ARNOLD F. NEGRIN, M.D.
CHILD, ADOLESCENT & FAMILY PSYCHIATRY
624 STEPHENSON AVENUE
SAVANNAH, GEORGIA 31405

Welcome to the Office of Arnold F. Negrin, M.D. Child, Adolescent, and Family Psychiatry

Thank you for choosing our facility for your medication needs.

Personal problems are often very difficult to discuss. Therefore, confidentiality is extremely important to us. We take every precaution in protecting the confidentiality of your visit. We do not discuss your situation with anyone except for reasons cited below, unless you *give* us written permission to do so. These are the limitations to confidentiality, which are beyond our control: (1) If we learn of sexual abuse or child abuse, we are required by law to report it to the appropriate regulatory agencies. (2) If, in our judgement, a client is dangerous to himself or others (suicidal or homicidal), it is our responsibility to do whatever we can, breaking confidentiality if necessary, to protect from harm. A Release of Information form must be filled out and signed in order to share information.

Office and Appointment Policies

We ask that you become familiar and adhere to our policies. You may request a copy at the sign in desk

- If you do not cancel your appointment 24 hours in advance, fail to keep your appointment, or arrive 30 minutes past your appointment time, your account(s) will be billed $30.00 and must be paid prior to your next appointment.
- As a courtesy to patients who arrived on time and to keep our office running smoothly we reserve the right to reschedule your appointment if you arrive 30 minutes past your appointment time.
- For your convenience we offer a 24 hour answering service: (912) 351-0325 for urgent concerns. We make every attempt to return calls by 5pm the next business day. If you need to speak to someone sooner, please call back during regular business hours.
- You must schedule-and keep-appointments to receive medications. Exceptions will be made *only* if there is a verifiable emergency.
- There will be an administrative fee of $25.00 for all letters and forms to be filled out and signed by the doctor or nurse practitioner. This fee must be paid ***prior*** to completion of the letter or form. This fee cannot be billed.
- Full payment (if self-pay) or copay/coinsurance is expected at each visit. You will be responsible for any balance not covered by the insurance at each visit when services are rendered. Our office will file the charges with your insurance company and the payment of insurance benefits will be assigned to the doctor. We file insurance as a courtesy to the client, but hold the client (or guarantor) responsible for any charges that are rendered. We will gladly answer any questions regarding fees.
- Your copayment and any previous balance are due at check-in. We accept cash, debit, or credit. We do not accept personal checks.
- Please inform us of any changes in insurance, address, and phone number at check-in. We must have a copy of your current insurance card on file at all times. If you do not have valid insurance card, you can choose to pay the full amount of the appointment at that time, or reschedule your appointment.
- If you have not been seen in our office within the previous 6 months, you will need to come in as a new patient. When you come in for that next appointment you will need to fill out *all* of the new patient paperwork and present your insurance card. This ensures up-to-date records and fulfills legal responsibilities.
- We value the comfort, privacy, and safety of all of our patients. While in the office, all patients *must* wait in the waiting area. Due to limited space in our office, we ask that you please not bring friends and family members who are not patients. This helps comply with HIPPA regulations, as well as OSHA and Fire Safety regulations.
- Please do not bring any food or beverages in the waiting area

I acknowledge that I have read and understand the above policies

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Printed Name of Patient or Legal Representative | Relationship or authority to act on patient's behalf

Informed Consent for Treatment

I, _____ (name of patient), agree and consent to participate in behavioral healthcare services offered and provided by the following health care providers at Arnold F. Negrin, MD Psychiatry. I understand that I am consenting and agreeing to receiving treatment, including both pharmacological and non-pharmacological treatment interventions. I understand that I am consenting and agreeing to those services that the above-named providers are qualified to perform within: the scope of the provider's license, certification, and training of the behavioral healthcare provider directly supervising the services received by the patient. If the patient is under the age of eighteen or unable to consent to treatment, I attest that I have legal custody of the above named individual and am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment, including prescription medications, on behalf of this individual. ***I acknowledge that I have read and understand the above policies***

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name of Patient or Legal Representative Relationship or authority to act on patient's behalf

Consent to Disclose Health Information for Treatment, Payment, and Health Care Operations

In the course of providing service to you, we create, receive, and store health information that identifies you. It is often necessary to use and disclose this health information in order to treat you, to obtain payment for our services, and to conduct health care operations involving our office. We have a comprehensive Notice of Privacy Practices, the use and disclosure of your health information for treatment purposes not only includes care and services provided here, but also disclosures of your health information as may be necessary or appropriate for you to receive follow up care from another health professional. Similarly, the use and disclosure of your health information for purposes of payment includes our submissions of claims to third-party payors or insurers for claims review, determination of benefits and payment, our submissions of your health information to auditors hired by third-party payors and insurers, among other aspects of payment described in our Notice of Privacy Practices. Our Notice of Privacy Practices will be updated whenever our privacy practices change. You can get an updated copy here at the office.

When you sign this document, you signify that you agree that we can and will use and disclose your health information to treat you, obtain payment for our services, and perform health care operations. You can revoke this consent in writing at any time, unless we have already treated you, sought payment for our services, or performed healthcare operations in reliance upon our ability to use or disclose our health information in accordance with this consent. We can decline to serve you if you elect not to sign this consent form. You have the right to ask us to restrict the uses or disclosures made for purposes of treatment, payment or healthcare operations, but as described in our Notice of Privacy Practices, we are not obligated to agree to these restrictions. If we do agree, however, the restrictions are binding on us. Our Notice of Privacy Practices describes how to ask for restrictions.

If you have additional individuals you would like to give permissions to release information to, you may request additional Release of Information forms from a staff member.

I have read this consent and understand it. I consent to the use and disclosure of my health information for purposes of treatment, payment, and healthcare operations.

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name of Patient or Legal Representative Relationship or authority to act on patient's behalf

Telehealth Consent

I hereby consent to participate in telehealth services with the providers at Arnold F. Negrin, MD Psychiatry, as part of my plan of care. I understand that telehealth is the use of electronic information and communication technologies by a health care provider to deliver services to an individual when he/she is located at a different site than the provider. I agree to the following:

- I understand that I will be responsible for any copayments or coinsurance that may apply to my telehealth visit.
- I understand that I have the right to withhold or withdraw my consent for the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment. I may also revoke my consent orally or in writing at any time by contacting the office of Arnold F. Negrin Psychiatry.
- I have been given information regarding the use of Telehealth and consent to participate in services utilizing this technology.
- I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
- I understand that the patient will be expected to have access to a two-way, real time interactive communication equipment. This includes audio and video communications designed to facilitate the delivery of services in a faced-to-face, interactive, though distant, engagement. This area should be safe, private, quiet, and free of distractions.
- I understand that the expectation for following the patient's plan of care is still expected, including but not limited to: appointment compliance, medication compliance, completion of requests for lab work, medical workups, psychological testing, and additional therapy services.
- I understand that the laws that protect the privacy and confidentiality of patient medical information also apply to telehealth services which include behavioral health unless an exception applies i.e. mandatory reporting of suspected abuse; danger to self or others; I raise mental/emotional health as an issue in a legal proceeding). As always, my insurance carrier will have access to medical records for quality review/audits.
- I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth health services are not appropriate and a higher level of care is required.
- For patient's receiving medications, the provider will require an updated list of medications, date of most recent menstrual cycle (if applicable), and access to scale to obtain the current weight. Medications that can be called into the pharmacy will be submitted to the preferred pharmacy on file.
- I understand that I am responsible for verifying the office has the correct mailing address, phone number, and insurance information on file.
- I understand that there are risks, benefits, and consequences associated with telehealth services, including but not limited to, disruption of transmission by technology failures, interruptions, and or breaches of confidentiality by unauthorized persons, and/or limited ability to respond to emergencies.
- I understand that for therapy services, the area should be quiet and private. That unless previously agreed upon, this is an individual session.
- I understand that during a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. If we are unable to reconnect within ten minutes, please attempt to contact me at phone number: _____ to discuss, as we may have to reschedule.

_____ _____

Signature of Patient or Legal Representative | Date

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Controlled Substance Agreement

We are committed to doing all we can to treat your psychiatric disorders. In some cases, the use of controlled medications for sleep disorders, benzodiazepines for anxiety, or stimulants for the treatment of ADHD may be prescribed. These medications are strictly regulated by both state and federal guidelines. This agreement is a tool to protect both you and the practitioners by establishing guidelines, within the laws, for the proper controlled substance use.

I, _____ **(PATIENT),** understand and voluntarily agree that:

- I agree not to consume excessive amounts of alcohol in conjunction with prescribed controlled substances. Additionally, I agree to not purchase, obtain, or use any illegal drugs.
- All controlled substances have a potential for dependency and abuse. If I, or anyone in my family, have a history of drug or alcohol problems there is a higher chance of dependency or abuse.
- I will participate in all other types of treatment I am asked to participate in. Unannounced urine drug screens may be requested and cooperation is required. Failure to complete the requested lab work, and/or presence of unauthorized substances will result in discontinuation of controlled medications and possible discharge from practice.
- I will keep the medicine safe and secure. I understand that if the medication is destroyed, lost, or stolen, it will not be replaced until my next appointment, and may not be replaced at all
- I will not share, sell, or otherwise permit others including spouse or family members to have access to these medications.
- I will take my medication as instructed and not change the way I take it without first talking to the doctor or other member of my treatment team
- I will keep (and be on time for) all my scheduled appointments. I will treat the office staff respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients, my treatment will be stopped.
- The prescribing practitioners have permission to discuss all treatment details with the dispensing pharmacist or other professionals who provide your health care for the purpose of maintaining accountability. I agree to allow this office access to my past prescription history.
- I will report all medications I take and let my prescribers know if I start a new medication.
- If the responsible legal authorities have questions concerning your treatment, as might occur if you are obtaining medication at several pharmacies, or you are arrested or incarcerated related to legal or illegal drugs, all confidentiality is waived and these authorities may be given full access to records.
- All controlled substances must be obtained from the same pharmacy, where possible.
- All benzodiazepines or stimulants must come from the physician whose signature appears below, unless specific authorization is obtained for an exception. Our office does not prescribe opioid medications or any form of marijuana/cannabinoid substances.

By signing below, I am agreeing that I have read and agree to the following. I understand the terms of this contract and have had the opportunity to have any questions answered. I understand that failure to comply with this contract may result in termination of the agreement, which may result in the discontinuation of my controlled prescriptions, and possible dismissal from the practice.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Printed Name of Patient or Legal Representative | Relationship or authority to act on patient's behalf

Acknowledgment of Receipt of Notice of Privacy Practices

I, _____, acknowledge that I have received a copy of Arnold F. Negrin, M.D.'s Notice of Privacy Practices. This notice describes how Arnold F. Negrin, M.D. may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

_____ _____

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Patient Insurance Information

Please attach of copy of your current insurance card and a valid photo ID

Primary Insurance *a copy of your current insurance card(s) will be required prior to your appointment*			
Insurance Company			Phone:
Insurance Address			
Insurance ID		Insurance Group Number	
Subscriber Name		Subscriber Relationship	
Subscriber DOB		Subscriber Social Security No.	
Tricare Sponsor ID		Tricare Authorization No.	

Secondary Insurance *a copy of your current insurance card(s) will be required prior to your appointment*			
Insurance Company			Phone:
Insurance Address			
Insurance ID		Insurance Group Number	
Subscriber Name		Subscriber Relationship	
Subscriber DOB		Subscriber Social Security No.	
Tricare Sponsor ID		Tricare Authorization No.	

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AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

Patient Name: _____ **Date of Birth:** _____

Address: _____

I hereby authorize the office of Arnold F. Negrin, Psychiatry, to disclose, release, or exchange protected health information, with these parties below:

Name of Person or Office: _____
Relationship: Primary Care Provider/Doctor

Address: _____

Phone Number: _____ Fax: _____

Information to be Released

☒ Medical History, Examination Reports	☒ Diagnostic Studies	☒ Mental Health
☒ Treatment or Tests	☒ Laboratory Reports	☒ Developmental Disabilities
☒ Prescriptions	☒ Substance Abuse	☒ Psychological Evaluations
☒ Therapy Notes and Consultations	☒ Consultations	☒ Hospital Records & Reports

Purpose of the Requested Use or Disclosure is:

☐ At the request of the individual ☒ Continuity of Care
☐ Other: _____

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be re-disclosed without obtaining my authorization. I understand that I have a right to:

- Receive a copy of this authorization
- Refuse to sign this authorization and that treatment, payment, enrollment in health plan, or eligibility for healthcare benefits may not be contingent on my signing this authorization.
- Revoke this authorization, except to the extent that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect while under the care of this provider, unless an earlier date or event is specified, or with the written revocation of this authorization:

☒ While under care of provider(s)
☐ Specific date of revocation of this authorization: _____

_____ _____
Signature of Patient or Legal Representative Date

_____ _____
Printed Name of Patient or Legal Representative Relationship or authority to act on patient's behalf

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☒ While under care of provider(s)

☐ Specific date of revocation of this authorization: _____

_____ _____

Signature of Patient or Legal Representative Date

_____ _____

Printed Name of Patient or Legal Representative Authority to act on patient's behalf

New Patient Registration

Patient Name				DOB	Age	
Preferred Name				Maiden Name:		
Gender	☐ Male	☐ Female	☐ Transgender	☐ Other		
Marital Status	☐ Single	☐ Married	☐ Partnered	☐ Separated	☐ Divorced	☐ Widowed
Occupation				Referral Source		
Social Security No.				Preferred Language		
Mobile Phone		Phone		Email		
Primary Address				Apt/Unit:		
	City:		State:	Zip code:		
Billing or Permanent Address				Apt/Unit:		
	City:		State:	Zip code:		

Emergency Contact	Relationship:	Phone:
Emergency Contact	Relationship:	Phone:

Please complete if the patient is under 18		
Legal Guardian	Relationship	Phone
Other Guardian	Relationship	Phone
Other individuals able to make changes or attend appointments with patient		
Name	Relationship	Phone
Name	Relationship	Phone

If parents are separated, is there a legal agreement specifying medical decision-making? ☐ No ☐ Yes

**If yes, please include copy of the legal agreement. **Please note our office does not get involved in legal or custody cases.*

Additional Comments:

☐ **DFCS Involvement** Please Explain:		County
Caseworker	Phone	Fax

**Please attach any guardianship paperwork and a separate Release of Information for the caseworker*

Additional Comments:

☐ **Receiving SSI** ☐ Medical ☐ Mental Health ☐ Developmental Disability ☐ Applying ☐ Other: _____

Additional Comments:

Answer all questions thoroughly. This information is necessary for our providers to understand your concerns and develop a plan of care that addresses patient needs, safety concerns, and provides quality care. Failure to complete paperwork may result in delays in receiving care.

Patient Name: **Date of Birth:**

Preferred Pharmacy: Pharmacy Location:

Height: **Weight:**

MEDICAL HISTORY

Primary Care Doctor: Location:

Other Providers *(rheumatology, cardiology, gastroenterology, pain management, neurology, endocrinology)*

Currently Treated for Pain: ☐ Yes ☐ No **Pain Doctor:**

Drug Allergies or significant drug reactions: ☐ No Drug Allergies

Current Medical Conditions ☐ None

☐ Autoimmune Disorder	☐ Anemia	☐ Asthma	☐ Auditory Disorder	☐ Bleeding Disorder	☐ Cancer
☐ Cardiac Disorder	☐ Diabetes	☐ Endocrine Disorder	☐ Endometriosis	☐ Epilepsy	☐ Fibromyalgia
☐ Gastric Disorder	☐ Headaches/Migraines	☐ Head Injury	☐ High Blood Pressure	☐ High Cholesterol	☐ Hypothyroid
☐ Kidney Disorder	☐ Liver Disorder	☐ Movement Disorder	☐ Neurological Disorder	☐ Pain	☐ PCOS
☐ Reproductive Disorder	☐ Respiratory Disorder	☐ Seizure	☐ Sleep Apnea	☐ Other:	

Other:

Surgical History:

Women's Reproductive Health **For all women over age 12*

Date of Last Menstrual: _____ ☐ Menopausal ☐ Hysterectomy ☐ Tubal Ligation ☐ Ablation

☐ Oral Contraceptive ☐ Depo IM/Nuva Ring ☐ IUD/implanted Pregnant: _____ wks ☐ Planning Pregnancy ☐ Breastfeeding

Current Medications *(including over the counter medications and supplements) *please list strength and frequency taken*

SUBSTANCE USE

☐ N/A - Child under 13

Do you currently use any nicotine products? *If yes, type and frequency of use:*

Do you have a history of substance use or medication misuse? ☐ Yes ☐ No

If yes, have you ever received treatment or hospitalization? *(If yes, list substances & dates)* ☐ Yes ☐ No

If yes, in the past year, how many times have you used the following:

Alcohol	☐ Never	☐ Rarely	☐ Monthly	☐ Weekly	☐ Daily
Marijuana	☐ Never	☐ Rarely	☐ Monthly	☐ Weekly	☐ Daily
Opioids	☐ Never	☐ Rarely	☐ Monthly	☐ Weekly	☐ Daily
Cocaine	☐ Never	☐ Rarely	☐ Monthly	☐ Weekly	☐ Daily
Ecstasy or "Party Drugs"	☐ Never	☐ Rarely	☐ Monthly	☐ Weekly	☐ Daily
Other Illegal Drugs (synthetics, hallucinogens, inhalants)	☐ Never	☐ Rarely	☐ Monthly	☐ Weekly	☐ Daily
Prescription drugs not prescribed to you *(pain, anxiety, focus, sleep)*	☐ Never	☐ Rarely	☐ Monthly	☐ Weekly	☐ Daily

Other Comments:

MENTAL HEALTH HISTORY

Have you ever seen a psychiatrist? *(If yes, who, when, and reason for leaving)* ☐ No ☐ Yes

Are you actively working with a counselor/therapist, or receiving therapy services? ☐ No, but interested in a referral

☐ If yes, please list name, type, and date last seen:

Have you had psychological testing to confirm diagnoses? ☐ No, but interested in a referral

Year: Psychologist: Diagnoses:

Year: Psychologist: Diagnoses:

Please indicate if you have a history of any of the following: *(If yes, please include details)*

☐ Inpatient hospitalization(s) for mental health (date, facility, reason)

☐ Suicide attempt, unreported ☐ Suicide attempt, reported

☐ Self-Harm Behaviors *(including cutting, burning, scratching)* ☐ Experienced a traumatic event

☐ Physical abuse ☐ Emotional abuse ☐ Sexual abuse ☐ Neglect/abandonment

Comments:

Family History	☐ None			☐ Unknown	☐ Adopted	
Parents	☐ Depression	☐ Anxiety	☐ ADHD	☐ Substance Use	☐ Mood Issues	☐ Unknown
Siblings	☐ Depression	☐ Anxiety	☐ ADHD	☐ Substance Use	☐ Mood Issues	☐ Unknown
Children	☐ Depression	☐ Anxiety	☐ ADHD	☐ Substance Use	☐ Mood Issues	☐ Unknown

Has any member of your family died by suicide? ☐ No ☐ Yes

Is anyone in your family currently on medications for these conditions and doing well? ☐ No ☐ Yes ☐ Unknown

If yes, please list medications:

CURRENT MENTAL HEALTH

Current Stressors: ☐ Academic ☐ Occupational ☐ Relationship ☐ Social

☐ Medical Concerns ☐ Traumatic Event ☐ Legal Issues ☐ Grieving/Loss ☐ Financial ☐ Family

Using a 0-10 scale (0=none and 10=the worst), rate the following, based on how you've felt over the past 2 weeks:

Depression: 0 1 2 3 4 5 6 7 8 9 10

Irritability: 0 1 2 3 4 5 6 7 8 9 10

Motivation: ☐ Good ☐ Fair ☐ Poor

Sleep Quality: ☐ Good ☐ Fair ☐ Poor

Anxiety: 0 1 2 3 4 5 6 7 8 9 10

Stress Level: 0 1 2 3 4 5 6 7 8 9 10

Mood Stability: ☐ Good ☐ Fair ☐ Poor

Concentration: ☐ Good ☐ Fair ☐ Poor

Comments:

Have you ever been treated for these concerns before? ☐ No ☐ Yes *If yes, when did symptoms start and what diagnoses? please complete medication sheet*

Briefly Describe the reason for your visit today: (*What brings you to our office?)*

How do these symptoms impact your daily life:

If you are currently on medications, do you feel like these medications are effective? ☐ No ☐ Yes

What are your goals for your appointment today? *(Specifically, what would you like to address or focus on?)*

Additional Comments or Concerns

Mental Health Symptoms and Concerns

Over the last two 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
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself; that you're a failure, or that you've let yourself or family down				
Trouble concentrating on things, such as reading or watching television?				
Moving or speaking so slowly that other people could have noticed?				
Being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead, or of hurting yourself in some way				
Feeling nervous anxious or on edge				
Not being able to stop or control worrying				
Worrying too much about different things				
Trouble relaxing				
Becoming easily annoyed or irritable				
Feeling afraid as if something awful might happen				
Feeling miserable or unhappy				
I didn't enjoy anything at all				
Feeling so tired I just sit around and do nothing				
I cry a lot				

Has there been a time in your life when you were not your usual self and you...	Yes	No
Felt so good or hyper that other people thought you were not your normal self, or it got you into trouble		
Were so irritable that you shouted at people or started fights or arguments		
Felt much more self-confident than usual		
Got much less sleep than usual and found you didn't really miss it		
Were much more talkative or spoke faster than usual		
Had thoughts racing through your head or you couldn't slow your mind down		
Had much more energy than usual		
Were much more active or did many more things than usual		
Were much more social or outgoing than usual		
Were much more interested in sex than usual		
Did things that were unusual for you or that others might have thought were excessive, foolish, or risky		
Spending money got you or your family into trouble		
If you checked YES to more than one response, have several of these happened during the same time	☐ No	☐ Yes
How much of a problem did any of the cause you *(like having family, work, academic, money, or legal troubles; getting into arguments or fights?* ☐ No problem ☐ Minor Problems ☐ Moderate Problems ☐ Serious Problems		

Answer the following questions describing how you have felt and conducted yourself over the past 6 months.	Never	Rarely	Some times	Often	Very Often
How often do you have trouble wrapping up final details of a project once the challenging parts have been done					
How often do you have difficulty getting things in order when you have to do a task that requires organization					
How often do you have problems remembering appointments or obligations					
When you have a task requiring a lot of thought, how often do you avoid or delay starting					
How often do you fidget or squirm with your hands or feet if you have to sit for a long time					
How often do you feel overly active and compelled to do things, like you're driven by a motor					
How often do you make carless mistakes when you have to work on a boring or difficult task					
How often do you u have difficulty keeping your attention when you are doing boring or repetitive work					
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly					
How often do you misplace or have difficulty finding things					
How often are you distracted by activity or nose around you					
How often do you leave your seat when you are expected to remain seated					
How often do you feel restless or fidgety					
How often do you have difficulty unwinding and relaxing when you have time to yourself					
How often do you find yourself talking too much in social situations					
When in conversation, how often do you find yourself finishing the sentences of the people you're talking to before they can finish for themselves					
How often do you have difficulty waiting your turn in situations when turn-taking is required					
How often do you interrupt others when they are busy					
If you indicated any of these issues, did these symptoms also occur prior to age 12	☐ No		☐ Yes		
Overall, how do these symptoms impact your daily functioning?	☐ No problem	☐ Minimally	☐ Moderately	☐ Significantly	

Patient Name: **Date of Birth:**

Treatment Plan

Barriers to Treatment:

- ☐ Compliance
- ☐ Poor Support System
- ☐ Traumatic Event
- ☐ Other: _____
- ☐ Socioeconomic
- ☐ Judgment
- ☐ Personal Beliefs
- ☐ Social Impairments
- ☐ Insight
- ☐ Medical Concerns
- ☐ Cultural
- ☐ Medical Concerns
- ☐ Legal Concerns

Strengths/Protective Factors:

- ☐ Intelligence
- ☐ Other Social Support
- ☐ Reasoning
- ☐ Other: _____
- ☐ Socioeconomic
- ☐ Judgment
- ☐ Insight
- ☐ Religion/Personal Beliefs
- ☐ Cooperative
- ☐ Compliance
- ☐ Coping Skills
- ☐ Family Support
- ☐ Willingness to seek help

Patient Needs/Issues to Address:

- ☐ Compliance
- ☐ Support System
- ☐ Aggression
- ☐ Sleep Hygiene
- ☐ Other: _____
- ☐ Impulsivity
- ☐ Judgment
- ☐ Irritability
- ☐ Coping skills
- ☐ Social Functioning
- ☐ Insight
- ☐ Mood Lability
- ☐ Suicidality
- ☐ Defiance
- ☐ Interpersonal Relationships
- ☐ Self-Harming Behaviors
- ☐ Mood Stability

	Short Term Goals:	Target Date/Status
☒	I will participate effectively in medication evaluation appointments and will honestly discuss my thoughts and emotions in order to increase effective communication and treatment progression, every 4 weeks	Ongoing, while under care; Re-evaluate in 90days
☒	I will be able to identify at least 5 skills I can use to effectively manage my emotional regulation, which can be exhibited by increases in symptoms of depression, anxiety, impulsivity, self-harming behaviors, irritability, and sleep, within the next 90 days.	Ongoing, while under care; Re-evaluate in 90days
☒	I will be free from any self-harming behaviors be able to identify at least 3 coping skill(s) I have used to control my symptoms/urges over the next 90 days.	Ongoing, while under care; Re-evaluate in 90days
☐	I will work in individual counseling sessions to help learn and implement healthy/effective coping skills. Progress towards this goal will be reassessed using self-report and progress updates from counseling sessions, within 90 days.	Ongoing, while under care; Re-evaluate in 90days
☒	I will comply with treatment recommendations and I will take medication(s) as prescribed, until my next evaluation.	Ongoing, while under care; Re-evaluate in 90days

Interventions Provided:

	Discipline	Focus	Frequency	Duration
☒	Providers Dr. Arnold Negrin Lindsey Crawford, FNP-C	The provider(s) will meet with the patient to assess the effectiveness of current prescribed medications and make medication adjustments as necessary.	*Every 4-12 wks*	Ongoing while under care; on an as needed basis
☒	Providers Dr. Arnold Negrin Lindsey Crawford, FNP-C	The provider(s) will meet with the patient to assess and discuss symptom severity, patient progress, and harm to self/others.	*Every 4-12 wks and as needed*	As needed
☒	Providers Dr. Arnold Negrin Lindsey Crawford, FNP-C	The provider(s) will meet with the patient to assess and discuss medication-related concerns.	*Every 4-12 wks and as needed*	As needed
☒	Providers Dr. Arnold Negrin Lindsey Crawford, FNP-C	The provider(s) will assess patient compliance and barriers that may interfere with treatment success.	*Every 4-12 wks and as needed*	As needed
☐	Providers Dr. Arnold Negrin Lindsey Crawford, FNP-C	The provider(s) will refer the patient for psychological evaluation which may help in further plan of care development.	*Once, As needed*	
☐	Providers Dr. Arnold Negrin Lindsey Crawford, FNP-C	The provider(s) will refer the patient for counseling/therapy which may help in the development of adequate coping skills.	*Once, As needed*	

_____ Patient Signature

_____ Guardian/Support Person Signature

_____ Arnold F. Negrin M.D. / Lindsey Crawford FNP-C

_____ Date

Medication	Result			Comment (if applicable)
Depression and Anxiety Medications (SSRI/SNRI/Tricyclics)				
Celexa (Citalopram)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Luvox (Fluvoxamine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Viibryd (vilazodone)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Trintellix (vortioxetine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Paxil (Paroxetine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Prozac (Fluoxetine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Zoloft (Sertraline)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Lexapro (Escitalopram)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Buspar (buspirone)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Effexor (Venlafaxine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Wellbutrin (Buproprion HCl)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Cymbalta (Duloxetine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Fetzima (levomilnacipran)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Pristiq (Desvelafaxine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Aplenzin (buproprion HBr)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Pamelor (Nortriptyline)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Elavil (Amitriptyline)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Doxepin (Sinequan)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Anafranil (clomipramine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Tofranil (Imipramine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Other:	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Mood Stabilizing Medications				
Lithobid (Lithium)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Depakote (valproic acid)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Lamictal (lamotrigine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Tegretol (carbamazepine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Topamax (topirimate)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Trileptal (oxcarbazepine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Gabapentin (Neurontin)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Seroquel (quetiapine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Seroquel XR	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Geodon (ziprasidone)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Zyprexa (olanzapine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Abilify (aripipazole)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Risperdal (Risperidone)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Saphris (Asenapine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Invega (paliperidone)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Rexulti (brexpiprazole)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Fanapt (iloperidone)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Vraylar (cariprazine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Haldol (haloperidol)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Thorazine (chlorpromazine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Prolixin (fluphenazine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Clozaril (clozapine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Latuda (lurasidone)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Other:	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	

Medication	Result			Comment (if applicable)
Miscellaneous Anxiety Medications				
Xanax (alprazolam)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Ativan (lorazepam)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Klonopin (clonazepam)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Valium (diazepam)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Restoril (temazepam)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Vistaril, Atarax (hydroxyzine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Gabapentin (Neurontin)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Seroquel (quetiapine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Gabitril (tiagabine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Inderal (propranolol)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Sleep Disorder Medications				
Ambien (zolpidem)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Ambien CR	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Lunesta (eszopiclone)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Seroquel (quetiapine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Sonata (zaleplon)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Belsomra (suvorexant)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Oleptro (Trazodone)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Remeron (mirtazapine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Vistaril, Atarax (hydroxyzine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Catapres, Kapvay (clonidine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Prazosin (Minipress)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Provigil, Nuvigil (modafinil)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Attention Deficit Hyperactivity Disorder Agents				
Strattera (atomoxetine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Wellbutrin (buproprion)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Guanfacine (Tenex, Intuniv)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Catapres, Kapvay (clonidine)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Ritalin IR (methylphenidate)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Concerta	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Metadate	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Daytrana (transdermal)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Quilivant XR (suspension)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Focalin (dexmethylphenidate)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Focalin XR	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Adderall (amphetamine salts)	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Adderall XR	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Adzenys XR ODT	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Vyvanse	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Cotempla XR ODT	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Mydayis	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Other:	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	
Other:	☐ EFFECTIVE	☐INEFFECTIVE	☐ INTOLERANCE	