Inspiration Health Services, LLC

104 - C Williamsport Circle
Salisbury, MD 21804
Office: 410-831-3899/Fax: 443-210-2786

Today's Date: _____

Patient Name: _____

Date of Birth: _____SSN: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Mobile: _____ e-mail address: _____

Where can we leave a message? _____

Sex	Employed:	Student:	Marital Status:
Non-Binary	Yes	No	Other

Employer:_____

Emergency contact and number: _____

**********Responsible Party**********

( ) Same as above

Relationship to patient: _____

Name: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Mobile: _____ e-mail address: _____

Employer: _____

****

Insurance (primary only)

Insured's Name: _____

SSN: _____ Relationship to patient: _____

ID number: _____ DOB: _____

Address: _____

Phone number: _____ Employer: _____

Inspiration Health Services, LLC

Treatment Consent/Authorization for Disclosure

Consent to Treatment

I, the undersigned, do voluntarily consent and authorize outpatient treatment as judged to be necessary by my clinician. Such treatment may include diagnosis/assessment procedures, psychotherapy and pharmacotherapy. I understand that this consent authorizes the use of standard and customary community standards, and I have been advised of the potential risks and benefits associated with treatment. I understand the practice of medicine, psychiatry and other mental health disciplines is not an exact science and I acknowledge that no guarantees have been made to me concerning my care. Because psychotherapy is a cooperative effort between patient and therapist, I will work with my therapist in a cooperative manner to resolve my difficulties. If I refuse the treatment that is suggested for me or discontinue treatment, I will not hold Inspiration Health Services, LLC or any individual responsible for any consequences resulting from my decision beyond that time. I understand that state and local laws require that my psychiatrist/therapist report all cases in which there exists a specific potential harm to others or in cases of reported or suspected physical, sexual and/or neglect of children which are required by Maryland law.

Authorize for Disclosure of Information

The undersigned hereby authorizes Inspiration Health Services, LLC, and its staff to release or disclose information in the medical, business or clinical record of the patient of the following:

- Any private or public entity with which a claim is being filed for a (all or part) of the patient's charges, including any insurance carrier or compensation carrier or any of the respective agents, representatives, and claims processing personnel;
- Any attorney, collection agency or other persons or entities engaged in the collection of responsible party to Inspiration Health Services, LLC
- Any other healthcare professional staff providing needed care;
- Any person, corporation, public or private agency to the extent necessary for Inspiration Health Services, LLC to obtain and/or maintain licensure, federal and/or state reimbursement for the provisions of health care services or clarification;
- Any public or private utilization review organization needing information by telephone or writing to certify the medical necessity or appropriateness of treatment services under review;
- Any Inspiration Health Services, LLC employee or provider requiring information including patient identity and address in order to provide care and/or maintain the medical records;
- For any release beyond the scope of this consent, the patient will be asked to sign a Release of Information Form.

The information release may include diagnosis and treatment including, but not limited to mental and physical condition, drug/alcohol and other information requested to determine coverage, medical necessity and other benefits determination.

This authorization may be revoked at any time except to the extent those actions have already been taken. To cancel this authorization, the patient and/or responsible party realizes that they must do so in writing and send it to Inspiration Health Services, LLC

_____ _____

Signature of Patient **Date**

_____ _____

Spouse/Parent/Guardian **Date**

Inspiration Health Services, LLC

Referral Source/Primary Care Physician Notification

The undersigned hereby authorizes Jorden Weiss, D.O., Inc. to notify the referral source of the patient's contact with Inspiration Health Services, LLC. The undersigned also authorizes Inspiration Health Services, LLC. to notify the primary care physician listed below to share diagnosis and treatment plan to insure integrated treatment.

Put your initials on the line for "yes" or "no"

Initial: _____YES _____NO Referral Source (Name) _____

Address_____ City, State, Zip_____

Initial: _____ YES _____NO Primary Care Physician_____

Address: _____ City, State, Zip_____

Inspiration Health Services, LLC

Policies & Procedures*:

Self-Pay Fees & Balances: All are due in full at time of check-in, or your appointment may need to be rescheduled.

Form Completion: Requested form completions (Letters, FMLA, etc.), will be charged based on clinician time involved with a minimum $25.00 paperwork fee assessed. Please allow **7-10** business days.

Record Transfers: There is a $25.00 fee to transfer patient records to other providers, due from the patient before the records will be sent. Psychiatric records cannot be released to patients but can be forwarded to other physicians.

Prior Authorizations: Patients are responsible for contacting their insurance companies when their medication requires a prior authorization. Your insurance company will then fax a form to our office for the doctor to complete and fax back.

After Hours: Message may be left on the company voice mail with concerns after hours. This voice mail is checked at a minimum of every 2 hours from the hours of closing until 11pm.. ***No medication refills should be requested during after hours. If you are experiencing acute distress, self-harm or suicidal thoughts, please call 911 or go to your nearest emergency room.***

Print name: _____ **Signature**: _____

Witness: _____ **Date**: _____

**Policies and procedures are subject to change*

_____Patient received copy of policy/procedures (please initial)

Updated 10/2018

Inspiration Health Services, LLC

Appointments/Cancellations*:

- A **48-*hour* *notice*** must be given when cancelling your appointment in order to avoid a charge. This will allow us to reach someone on our waiting list and offer them the appointment time.

- Failure to give 48-hour notice for cancellations will result in a charge of $75.00 ***this is due ON OR BEFORE your next appointment.***

- For new patient evaluations, we ask that you give **48 hour** notice for cancelling. If you do not provide 48 hour notice we will not reschedule your appointment.

- **Late Arrivals** may lose appointment times and will either need to reschedule or be seen after other patients. Punctual arrivals will have priority.

- **Termination of Service:** More than 2 late cancellations, no-shows and other forms of non-compliance with treatment may result in termination of services.

- **Reminder calls:** As a courtesy, we offer reminder calls about your upcoming appointment, typically 2 business days in advance. Due to unforeseen circumstances, we are not always able to do so, but please remember that you are ultimately responsible for your scheduled appointments.

Professional Services

The fee for phone conferences, extended sessions, preparation of letters and treatment summaries, reading and responding to correspondence (including past records and email), site visits, travel time, and consultation with other professionals is $250.00 per hour. Payment is due at the time services are rendered.

Forensic Services: Fees apply to time spent and attorney's fees in connection with a subpoena or other record requests that your doctor might receive involving your (or your child's) treatment. This includes the cost of seeking to block a release of information to the court, should you choose this course. Fees will also apply to legal testimony, preparation time, travel time, and time spent waiting to testify. The fee for these services is $400.00 per hour.

Print name: _____ **Signature**: _____

Witness: _____ **Date**: _____

**Policies and procedures are subject to change*

_____Patient received copy of medication policy (please initial)

Updated 10/2018

Inspiration Health Services, LLC

Prescription Drug Policy*:

A comprehensive psychiatric evaluation with a provider will be required in order to receive a prescription for medication. Patients will be scheduled for follow-up medication management sessions to assure the best continuity of care. When you attend your appointment, you will always be given enough medication until your next scheduled appointment. In order to provide the best ongoing care, we ask that our patients be aware of the following:

- **Any lost or stolen schedule II or IV prescriptions will not be replaced or re-written.**
- If you miss or cancel an appointment, it is at the physician's discretion to write a prescription for enough medication to last only until the next appointment.
- Medication changes will only be addressed during scheduled appointment times. If you are having side effects or urgent issues with the medication you are taking, this can be addressed over the phone with our support staff. After hours issues will need to be directed to urgent care or emergency facilities.
- All requests for 90-day prescriptions will only be written during scheduled appointments. Inspiration Health Services, LLC is unable to provide 90 day prescriptions for controlled substances such as stimulants and benzodiazepines.
- If it has been six months or longer since your last appointment, you will need to be seen for a re-assessment before medication will be prescribed.
- Prescriptions will not be refilled on weekends, holidays or after 12:00 pm on Friday.

In addition, when you leave a message on our voicemail, please leave a phone number where you can be easily reached during office hours. Due to the high number of patient messages left every day, it is not possible for us to repeatedly return phone calls.

Print name: _____ **Signature**: _____

Witness: _____ **Date**: _____

**Policies and procedures are subject to change*

_____Patient received copy of medication policy (please initial)

Updated 10/2018

Inspiration Health Services, LLC
104 C Williamsport Circle
Salisbury, MD 21804

ADULT INTAKE

Biopsychosocial Database

Patient's Name: _____ Date: _____

SSN: _____ - _____ - _____ DOB: _____ Age: _____

Person completing this form: □ Patient or Other (give name): _____

Who referred you to Dr. Weiss? Name: _____

What kind of help are you seeking? _____

Length of time symptoms: _____

SYMPTOM CHECK LIST: Please circle (use blank space to add items not listed)

□ Agitated	□ desperate	□ distracted	□ impaired performance
□ Fearful	□ overly tired	□ see things	□ obsessive/compulsive
□ Cry often	□ hear voices	□ suspicious	□ anxiety attacks
□ Hopeless	□ rapid speech	□ aggressive	□ avoidance of people
□ Withdrawn	□ anger/aggression	□ racing thoughts	□ headaches
□ Chest pain	□ irritable	□ appetite increase	□ Indecisive
□ Mood swings	□ anxious	□ appetite decrease	□ sexual difficulties
□ Homicidal	□ depressed	□ self-harm thoughts/actions	
□ Restless/on edge	□ confused	□ feeling "out of control"	
□ Worry a lot	□ sad	□ personality changes	
□ Helpless	□ guilt	□ can't concentrate	

SLEEP CHANGES? DESCRIBE:

_____

_____

Energy Level: □ Tire easily □ Average energy □ High energy

DESCRIBE CURRENT STRESSORS: _____

_____

TREATMENT HISTORY: (CHECK ALL PRIOR Psychiatric/Psychological Treatment or Counseling)

□ None □ Inpatient Care When/Where: _____

Please identify where treated or who provided the following treatment:

□ Individual OP Therapy: _____

□ Family Therapy/Marital: _____

□ Partial/Day Hospital: _____

□ Medication Management: _____

CHEMICAL ABUSE/DEPENDENCY HISTORY

Have you ever felt you should cut down on your drinking? ☐ NO ☐ YES
Have people annoyed you by criticizing your drinking? ☐ NO ☐ YES
Have you ever felt bad or guilty about your drinking? ☐ NO ☐ YES
Have you ever had a drink first thing in the morning to steady your nerves or to get rid of a hangover?
□ NO □ YES
Is there a patient history of alcohol, marijuana, street drugs, and/or medication abuse/dependence?
□ NO □ YES, If YES please explain:

_____

Drug abused	Age at Onset	Dose/Amount	How Often	Last Used

Do you smoke? □ NO □ YES If yes, how much? _____ Trying to Quit? □ NO □ YES

Amount of caffeine consumed in a day: _____

Has there been exposure to toxic substances? _____

FAMILY HISTORY

Describe current home living arrangements, including who is living in your home with you:

□ Live with Parents □ Spouse/Significant other □ Children □ Group Home □ Nursing home/Assisted Living

Has there been exposure to abusive behavior(s)? □ NO □ YES

If yes, answer the following:
Current exposure? □ NO □ YES Past exposure? If so, when? _____

Who was the abuser? _____ Type of abuse: □ Physical □ Sexual □ Verbal

Did it occur: □ within the family □ outside the family?

Have any other family members sought or received mental health treatment? □ NO □ YES

Relationship: Type of Problem/Care Needed:

_____ _____

_____ _____

_____ _____

Is there a family history of alcohol or drug abuse/dependency? □ NO □ YES If yes, please describe:

_____

_____

MEDICAL HISTORY

Family Physician: Name: _____ Phone: _____

Address: _____

Date of your last complete physical exam? _____ Problems? _____

Accidents/Surgeries: _____

MEDICATIONS CURENTLY IN USE: (Prescribed or over-the-counter) □ None Used

Medication	Dosage	How Taken	Last Used

Psychiatric medications taken in the past: _____

_____

Medication allergies: _____

_____

Other allergies: _____

Review of Systems:

VISUAL
□ No Problem □ State Problem: _____

HEARING
□ No Problem □ State Problem: _____

RESPIRATORY
□ No Problem □ Asthma □ Hay Fever □ Congestion □ Short of Breath
□ Emphysema □ Wheezing □ Tuberculosis □ Sputum production □ Cough up blood

CARDIOVASCULAR
□ No Problem □ High blood pressure □ Low blood pressure □ Chest pain
□ Palpitations □ Prior heart attack □ fainting episodes

EXCRETORY
□ No Problem □ Urinary infections □ Bladder infections □ Incontinence of _____Urine _____stool
□ Excessive night urination

NEUROLOGICAL
□ No problem □ Seizures □ Frequent headaches □ Migraine or ____Cluster headaches □ Dizziness
□ Tremors □ Memory problems □ One-Sided body Weakness □ Pins and Needles Sensations
□ Past history of head injuries □ Loss of consciousness □ Meningitis

REPRODUCTIVE Sexual orientation (is helpful to your therapy)
□ Heterosexual ■ Homosexual □ Bisexual □ HIV+ □ Genital herpes □ Sexually transmitted diseases
□ High risk for HIV/AIDS □ Sexual worries □ Birth control issues

ENDOCRINE
□ No Problem □ Diabetes □ Hypoglycemia □ Thyroid dysfunction □ Edema or Swelling

GASTROINTESTINAL
□ No Problem □ abdominal pain □ frequent nausea □ frequent vomiting □ frequent diarrhea
Weight □ Loss □ Gain Amount? _____ □ Appetite □ Poor □ Ravenous □ frequent constipation

MUSKULOSKELETAL
□ No Problem □ Muscle impairment/tenderness □ Joint pain Back pain

CANCER
Describe (type & treatment): _____

EDUCATION-OCCUPATION-COMMUNITY BACKGROUND

Highest level of education
□ BA or BS Degree □ High School Diploma □ Elementary education, level completed _____ □ GED
□ Master's Degree □ Technical Degree □ Doctoral Degree

Have you been told you have learning difficulties/impairments? □ NO □YES if yes, please describe:

_____

What community resources do you need or use? (I.e. social groups, clubs, self-help groups, community,

Church and social services) _____

What or on whom do you rely on in times of stress? _____

Patient currently is: □ Employed Full-Time □ Employed Part-Time □ Disabled □ Unemployed

□ Student: □ Full-time □ Part-time □ Retired, Retirement date: _____

Occupation or employment circumstance: _____

Are you a Veteran of Military Service? □NO □ YES If yes, what branch of service and describe and related

problems: _____

Religious/Cultural Background:

□Protestant □Catholic □Jewish □Other (specify):_____

How significant a role does religion play in your life?
□Very important□Somewhat important □Minor importance □Not important

Your cultural/ethnic background: _____

Are there any cultural/spiritual/ethnic needs which might impact treatment or that you want us to know about?

□ Yes □ No If yes, please explain: _____

RISK ASSESSMENT

	Past	Present
Have you ever had thoughts of hurting yourself?	_____	_____
Have you ever had thoughts of committing suicide?	_____	_____
Have you ever had a plan to commit suicide?	_____	_____
Have you made threats to kill yourself?	_____	_____
Have you ever made a suicide attempt?	_____	_____
Have you ever mutilated yourself?	_____	_____
Have you ever had thoughts of harming someone?	_____	_____
Have you ever had plans to harm someone?	_____	_____
Have you ever attempted to harm someone?	_____	_____
Have you made any threats to harm someone?	_____	_____

_____ _____

Signature **Date**