Cal Psychiatric Services

Akindele Kolade, MD
3201 S. Maryland Parkway, Suite 318
Las Vegas, NV 89109
Ph. (702) 629-7490 Fax. (702) 629-7685

Rev: 6/2015

HEALTH CARE INTAKE FORM

Personal Information

Name: _____ Date: _____
Address _____
Phone: _____ Email: _____
DOB: _____ Sex: _____
Primary Physician: _____ Phone: _____
Current Therapist: _____ Phone: _____

Complaint

What is your major complaint? _____
Start Date: _____ Have you previously suffered from this complaint ? _____
Previous therapist(s) seen complaint? _____
Aggravating Factors: _____
Relieving Factors: _____

☐ Anxiety	☐ Appetite issue	☐ Avoidance	☐ Crying Spells
☐ Depression	☐ Excessive Energy	☐ Fatigue	☐ Guilt
☐ Hallucinations	☐ Impulsivity	☐ Irritability	☐ Libido
☐ Loss of Interest	☐ Panic Attacks	☐ Racing Thoughts	☐ Risky Activity
☐ Sleep Changes	☐ Suspiciousness		

Medical History

Excessive frequency: _____ Exercise Type(s): _____
Allergies: _____
What medications are you currently using? _____
Previous diagnosis/mental health treatment : _____
Previous treated by: _____
Previous medications: _____
Dates treated: _____
Previous medical conditions: _____
Previous surgeries: _____

Family History

Were you adopted? _____ If yes, at what age? _____
How is your relationship with your mother? _____
How is your relationship with your father? _____
Siblings and their ages: _____
Are your parents married? _____
Did your parents divorce? _____ If yes how old were you? _____
Did your parents remarry? _____ If yes how old were you? _____
Who raised you? _____ Where did you grow up? _____
Family member mental condition(s): _____
Family member medical condition(s): _____
Treated with medication? _____
Medications: _____

Early Development

Where did you grow up? _____
How often did you move, and where? _____
How old were you when you left home? _____

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Personal Information (cont.)

Have any immediate family members died? _____ Who? _____
Have any committed suicide? _____ Who? _____
Describe any neglect you suffered, and by whom: _____
Trauma suffered and by whom: _____
Abuse suffered and by whom: _____
Highest education level completed: _____
Date completed and location _____
Have you ever served in the military _____ If yes, where? _____
Dates of service: _____ Highest rank achieved: _____

Present Situation

Work: ☐ Full time ☐ Part time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

Are you married _____ If yes, date of marriage _____
Are you divorced _____ If yes, date of divorce _____
Prior marriages _____ If yes, how many? _____
What is your sexual orientation? _____ Are you sexually active? _____
How is your relationship with your partner? _____
Do you have any children? _____ Dates of birth _____
How is your relationship with your children? _____
List anyone else who lives with you: _____
Are you a member of a religion/spiritual group? _____
What is your level of involvement? _____
Have you ever been arrested? _____ When and why? _____

Have you ever tried to following (check all that apply)

☐ Alcohol	☐ Tobacco	☐ Marijuana	☐ Hallucinogens (LSD)
☐ Heroin	☐ Methamphetamines	☐ Cocaine	☐ Stimulants (pills)
☐ Ecstasy	☐ Methadone	☐ Tranquilizers	☐ Pain killers

If yes to any, list frequency and dates of use: _____

Have you ever been treated for drunk alcoholic abuse?_____ If yes when? _____
For what substances? _____
Do you smoke cigarettes?_____ If yes, how many per day?_____
Do you drink caffeinated beverages? _____ If yes, how many per day?_____
Have you ever abused prescription drugs? _____ If yes, which ones? _____

Anything else you want the doctor to know

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Rev: 10/2016

Medical Insurance Request Form

Primary Insurance

Patient Name: _____ Date of Birth: _____

Effective Date: _____ Insurance Name: _____

Subscriber's Name: _____ Date of Birth: _____

Member ID/Policy ID: _____ Group No.: _____

Patient Social Security # :

Who is the Subscriber's Employer? _____

Insurance Claims Address: _____

Please provide the Provider Number (on the backside of your card): _____

Is the Patient covered by this plan? ☐ YES ☐ NO

What is the Subscriber's relation to the Patient? _____

Does the Patient have additional coverage by another plan? ☐ YES ☐ NO

Secondary Insurance

Effective Date: _____ Insurance Name: _____

Subscriber's Name: _____ Date of Birth: _____

Member ID/Policy ID: _____ Group No.: _____

Who is the Subscriber's Employer? _____

Insurance Claims Address: _____

Is the Patient covered by this plan? ☐ YES ☐ NO

What is the Subscriber's relation to the Patient? _____

Does the Patient have additional coverage by another plan? ☐ YES NO

If yes, please ask the office staff for an additional form to complete.

If this Document/Form is not filled out and Returned to the Office Staff, ALL APPOINTMENTS will be your RESPONSIBILTY on a CASH PAY BASIS.

NOTICE: If your Insurance requires a Deductible or COPAY/CO-INSURANCE, it must be collected at time of service.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Cal Psychiatric Services

CONSENT FOR PSYCHOTROPIC MEDICATIONS

1. I have the right to refuse medication.
2. The nature of my mental health condition has been explained to me by the doctor.
3. I have been informed that medication is a helpful form of mental health treatment, that there is a reasonable expectation I may benefit from prescribed medication, but there is no guarantee of improvement.
4. I have been given an explanation of the reasonable alternative treatments available (including other medications and non-medication oriented treatment) and why the physician is recommending this/these medication(s).
5. The name, type of medication(s) that I will be receiving, (brochures available upon my request), the range of dosages, frequency, and amount (including use of PRN orders), the method by which I will take the medication(s) (shots or by mouth), and duration of such treatment(s) have been explained to me by the doctor.
6. The probable side effects commonly known to occur with the drugs being prescribed have been discussed with me, and any particular side effects that may be specific for me. I understand that if I want to know more about my medications I can ask for further information.
7. If the doctor prescribed a major tranquilizer (neuroleptic), he/she discussed with me Tardive Dyskinesia, an additional side effect which may cause involuntary movement of the face, or mouth, hands and feet if the medication is taken beyond 3 months. I have been informed that this side effect may be potentially irreversible and may appear after the medication has been discontinued.
8. I have been informed that the use of alcohol and/or other medications while taking the prescribed medications may cause unexpected reactions and may increase the severity of the side effects described.
9. I understand that this consent may be withdrawn at any time by my stating such intention to any member of the treatment staff.

MEDICATION	INITIAL DOSE AND FREQUENCY	DAILY DOSE UP TO

I acknowledge that I have read and understand the above and agree to accept the medication (s) prescribed to me.

Signature of Patient

Signature of Physician

Parent/Guardian/Conservator

Date

	CONSENT FOR PSYCHOTROPIC MEDICATIONS	Patient Name and ID #

ReviewedLEforms04/04/06

Cal Psychiatric Services

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I, _____

Address: _____

City\State: _____

Phone: _____

Hereby authorize Cal Psychiatric Services to conduct psychiatric evaluation, diagnosis and treatment of me (or my child). _____

I understand that records concerning my (my child's) treatment will be retained. Such data will be kept confidential. No information about me (my child) will be released without my written consent, except in the case of a medical emergency, or as permitted by law.

Patient Financial Consent Form

Please Initial

_____ I have been informed of financial responsibility involved in my (my child's treatment). Unless arrangements have been made in advance, full payment will be required at the time of each visit.

_____ Rescheduling/Cancellation/No-Shows policy is 24 hours' notice before the time of the appointment. Rescheduling/Cancella ions/No-Shows with less than 24 hour no ice before the appointment ime will be charged full customary fee of $50.

_____ In case of an agreement to bill insurance, deductibles and co-payments will be collected at the time of each visit. **Patients are ultimately responsible for all payment of fees.**

_____ In the event that you cancel or miss 3 appointments with less than 24 hours' notice, we will have to refer you to another doctor for treatment.

Signature: _____ **Date:** _____

☐ Patient ☐ Parent ☐ Legal Guardian ☐ Witness

Cal Psychiatric Services
Akindele E. Kolade, MD
Board Certified Psychiatrist
Diplomat American Board of Psychiatry and Neurology

Pharmacy Information

Name of your pharmacy:

_____

Address:

_____

Tel Number: _____

Primary Care Physician:

Name: _____

Tel Number:

_____

Address:

_____

if the patient is a child, are you the legal guardian? Yes_____ No_____

If the answer is No please be aware we need the legal guardian or a signed letter by legal guardian authorizing you to bring child to their appointments.

If you are not the parent of the patient and you are the legal guardian, we will need paper work from the courts showing the Guardianship. If we do not have that paperwork we will not be able to see the patient or discuss any matter of the patient with you.

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Board Certified Psychiatrist
Diplomat American Board of Psychiatry and Neurology

UA / TOXICOLOGY SCREEN

Name _____

____ I give my consent to Cal Psychiatric Services to obtain a drug screen for me via urine or saliva as a diagnostic tool to further aid in my intervention/treatment.

____ I understand that testing will be incorporated as an accountability measure to ensure continued compliance with treatment, prevention of relapse and/or diversion, and to reinforce accountability. Results will be analyzed as expected and consistent with patient history and prescribed medication.

____ I understand that testing will be sent to designated laboratory for analysis. I am aware that results inconsistent with patient history and prescribed medications may result in action which may include increased level of care, termination of services, and if released by consent to my referral source possible legal consequences.

____ Results of collection will be forwarded, provided authorization, for the release has been obtained via consent for release of confidential information to the referring agency/person, i.e.

_____ _____

Patient **Date**

_____ _____

Parent/Guardian **Date**

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AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: _____ Date of Birth: _____

Previous Name: _____ Social Security: _____

I request and authorize _____ to release health care information of the patient named above to:

Name: Akindele Kolade, MD - Cal Psychiatric Services

Address: 3201 S. Maryland Parkway, Suite 318

City: Las Vegas **State:** NV **Zip Code:** 89109

Phone: 702-629-7490 **FAX:** 702-629-7685

This request and authorization applies to:
Healthcare information relating to the following treatment, condition, or dates:

_____

_____

All healthcare information
Other: _____

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia ,non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human immunodeficiency Virus), AIDS (Acquired immunodeficiency Syndrome), and gonorrhea.

☐ **Yes** ☐ **No** I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

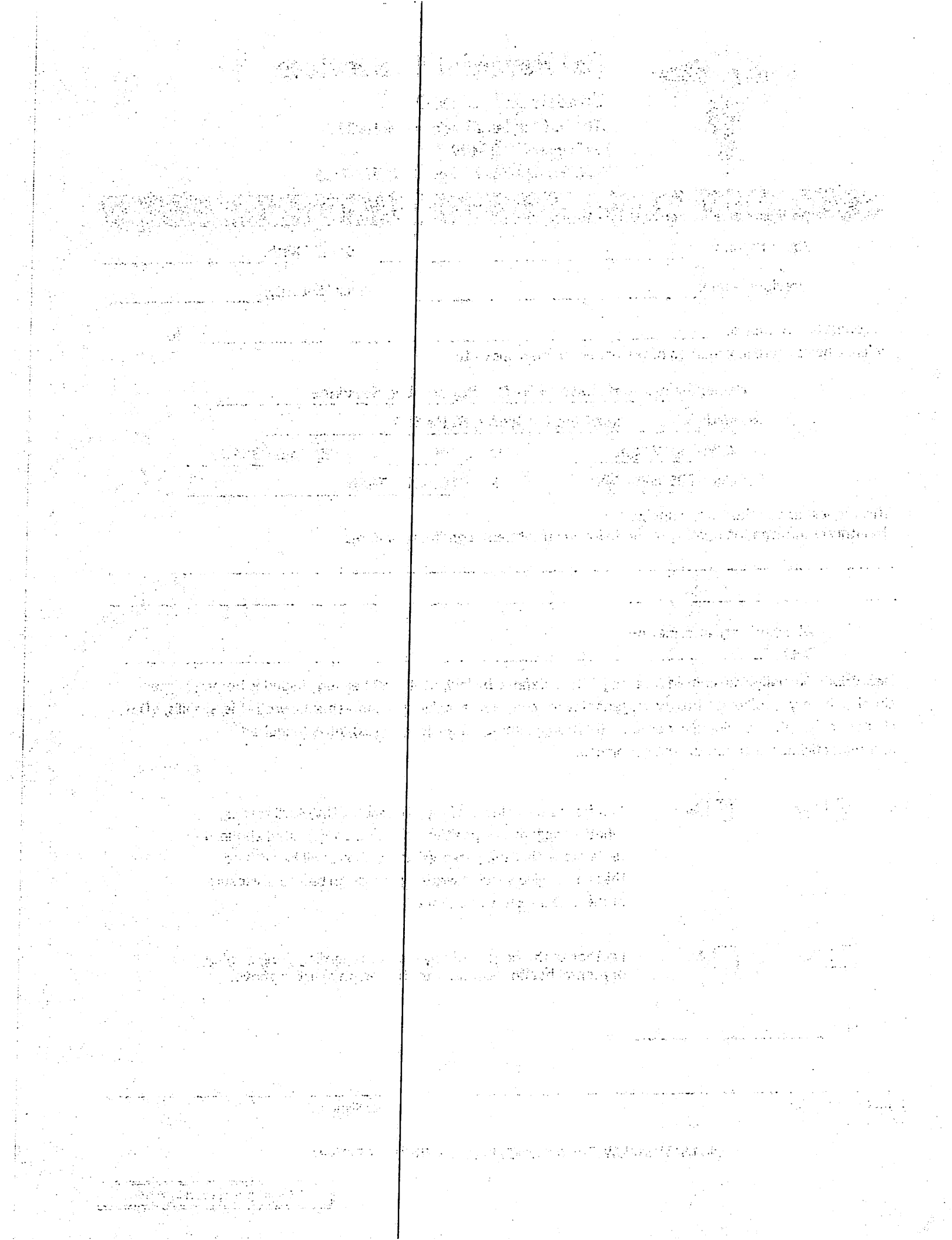
☐ **Yes** ☐ **No** I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Date: _____

_____ _____

Signature of Patient Date Signed:

AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.



HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize _____ (healthcare provider) to use and disclose the protected health information described below to _____ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ _____ to _____.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _____ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

Signature of patient or personal representative

Printed name of patient or personal representative and his or her relationship to patient

---

Date

Cal Psychiatric Services
3201 S. Maryland Parkway
Ste 318 Las Vegas NV 89109
Ph: (702) 629 –7490
Fax: (702) 629– 7685

PATIENT INTAKE: MEDICAL HISTORY

(To be completed by patient)

Use the opposite side of the page as necessary to complete your answers. **Please print legibly.**

Name _____

Address _____

Phone (w) _____ (h) _____ (c) _____

DOB _____ Age _____ SS# _____

Emergency Contact _____

Relationship to patient _____ Phone _____

Primary care physician _____ Phone _____

Date of last physical _____ Have you ever had an EKG? ( ) N Date _____

Current or past medical conditions (check all that apply)

( ) Asthma/respiratory
( ) Cardiovascular (heart attack, high cholesterol, angina)
( ) Hypertension
( ) Epilepsy or seizure disorder
( ) GI disease
( ) Head trauma
( ) HIV/AIDS
( ) Diabetes
( ) Liver problems
( ) Pancreatic problems
( ) Thyroid disease
( ) STDs
( ) Abnormal Pap smear
( ) Nutritional deficiency

Other (Please describe) _____

_____

_____

If there a family history of any of the illnesses listed above, **please put an "F" next to that illness**

MD NOTES _____

_____

_____

Is there a family history of anything NOT listed here? (Please explain) _____

_____

_____

MD NOTES _____

_____

Have you ever had **surgery** or been **hospitalized**? (Please describe) _____

_____

_____

MD NOTES _____

_____

Childhood Illnesses

Measles ( ) N ( ) Y Mumps ( ) N ( ) Y Chicken Pox ( ) N ( ) Y

Have you or a family member ever been diagnosed with a **psychiatric** or **mental illness**? (Please describe)

_____

Have you ever taken or been prescribed **antidepressants**? ( ) N For what reason _____

Medication(s) and dates of use _____ Why stopped _____

Please list all current **prescription medications** and how often you take them (example: Dilantin 3x/day).

DO NOT include medications you may be currently misusing (that information is needed later) _____

_____

_____

Please list all current **herbal medicines, vitamin supplements**, etc. and how often you take them

_____

MD NOTES _____

_____

_____

Please list any **allergies** you have (penicillin, bees, peanuts)

_____

MD NOTES _____

Tobacco History

Cigarettes: Now? ( )N ( )Y In the past? ( )N ( )Y

How many per day on average? _____ For how many years? _____

Pipe: Now? ( )N ( )Y In the past? ( )N ( )Y

How often per day on average? _____ For how many years? _____

Have you ever been **treated for substance misuse?** ( )N (Please describe when, where and for how long)

_____

How long have you been **using substances?** _____

Substance Use History

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Other							

Did you ever stop using any of the above because of dependence? ( ) N (Please list) _____

What was your longest period of abstinence? _____

MD NOTES _____

Cal Psychiatric Services, 3201 S. Maryland Parkway Ste 318 Las Vegas NV 89109

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PATIENT TREATMENT CONTRACT

Patient Name _____ **Date** _____

As a participant in buprenorphine treatment for opioid misuse and dependence, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to all my scheduled appointments.
2. I agree to adhere to the payment policy outlined by this office.
3. I agree to conduct myself in a courteous manner in the doctor's office.
4. I agree not to sell, share, or give any of my medication to another person. I understand that such mishandling of my medication is a serious violation of this agreement and would result in my treatment being terminated without any recourse for appeal.
5. I agree not to deal, steal, or conduct any illegal or disruptive activities in the doctor's office.
6. I understand that if dealing or stealing or if any illegal or disruptive activities are observed or suspected by employees of the pharmacy where my buprenorphine is filled, that the behavior will be reported to my doctor's office and could result in my treatment being terminated without any recourse for appeal.
7. I agree that my medication/prescription can only be given to me at my regular office visits. A missed visit may result in my not being able to get my medication/prescription until the next scheduled visit.
8. I agree that the medication I receive is my responsibility and I agree to keep it in a safe, secure place. I agree that lost medication will not be replaced regardless of why it was lost.
9. I agree not to obtain medications from any doctors, pharmacies, or other sources without telling my treating physician.
10. I understand that mixing buprenorphine with other medications, especially benzodiazepines (for example, Valium®*, Klonopin®†, or Xanax®‡), can be dangerous. I also recognize that several deaths have occurred among persons mixing buprenorphine and benzodiazepines (especially if taken outside the care of a physician, using routes of administration other than sublingual or in higher than recommended therapeutic doses).
11. I agree to take my medication as my doctor has instructed and not to alter the way I take my medication without first consulting my doctor.
12. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my doctor and specified in my treatment plan.

13. I agree to abstain from alcohol, opioids, marijuana, cocaine, and other addictive substances (excepting nicotine).

14. I agree to provide random urine samples and have my doctor test my blood alcohol level.

15. I understand that violations of the above may be grounds for termination of treatment.

_____ Date _____

Patient Signature