Lumina
PSYCHIATRY & WELLNESS

Demographic Information

Full name	**Date of Birth**	**Gender Identity** Male / Female / Transgender / Non-Binary / Other
Nick name (if any)	**Marital Status** Single / Married / Widowed / Divorced / Living with partner / Other	
Mailing Address	**City/State**	**Zip Code**
Primary Phone	**Secondary Phone**	**Work Phone**
I authorize detailed messages containing pertinent medical information to be left in a voicemail at the following numbers: □Primary Phone □ Secondary Phone □ Work Phone □ Emergency Primary □ Emergency Secondary		
I would like to be added to the patient portal: □ Yes □ No	**Email**	
Employer	**Spouse/Parent's Name**	
Emergency Contact's Name	**Relationship to Patient**	
Emergency's Primary Phone	**Emergency's Secondary Phone**	
Primary Care Physician	**Therapist/ Psychologist**	**Referring Physician**
Pharmacy Name and Address	**Pharmacy Phone Number**	
Ethnicity □ Hispanic or Latino □ Not Hispanic or Latino □ Unknown	**Language** □ English □Other_____	
Race □ American Indian or Alaska Native □ Asian □ White □Other □ Black or African American □ Native Hawaiian or Other Pacific Islander	**Appointment Confirmation Preference** □Email □Primary Phone □Text □None □Other Contact_____	

Protected Health Information Authorization

Name	Relation	
1.		□All □Scheduling □Medical □Billing
2.		□All □Scheduling □Medical □Billing

I have reviewed the above information and authorize my protected health information to be released to the individuals listed, as specified. I understand that this authorization applies to both written and verbal communications. I also understand that I may request to revoke this authorization, in writing, at any time.

_____ _____

Signature of Patient/Legal Representative **Date**

Insurance Information

Primary	Secondary
Insurance Company	Insurance Company
Member ID/ Policy Number	Member ID/ Policy Number
Group #	Group #

Patient Financial Policy Sheet

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with us. We are dedicated to providing the best possible care and service to you and regard your understanding of your financial responsibilities as an essential element of your care and treatment.

Unless other arrangements have been made in advance by either you or your health insurance carrier, full payment is due at the time of service. For your convenience, we accept payment by check, cash, debit card, Visa or Mastercard.

Your Insurance

We have made prior arrangements with many insurers and health plans to accept an assignment of benefits. This means that we will bill those plans for which we have an agreement and will only require you to pay the authorized co-payment at the time of service. The office policy is to collect the co-payment when you arrive for your appointment.

Your assistance in securing timely payments of your claims may be required. If your health plan requires that you obtain prior authorization in the form of a REFERRAL from your primary care physician (PCP), or PRECERTIFICATION before procedures or treatment plans may be initiated, we ask that you inform our staff and assist us to assure these arrangements are made in advance.

If you have insurance coverage with a plan for which we do not have prior agreement, we will prepare and send claims on your behalf. You should be aware however, that the patient's share of the medical fees owed when using non-contracted physicians will usually be more than when using contracted physicians.

Not all services are a covered benefit in all insurance plans. Some health plans select certain services that will not be covered. In the event that your health plan determines a service to be "not covered", you will be responsible for the complete charge. Payment of the balance that is designated as the patient's responsibility is due upon receipt of a statement from our office.

We will bill your health plan for all services provided in the hospital. Any balance due is your responsibility and is due upon receipt of a statement from our office or from your insurance.

Keep in touch: Do not assume your insurance carrier is "working on it". Contact them if you have not received a notice of payment within 30 to 45 days of your services. If payment is delayed by your health plan, you will be asked to contact them or your health benefits office to identify the issues. You will be held responsible for services not paid by your health plan.

Minor Patients

For all services rendered to minor patients, we will look to the adult accompanying the patient, the parent or the guardian with custody for payments.

I have read and understand the financial policy of the practice, and I agree to be bound by the terms. I also understand and agree that the practice may amend such terms from time to time.

Printed Name of Patient	**Date of Birth**
Signature of Patient/Legal Representative	**Date**

Acknowledgement of Receipt of Notice of Privacy Practices

Our practice reserves the right to modify the privacy practices outlined in the notice.

I have reviewed or have been given the opportunity to review this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of the Notice of Privacy Practices.

** If you would like to receive a copy of our Notice of Privacy Practice, please ask an associate.*

Printed Name of Patient	**Date of Birth**
Signature of Patient/Legal Representative	**Date**

Authorization for Disclosure of Mental Health Treatment Information

2160 N. Lake Forest Dr., Ste. 600,
McKinney, TX 75071
Phone: (972) 707-2100
Fax: (972) 707-3100

I,_____, authorize Premier Care Psychiatry to disclose to and/or obtain from

_____the following information:

Description of Information to be Disclosed

_____Assessment	_____Presence/Participation in Treatment
_____Diagnosis	_____Discharge/Transfer Summary
_____Psychosocial Evaluation	_____Continuing Care Plan
_____Psychological Evaluation	_____Progress in Treatment
_____Psychiatric Evaluation	_____Demographic Information
_____Treatment Plan or Summary	_____Psychotherapy Notes
_____Current Treatment Update	_____Other_____
_____Medication Management Information	_____Other_____

Revocation: I understand that I have a right to revoke this authorization, in writing, at any time by sending written notification to Premier Care Psychiatry. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization.

Conditions: I further understand that Premier Care Psychiatry will not condition my treatment on whether I give authorization for the requested disclosure.

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format or electronically.

Redisclosure: I understand that there is the potential that the protected health information that is disclosed pursuant to this authorization may be redisclosed by the recipient and the protected health information will no longer be protected by the HIPAA privacy regulations, unless a state law applies that is stricter than HIPAA and provides additional privacy protections.

_____ _____

Printed Name of Patient **Date of Birth**

_____ _____

Signature of Patient/Legal Representative **Date**

_____Check here if patient/client refuses to sign authorization

Office Location

2160 N. Lake Forest Dr., Ste. 600,
McKinney, TX 75071
Phone: (972) 707-2100
Fax: (972) 707-3100

Authorization to Release Healthcare Information

This is a release form for authorization of your medical information to be used/and or disclosed between **health care providers, health insurance companies, and any other party involved in your medical care.**

I,_____, hereby authorize the following facilities/hospitals and doctor(s) to release all medical information to Premier Care Psychiatry to better manage my health.

This request includes hospital summaries, laboratory reports, physician progress notes, and any other healthcare information relating to my condition.

**List facility name(s), hospital name(s) and/or physician(s) below where you have been seen so that we may obtain your medical information:*

*1*_____

*2*_____

*3*_____

*4*_____

*5*_____

Printed Name of Patient	**Date of Birth**
Signature of Patient/Legal Representative	**Date**

Cancellation and No-Show Policy Acknowledgement

In an effort to minimize waiting periods and improve appointment availability we have found it necessary to enact a Patient Cancellation Policy. Any patient that cancels an appointment **with less than 24-hour notice** and/or does not show up for their appointment will have the credit card on file automatically charged a fee of $75 for missed appointment. **If there is no credit card on file, patient will have to make the late charge payment prior to being given another appointment.** Additionally, after 2 cancelled appointments, we will be unable to accommodate schedule requests. We hope this policy will ultimately benefit all patients by improving the quality of your treatment experience.

I understand Lumina Psychiatry & Wellness's cancellation policy.

_____

Signature Date

CREDIT CARD ON FILE: BILLING AUTHORIZATION

The undersigned agrees and authorizes Premier Care Psychiatry to charge the credit card indicated below for collection of patient responsibility for appointment payments, late cancellations, new patient deposits and no-show fees.

Name as it appears on card: _____

Type of Card:

☐ MasterCard ☐ Visa ☐ Discover ☐ American Express

Card Number:

Expiration Date:_____(month/year) Security Code:_____(last 3 digits on back)

I authorize Premier Care Psychiatry to process credit card as "signature on file" for appointment payments, late cancellations, and no-show fees. I understand this authorization will expire upon conclusion of care.

_____

Cardholder's Signature Date

Patient name:_____DOB:_____Date: _____

Patient/Provider Controlled Medication Agreement

The purpose of this agreement is to be certain that long-term controlled substances are prescribed in the safest, most effective manner in compliance with current law. Utilization of controlled substances over a long period of time may be medically useful, but may carry the risk of dependency, addiction, and loss of effectiveness. You must understand and agree to the following terms in order for us to enter with into a prescribing relationship. I understand that breaking the terms of this agreement will mean my doctor will no longer prescribe controlled substances for my condition. I understand that violating the terms of this agreement could result in discharge from the practice. **Please initial next to each number.**

_____1. The goal of treatment will be established with my provider and will focus on improving function, not total symptom elimination.

_____2. All controlled medications must be prescribed by my regular provider. I will not obtain controlled substances from any other provider, emergency room, or urgent care facility without notifying my prescribing provider.

_____3. I will not share, sell, or let others have access to my controlled medications.

_____4. I will not alter a prescription, use deception to obtain a prescription, or provide prescription medicine to anyone else. I understand that any such activity not only violates this agreement but is also a felony offense.

_____5. My provider will decide how often I need to be seen for office evaluation and assessment. My treatment will be continued only if I return to the office for these visits. I must schedule these visits so that I do not run out of medications. I will not ask for early prescriptions for renewals. We will not issue prescriptions for controlled substances when the office is closed. The assessment interval shall not exceed 3 months in any case.

_____6. I understand that if I use my medication at a greater rate than it is prescribed for that I will run out of my medication for a period of time and that I may experience withdrawal or other dangerous effects. If my prescription is lost or stolen, I understand that I should file a police report.

_____7. I understand that controlled substances are used as a component of a total treatment plan to control symptoms. I agree to participate in any and all aspects of this treatment plan that my provider feels would be in my best interest.

_____8. I will not adjust any dosage of medication unless specifically directed by my provider.

_____9. My provider will evaluate the effectiveness of my treatment plan on an ongoing basis. I agree to communicate fully the effect of my prescription on my symptoms.

_____10. If controlled medications are not effective, I agree that discontinuing them under my provider's direction is an appropriate treatment option.

_____11. I agree to notify my provider of all other medications and substances I am taking. Sedatives, alcohol, and street drugs should not be taken with controlled prescriptions.

_____12. Monitoring of blood or urine of patients taking controlled substances will be a part of my care, I agree to provide samples when asked. I understand that my provider may wish to dedicate an appointment solely for this purpose.

_____13. I agree to provide photo identification and comply with any other office policies for retrieving printed prescriptions.

_____14. I understand that controlled medications may be harmful during pregnancy and agree to notify my provider if I become pregnant.

I have read and understand this agreement and have had the opportunity to have all questions answered to my satisfaction. I agree to the use of controlled substances for my condition under the terms of this agreement. I understand that this agreement is essential to the trust and confidence necessary in a doctor/patient relationship and that my doctor will be treating me based on the terms of this agreement. I understand that breaking the terms of this agreement will mean my doctor will no longer prescribe controlled substances for my condition. I understand that violating the terms of this agreement could result in discharge from the practice.

Patient or Guardian Signature:_____Date:_____

Provider Signature:_____Date:_____

NAME		DATE			
DOB		AGE		SEX	

BRIEFLY DESCRIBE YOUR PRESENT SYMPTOMS:

PSYCHIATRIC HISTORY

Have you ever seen a specialist/psychiatrist? □ Yes □ No If yes, please fill in below.

Name of Physician/Clinic	Duration of treatment (mo or yr)	Location (City/State)	Reason for treatment

Have you ever been hospitalized in a psychiatric facility? □ Yes □ No If yes please fill in below:

Name of Hospital	Date of hospitalization	Location (City/State)	Reason for treatment

Have you ever presented to emergency room for any anxiety/mood related issue? □ Yes □ No (please explain):

What diagnoses have you been treated for:

□ Major depression □ General anxiety disorder □ Obsessive compulsive disorder □ Bipolar disorder □ Schizophrenia □ Autism

□ Schizoaffective disorder □ Eating disorder □ Personality disorder □ ADHD/ADD □ Post-traumatic stress disorder

□ Other:_____

Please check any that apply to your psychiatric history:

History of suicidal ideation: □ Yes □ No Suicide attempts: □ Yes □ No If yes,

please specify number of suicide attempts in lifetime: _____

Any hospitalization as a result? □ Yes □ No History of aggressive/threatening behavior: □ Yes □ No

History of self-Injury/Cutting: □ Yes □ No

Any past history of trauma? (Please explain)

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ☐ Diabetes
- ☐ Heart murmur
- ☐ Crohn's disease
- ☐ High blood pressure
- ☐ Pneumonia
- ☐ Colitis
- ☐ High cholesterol
- ☐ Pulmonary embolism
- ☐ Anemia
- ☐ Hypothyroidism
- ☐ Asthma
- ☐ Jaundice
- ☐ Goiter
- ☐ Emphysema
- ☐ Hepatitis
- ☐ Cancer (type) _____
- ☐ Stroke
- ☐ Stomach or peptic ulcer
- ☐ Leukemia
- ☐ Epilepsy (seizures)
- ☐ Rheumatic fever
- ☐ Psoriasis
- ☐ Cataracts
- ☐ Tuberculosis
- ☐ Angina
- ☐ Kidney disease
- ☐ HIV/AIDS
- ☐ Heart problems
- ☐ Kidney stones
- ☐ Other pertinent history_____

Other medical conditions (please list):

Have you had any surgeries in the past (please list procedure and date):

_____

CURRENT MEDICATIONS

Drug allergies: □ Yes □ No List medication(s):

What reactions did you have:_____

Please list any medications that you are currently taking. Include non-prescription medications & vitamins or supplements.

Please include name of drug, dose, how many times per day, and how long have you been taking this?

1		9	
2		10	
3		11	
4		12	
5		13	
6		14	
7		15	
8		16	

Have you tried any **psychiatric medications** for mood/anxiety/sleep before? □ Yes □ No

Psychiatric Medication(s)	Duration of treatment (mo or yr)	Current or Failed	Reason for stopping

Additional Concerns:

SUBSTANCE ABUSE HISTORY

Are you a smoker? □ Yes □ No
If yes, how many packs do you smoke?_____Any attempts to quit: _____
If you quit using, how long? _____

Do you consume alcohol? □ Yes □ No
How often do you drink? □ Weekly_____/wk □ Monthly_____/Month_____ □ Rarely _____
□ Quit drinking_____(specify last usage)
Specify amount you drink in each setting: _____
Do you have a history of Substance Abuse? □ Yes □ No Have you ever attended rehab? □ Yes □ No

If yes, please state when and for treatment of what:

Substance	Quantity Used	Frequency of Use	Quit (Y/N)	Last Used

FAMILY HISTORY LIST BLOOD RELATIVES WHO HAVE BEEN DIAGNOSED WITH THE FOLLOWING CONDITIONS

Alcoholism	Heart Disease/High blood pressure/Irregular Heart rhythms
Anxiety disorders	Osteoporosis
Bipolar disorder	Seizures
Cancer	Schizophrenia
Depression	Stroke
Diabetes	Suicides
Drug abuse	Thyroid disease

SOCIAL HISTORY

Relationship Status: □ Single □ Married □ Divorced □ Widowed □ Life/serious partner
Are you happy in your relationship: □ Yes □ No
Describe your relationship satisfaction: □ Not applicable □ Very Satisfied □ Somewhat satisfied □ Dissatisfied.
Any children: □ Yes □ No

Education History:
□ Currently in school:_____(specify) □ Less than a high school education

□ Graduated from high school □ GED Obtained- Specify highest grade completed: _____

□ Associates Degree □ College Degree □ Some College □ Professional Degree □ Technical Degree □ Master's Degree

Employment status: □ Full-time □ Part-time □ Unemployed □ Retired □ Disabled □ Homemaker

Occupation:_____Employer:_____How long have you had this job: _____

Residential Status: □ Own a home □ Rent □ Live w/parents □ Foster Care □ Homeless □ Nursing Home Facility
□ Live w/roommate(s)

Social Supportive Network: □ Supportive Family □ Friends □ Religious Congregation □ Co-workers □ Internet-based
□ Social Services □ Sponsor

Please check all stressors you are experiencing currently
□ Economic/Financial □ Education/School □ Family Conflict □ Grief/Loss □ Legal Problems □ Medical Illness

□ Work □ Living Situation □ Social Environment □ Substance Abuse □ Marital Conflict

□ Family Disruption due to divorce or separation □ Personal Injury □ Relationship □Environmental change

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? (Circle your answer)	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
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	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 +_____ +_____ +_____

=Total Score: _____

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**
☐	☐	☐	

Patient name:_____DOB:_____Date: _____

GAD-7 ANXIETY

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. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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
☐	☐	☐	☐

Patient name:_____DOB:_____Date: _____

MOOD DISORDER

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...	☐	☐
...you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?		
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head, or you could not 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 to trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of this cause you - like being unable to work; having family, money, or legal troubles; getting into arguments or fights?

Please circle one response only.

No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐