physician prior to your visit (Tricare plans require this referral). *Please note that a written referral is a requirement of the insurance company and that we must adhere to the plan's administrative requirements in order to receive payment on your behalf.*

- **Limits:** Frequently, mental health benefits are limited per calendar or plan year. Please consult your policy manual regarding your maximum calendar year or plan year benefits.

- **Testing:** Neuropsychological, psychological, and developmental testing are frequently requested by our clinicians and referrals will be made for the needed testing. Most insurance companies limit the number of testing hours covered. Please contact your insurance provider prior to the referral being placed to verify limits and coverage.

DEMOGRAPHICS

Patient's Name (Last, First, MI) ______________________ Patient's Date of Birth ______________

Sex ________ Gender Identity ________ Race ________ Social Security Number ________

Address (**No PO Boxes allowed – must be a physical address**) ______________________

Home Telephone ______________ Cell Number ______________

Email Address (required) ______________________

REASON FOR SEEKING MENTAL HEALTH SERVICES (check all that apply)

□ Behavior Problems
□ Anxiety
□ Obsessive Compulsive Disorder
□ Homicidal Ideation
□ Bipolar Disorder
□ Attention Deficit/Hyperactivity Disorder
□ PTSD
□ Oppositional Defiant Disorder
□ Visual Hallucinations
□ Substance Use/Abuse
□ Depression
□ PANDAS/PANS
□ Suicidal Ideation
□ Audible Hallucinations
□ Other

WHO REFERRED YOU TO STANBRO HEALTHCARE GROUP? ______________________

INSURANCE INFORMATION (WE DO NOT ACCEPT MEDICARE)

Primary Insurance Company: ______________________ Telephone Number ______________
Policy/Identification Number: ______________________
Group Name: ______________________ Group Number: ______________
Subscriber's/Policy Holder's Name: ______________________
Subscriber's/Policy Holder's Date of Birth: ______________ Social Security Number: ______________
Secondary Insurance Company: ______________________ Telephone Number ______________
Policy/Identification Number: ______________________
Group Name: ______________________ Group Number: ______________
Subscriber's/Policy Holder's Name: ______________________
Subscriber's/Policy Holder's Date of Birth: ______________ Social Security Number: ______________

FINANCIALLY RESPONSIBLE PARTIES (GUARANTORS)

Primary Guarantor's Name: ______________________
Relationship to Patient: ______________________
Address (if different from patient): ______________________

Employer: ____________________
Address: ____________________
Home Telephone: ____________________ Cell Number: ____________________
Work Telephone: ____________________ Email: ____________________
Date of Birth: ____________________ Social Security Number: ____________________

ARE THERE OTHER FAMILY MEMBER'S WHO ARE CURRENT PATIENTS AT STANBRO HEALTHCARE GROUP?

□ Yes (please list below) □ No

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

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

Condition			
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 for what reason, when and where.

REASON	DATE HOSPITALIZED	WHERE

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)			

	Dates	Dosage	Response/Side-Effects
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			

Antianxiety 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
Substance use (continued)
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 at 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/Sleeping □ No □ Yes If yes, how long and when did you last use? ____________________
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 If yes, how long? _________
Are you sexually active? □ No □ Yes
How would you identify your sexual orientation?
□ Straight/Heterosexual □ Lesbian/Gay/Homosexual □ Bisexual □ Transsexual
□ Unsure/Questioning □ Asexual □ Other □ Prefer not to answer
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 gender: ________________________
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

AUTHORIZATION FOR USE & DISCLOSURE (RELEASE OR REQUEST) OF PROTECTED HEALTH INFORMATION

I authorize Stanbro Healthcare Group to use and disclose or request health information. This information specified below may be

☐ released to or ☐ requested from:

Name/Agency ____________________ Reason for Disclosure ____________________

Address, City, State, Zip ____________________

Telephone Number ____________________ Fax Number ____________________

The following information:

INFORMATION	DATES OF SERVICE	INFORMATION	DATES OF SERVICE
☐ Psychiatric Records		☐ Psychosocial Assessment	
☐ Laboratory Reports		☐ EKG	
☐ Entire Health Record		☐ History and Physical	
☐ Progress Notes		☐ Psychological/Educational Assessments	
☐ Current Medications		☐ Discharge Summary	
☐ Verbal Communication		☐ Other (specify)	

I also understand that my insurer requires information regarding my treatment; I agree to have this information released as requested. I may revoke this authorization at any time by providing my written revocation. My revocation will not apply to the information already retained; used or disclosed in response to this authorization. The information authorized for release may include protected health information related to mental health. Release of mental health records or psychotherapy notes may require consent of the treating provider or a court order.

The information authorized for release may include drug/alcohol abuse, mental health treatment and other sensitive information. This category of medical information/records is protected by Federal law (42CFR Part 2). Federal law prohibits anyone receiving this information or record from making further release unless further release is expressly permitted by the written authorization of the patient or is permitted by 42CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. Federal law restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient. As a result, by signing below, I specifically authorize any such records included in my health information to be released.

_____ Initial Here: I understand that if my records are released, I will be charged a Records Request Fee of 50 cents per page, payable prior to the release of the requested records. Your health insurance coverage will not reimburse you for this charge.

Printed Name of Patient ____________ Date of Birth ____________ Date/Time (expires after 1 year)

Parent/Guardian Signature / Patient Signature ____________ Date/Time (expires after 1 year)

CONSENT TO RECEIVE OUTPATIENT MENTAL HEALTH SERVICES

I seek to receive outpatient mental health services at Stanbro Healthcare Group. Outpatient services may be provided in office or by telepsychiatry. Outpatient mental health services include any or a combination of the following: evaluation, supportive therapy, referral to psychological or neuropsychological testing, and medications. Telepsychiatry is an extension of patient care that allows patients to access psychiatric care using audio-video interface videoconferencing. Electronic videoconferencing systems used will incorporate network and software security protocols including but not limited to encrypted data transmission of video conference, password protected screen savers and privacy protected virtual waiting rooms to protect the confidentiality of patient identification and imaging data. This will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telepsychiatry, and that no information obtained in the use of telepsychiatry, which identifies me, will be disclosed to researchers or other entities without my consent. I understand that a variety of alternative methods of psychiatric care may be available to me, and that I may choose one or more of these at any time. I understand that there will be no recording of any of the online session and that all information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without my written permission, except where disclosure is required by law. I agree to take full responsibility for the security of any communications or treatment on my own device and in my own physical location. I also understand that I am responsible for using this technology in a secure and private location so that others cannot hear my conversation. I consent to participate in program activities directly associated with my mental health evaluation and treatment, and as appropriate, to involve my family members. I authorize Stanbro Healthcare Group to review my medical record for teaching purposes. I understand that all the personal information that I provide about myself and my family will remain confidential and any published data will keep my identity and my family's identity confidential.

Psychiatric assessment and evidence-based treatment includes a variety of methods aimed at two objectives:

1. Reducing or eliminating disturbing symptoms, and
2. Helping you or your child achieve greater psychological comfort, improved behavioral functioning and/or self-control and achieve better adjustment to life circumstances. Treatment generally consists of therapy and/or prescription of medications, psycho-education, and modification of health-related behaviors.

Please note: The purpose of the evaluation is not meant to be used for any type of court or forensic evaluation, nor is it meant to be a substitute for a disability determination.

No patient will be required to take medication and always have the right to either refuse and/or request to be taken-off of any medication at any time.

With this consent for treatment, you acknowledge that any medication prescribed for you or your child will be taken *exactly* as prescribed. You should not change the amount or frequency of the medication without consulting first with your medical provider. It is important to consult with your medical provider *before* stopping any prescribed medication. You will complete all lab work that is requested by your medical provider. Because some medications may interact negatively with other drugs (e.g. other prescribed medications, over-the-counter substances, herbs, vitamins, illegal drug, etc.) you MUST inform your medical provider about any of these currently being taken. **Please notify your medical provider if you think you are pregnant**.

DISCONTINUATION OF TREATMENT POLICY

NO SHOW POLICY: All new and follow up appointments must be cancelled at least 24 hours prior to the appointment time. Cancellation or reschedule requests on the day of the appointment are considered NO SHOW appointments.

Please be aware that Stanbro Healthcare Group may discontinue your treatment for any of the following reasons:

- ✓ Noncompliance of treatment goals.
- ✓ Failure to appear for two or more appointments within a three-month period, without at least a 24-hour notification.
- ✓ Being consistently late for appointments or consistently cancelling appointments.
- ✓ Being disrespectful to staff and/or disrupting the care of other patients.Innapropriate behavior will not be tolerated.

By signing below, you are giving consent for treatment.

______________________	______________________	________
Printed Name of Patient	Signature	Date

PATIENT RIGHTS

As a patient at Stanbro Healthcare Group (SHG), you have a right:

- To be treated with dignity and respect.
- To receive the most appropriate treatment regardless of age, gender, race, religion, sexual orientation, national origin or method of payment.
- To know what fees will be charged for your treatment in advance.
- To know the name and professional status of those persons providing your treatment.
- To participate in the development of a comprehensive Individual Treatment Plan (ITP) and to receive treatment according to this treatment plan.
- To be informed of any possible side effects of prescribed medication.
- To privacy and confidentiality concerning your treatment and medical record. Information from your record will be released only with your written permission. However, all SHG staff involved with your treatment will share information with one another.
- To be free from physical, mental and sexual abuse or harassment.
- To be free from intrusive research.
- To have your concerns addressed in a timely manner, generally at the point of service, without fear of retaliation.
- To file a confidential verbal or written complaint regarding your treatment. An impartial investigation will be initiated within 24 hours of receipt of complaint. All complaints will be resolved within 30 days of the date of complaint. To file a complaint, you may:
    1. Start informally by contacting any staff member. If your claim is not resolved in five (5) business days, you may contact;
    2. The Practice Manager at 405-341-1697.

As a patient at Stanbro Healthcare Group (SHG), you have a responsibility:

- To keep your appointment or notify us of any changes as early as possible.
- To collaborate in the development of your Individualized Treatment Plan (ITP).
- To work toward the achievement of your treatment goals.
- To be honest with staff by sharing anything that might impact upon your treatment.
- To obtain all necessary treatment referrals/prior authorizations from your primary care physician and from your health plan.
- To pay your fees on time/or discuss with staff any related financial difficulties.
- To promptly provide information regarding changes in health insurance, address, phone numbers and/or email address.
- To let staff know if you are dissatisfied in any way with your treatment.
- To inform staff of your desire to terminate treatment, especially if you have not achieved your treatment goals.

______________________________	______________________________	______________
Printed Name of Patient	Signature	Date

CONSENT, AUTHORIZATION AND ASSIGNMENT OF INSURANCE AGREEMENT

I, ____, hereby authorize Stanbro Healthcare Group to apply for benefits on my behalf for services rendered. I request that payments be made directly to Stanbro Healthcare Group. I affirm that the information provided regarding insurance coverage is true and accurate. I further authorize the release of any necessary medical or other information for this or any related claim to any insurance company. A copy of this consent, authorization and assignment agreement may be used in place of the original. This agreement will remain in effect until revoked by me in writing. I understand that I am financially responsible for all charges, *whether or not paid by my medical insurance*. I agree to assume responsibility for all charges incurred, should collection of this balance become necessary, including court costs and attorney's fees. I also understand that I will be charged a $50 Returned Check Fee for any checks returned for non-payment from my bank. Additionally, I understand that I am financially responsible for all non-appointment services, such as report preparation, telephone consultations, record requests, appointment no show and cancellation charges. Payment for services is expected at the time of your appointment. If you need to make payment arrangements or questions regarding your medical insurance coverage, please contact our Business Office at 405-341-1697 prior to your appointment. Services are offered to you, the client. Responsibility for payment rests with you, not your insurance company. We will not accept responsibility for collecting from your insurance company.

Printed Name of Patient ______________________ Signature ______________________ Date ________

USER ELECTRONIC MAIL AUTHORIZATION FORM FOR ELECTRONIC NOTIFICATIONS

Stanbro Healthcare Group utilizes an electronic patient notification system. This system is used to notify you of appointment date/times, appointment reminders, practice alerts (e.g. rescheduled appointments, unscheduled office closure do to severe weather, illness, etc.).

The electronic notifications are sent via text message, email, and automated voice messaging. By signing below, you are giving consent for us to text message, email you, or leave you a voice message regarding your appointments or group related messages. This system will not be used for marketing.

Printed Name of Patient ______________________ Signature ______________________ Date ________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have been provided the Stanbro Healthcare Group Notice of Privacy Practices:

- It tells me how Stanbro Healthcare Group will use my health information for the purpose of my treatment, payment for treatment and Stanbro Healthcare Group health care operations.
- It explains in detail how Stanbro Healthcare Group may use and share my health information for other than treatment, payment and health care operations.
- Why Stanbro Healthcare Group will use and share my health information as required/permitted by law.

Printed Patient Name ______________________ Signature ______________________ Date ________

Controlled Substances Agreement

I, ____, understand and voluntarily agree that
(initial each statement after reviewing)

________ I will keep and be on time for all my scheduled appointments with Stanbro Healthcare Group. Cancellations and/or no showing my scheduled appointments may result in denial of my prescription until I am seen by my provider.

________ I understand that some controlled substances are not intended to be taken long term and my provider may taper and discontinue my controlled substance at any time.

________ If at any time I am prescribed a narcotic by an outside provider, I will immediately contact my provider with Stanbro Healthcare Group. Concurrent use of a narcotic and a benzodiazepine will result in an immediate taper of my controlled substance (i.e. Ativan, Xanax, Valium, Klonopin).

________ I am responsible for the controlled substance medications (i.e. Adderall, Xanax, Ambien) prescribed to me. If my prescriptions are lost, stolen, or if "I run out early", I understand this medication will not be replaced regardless of the circumstances.

________ I may be asked to complete random urine testing.

________ I understand my refill request may take up to 72 hours to process if requested outside of my scheduled office visit. It is my responsibility to schedule follow-up appointments for refills.

________ I will treat the staff at the office respectfully at all times. Being disrespectful to staff or disrupting the care of other patients will not be tolerated.

________ I understand that if I violate any of the above conditions, my treatment which includes prescriptions for controlled medications, may be terminated and I will be subject to dismissal from Stanbro Healthcare Group.

________________________	________________________	__________
Patient Name (please print)	Patient Signature	Date
________________________	________________________	__________
Parent Name/Guardian (please print)	Signature of Parent/Guardian	Date

Communicating with You

In order to effectively communicate with you about your medical information we request that you complete this form identifying the best ways to provide you with your confidential information. We may need to communicate test results, prescription information or respond to a message you left your provider. **We may communicate with your through mail, secure email, and telephone, including leaving messages on your answering machine/voice mail.**

☐ **You may contact me by telephone**	**Telephone Number:**
☐ **You may leave a message/voicemail**	**Email Address:**
☐ **You may contact me by email**	
☐ **You may contact me by mail**	

Name/Phone Number	Relationship	Options
1.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
2.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
3.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
4.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information
5.		☐ Billing Information ☐ Appointment Information ☐ Medical/Health Information

This request supersedes any prior request for communication of information I may have made.

__________________________________ ______________________

Signature of Patient/Responsible Party Date

__________________________________ ________________________________

Name of Patient/Responsible Party (Print) Relationship to Patient

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_________________ Patient Name:_____________________________________ Date of Birth: ___________

Over the last 2 weeks, how often have you been bothered by any of the following problems? Place X in the box that best describes yourself.

PHQ-9	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, such as reading the newspaper or watching television.				
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 that you would be better off dead, or of hurting yourself in some way.				
Add the score for each column				

Total Score (Your provider will add column scores): ______________

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Check one)

Not difficult at all ☐ **Somewhat difficult** ☐ **Very Difficult** ☐ **Extremely Difficult** ☐

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	Not at all sure	Several days	Over half the days	Nearly every day
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's hard to sit still.				
6. Becoming easily annoyed or irritable.				
7. Feeling afraid as if something awful might happen.				
Add the score for each column				

Total Score (Your provider will add column scores): ______________

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Check one)

Not difficult at all ☐ **Somewhat difficult** ☐ **Very Difficult** ☐ **Extremely Difficult** ☐

UHS Rev 4/2020

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc.
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Mood Disorder Questionnaire (MDQ)

Name: ____ Date: _______________

Check the answer that best applies to you. Please answer each question as best as 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?	◯	◯

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

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

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 review it carefully. It is the policy of Stanbro Healthcare Group, in accordance with the Oklahoma State Department of Health (OSDH), to keep your medical and personal information confidential. We will only use or disclose your information for the following reasons:

- **Treatment:** We will share your medical information with other medical providers who are involved in your care (including hospitals and clinics), to refer you for treatment, and to coordinate your care with others. We also participate in Electronic Health Information Exchange.
- **Payment:** We may use and disclose PHI when it is needed to receive payment for services provided to you. For example, if you have Medicaid benefits, we will release the minimum information necessary for the Medicaid program to pay us.
- **Health Care Operations:** We will use and disclose PJI when it is needed to make sure we are providing you with good patient care. For instance, we may review your records in order to make certain quality service was given.

Other uses or disclosures of your PHI that may occur include:

- If you have given us permission in writing to release part of your information.
- When ordered to do so by a valid court order.
- When cases of child abuse or neglect are investigated.
- Immunization information is shared with schools and childcare centers.
- When business associates of OSDH, such as community clinics, sign agreements to protect your privacy.
- The SoonerStart Program shares information with the State Department of Education.
- When required by State law.
- We can share your information with anyone as necessary, consistent with Oklahoma law and the OSDH policies and procedures, if we feel there is imminent danger. For example, we will release the minimum information necessary if we believe it will prevent or lessen a serious and imminent threat to the health and safety of a person or the public.
- When services are provided to minors, information will be shared with the Joint Oklahoma Information Network (JOIN). This is done to help us improve the services given to children. However, no one can use your child's information unless you have given permission in writing.
- In the case of a severe disaster we can disclose your information.
- We will share your PHI with other medical providers who are involved in your care to coordinate your care with others.
- We can share your information as necessary to identify, locate and notify family members, guardians, or anyone else responsible for your care, of your location, general condition or death.

Your Rights

You have the right to:

- Receive a list of persons or organizations, other than those listed above, to whom we release your information.
- Request limits on how your information is used or disclosed; however, we are not required to agree to those limits.
- Ask that we not contact you at work.
- Inspect and copy your medical records except in cases involving certain psychotherapy notes.
- Amend incorrect information in your record.
- Revoke your written permission for release of information.
- Receive a paper copy of this Notice of Privacy Practices.

Our Responsibilities

Federal law and the OSDH and its entities require Stanbro Healthcare Group to:

- Maintain the confidentiality of your PHI.
- Provide you with a copy of this notice.
- Abide by the terms of this notice.
- Only change this notice as permitted by Federal law.
- Provide you with a way to file complaints regarding privacy issues.

For additional information regarding this notice and your rights, or to report any complaints regarding privacy issues, contact:

HIPAA Privacy Officer
Community Health Services
Oklahoma State Department of Health
1000 NE 10th Street
OKC, OK 73117-1299
405.271.5585 privacyofficer@health.ok.gov

Secretary of Health and Human Services
The US Department of Health and Human Services
Office of Civil Rights
1301 Young Street, STE 1169
Dallas, TX 75202
214.767.4056 TDD214.767.8940