Further Care Psychiatric Services
Psychiatric Care For Northern New England
330 Borthwick Ave Ste 111 • Portsmouth, NH 03801 • Phone: (603)294-4424 • Fax: (603)319-1603

Depression Screening

As part of our ongoing effort to recognize and treat depression and in conjunction with the Centers for Medicare and Medicaid, we ask each new patient to fill out the appropriate (based on your age) depression screening form below. Your provider will review the results as a part of your first appointment. Please fill out the form regardless or if you are coming to our office for depression treatment.

PATIENT HEALTH QUESTIONNAIRE (PHQ-9) AGE 18 AND ABOVE

NAME: ______________________ **DATE:** ____________

Over the last *2 weeks,* how often have you been bothered by any of the following problems? *(use "✓" to indicate 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 figety 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	0	1	2	3
	add columns	____	+ ____	+ ____

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL: ____

10. 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 ________

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PHQ-9 modified for Adolescents (PHQ-A)

AGE 12 THROUGH AND INCLUDING 17

Name: ____________________________ **Clinician:** ________________________ **Date:** ________

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	**(1) Several days**	**(2) More than half the days**	**(3) Nearly every day**
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, 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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** __________

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)

Patient Communication Preferences

Patient's Printed Name: ______________________________________ Date of Birth: ______________

Further Care Psychiatric Services respects each patient's communication preference. There are many scenarios that may fall outside of the below options and in those cases we will error on the side of caution. Please fill out your preferences below: **NOTE: Personal Email is unencrypted. You have the right to receive protected health information through our patient portal (OnPatient) to protect your privacy. If you choose Email below, the messages may not be secure. _______ (Initial Here)**

CELLULAR PHONE ____

HOME PHONE ____

EMAIL ____

OTHER ____

Appointment, Appointment Reminders and Billing Communication (YOU MUST CONFIRM ALL APPOINTMENTS BY 2 PM THE DAY PRIOR OR THEY WILL BE CANCELED) ______ (Initial Here)

PRIMARY CHOICE: PLEASE CIRCLE ONE	CELLULAR PHONE	HOME PHONE	EMAIL	OTHER
SECOND CHOICE: PLEASE CIRCLE ONE	CELLULAR PHONE	HOME PHONE	EMAIL	OTHER

OTHER ____

Medical Records, Lab Testing, Lab Results and Other Patient Medical Information

Please note that **OnPatient**, the patient portal for Further Care, is a HIPAA compliant method of communicating with a patient about personal medical information as it is password protected with the free account that you, the patient, set up. Unless noted here, if you choose to sign up for OnPatient, Further Care will assume that this is an acceptable method of communicating with you about your personal medical information.

PRIMARY CHOICE: PLEASE CIRCLE ONE	CELLULAR PHONE	HOME PHONE	EMAIL	OnPatient	OTHER
SECOND CHOICE: PLEASE CIRCLE ONE	CELLULAR PHONE	HOME PHONE	EMAIL	OnPatient	OTHER

IT IS (PLEASE CIRCLE ONE) OK / NOT OK TO LEAVE A MESSAGE ABOUT PERSONAL PATIENT MEDICAL INFORMATION

Patient's Signature: ____ Date: ___________________

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PATIENT RESPONSIBILITY & FINANCIAL AGREEMENT

1. FINANCIAL RESPONSIBILITY: I am responsible for all expenses for treating the patient. All payment is due at the time of service. If I fail to pay my outstanding FURTHER CARE P.A. balance, I understand FURTHER CARE P.A. will have a lien against me equal to the full amount of any unpaid FURTHER CARE P.A. bill. I also understand and agree to pay a $30 fee incurred for any returned checks.

2. INSURANCE AND PAYMENTS DUE AT TIME OF SERVICE: Further Care PA does not accept insurance. By signing this agreement, I agree to accept full responsibility of all FURTHER CARE P.A. charges. Full payment is required at the time of service unless other arrangements are made. I agree to pay both reasonable collection agency and attorney fees associated with recovering any outstanding balance.

Print Patient's Name ____________ Date of Birth ____________ Date ____________

Patient or Responsible Party Signature ____________ Relationship to Patient ____________

4. AUTHORIZATION TO RELEASE MEDICAL INFORMATION AND ASSIGNMENT OF BENEFITS: I authorize FURTHER CARE P.A. to share my medical information and medical records, including drug and alcohol and HIV positive test results, to my insurance company and third party payers as needed to process my insurance claim. I authorize my insurance company to make payments directly to Further Care P.A. for covered medical services. I assign the benefits payable for physician services to FURTHER CARE P.A. or the physician furnishing the services. If applicable, I authorize Further Care P.A or the provider to submit a claim to Medicare for payment.

Print Patient’s Name ____________ Date ____________

Patient or Responsible Party Signature ____________ Relationship to Patient ____________

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Acknowledgement of Receipt/Refusal of Further Care's Notice of Privacy Practices

Patient's Printed Name: ___________________________ Date of Birth: ____________

By signing below, I hereby acknowledge that I have been offered a copy of Further Care's Notice of Privacy Practices, and that I have:

Received a copy of the Notice of Privacy Practices

Refused a copy of the Notice of Privacy Practices

Date: ____________

____
Signature of Patient or Authorized Representative

If patient is unable to sign:

____
Printed Name of Authorized Representative

____
Legal Authority of Authorized Representative (e.g. Parent of minor, Health Care Power of Attorney, Guardian, Health Care Surrogate)

For FCPS Staff to Complete if Patient/Representative Refuses or Is Unable to Sign Acknowledgement

The patient/authorized representative did not acknowledge receipt of the Notice of Privacy Practices because:

Patient/authorized representative declined the Notice of Privacy Practices and refused to sign the acknowledgement of refusal.

Patient/authorized representative accepted the Notice of Privacy Practices but refused to sign the acknowledgement of receipt.

Patient was incapacitated at the time the Notice of Privacy Practices was offered and no other authorized representative was available to receive or acknowledge receipt of the Notice of Privacy Practices.

Other Reason: ___________________________________

Date: ____________

____
Signature of FCPS Staff Member Representative

MEDICATION RECONCILIATION

Further Care Psychiatric Services electronically reconciles patient medications prescribed by other healthcare providers.

"I understand that performing a medication reconciliation in order to prevent adverse drug interactions and overdose is a critical component to my care. By signing this form I authorize my provider to query and review my medication fill history including drug, dose, form, strength, prescribing provider, and pharmacy."

Print Patient's Name	Date of Birth	Date

Patient or Responsible Party Signature	Relationship to Patient

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REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Patient's Printed Name: ____________________________________ Date of Birth: _________________

PATIENT'S REQUEST: I request and authorize the release of the information specified below to the organizations, or individuals named on this request. ***(If I do not want information shared BOTH ways, I will cross out the appropriate "OBTAIN" or "DISCLOSE" below.)***

To OBTAIN from AND to DISCLOSE to:

____
Person or Entity | Phone | Fax

____
Address

____
Purpose of disclosure note if restrictions desired

To OBTAIN from AND to DISCLOSE to:

____
Person or Entity | Phone | Fax

____
Address

____
Purpose of disclosure note if restrictions desired

To OBTAIN from AND to DISCLOSE to:

____
Person or Entity | Phone | Fax

____
Address

____
Purpose of disclosure note if restrictions desired

Initials ____________

To OBTAIN from AND to DISCLOSE to:

Person or Entity	Phone	Fax

Address

Purpose of disclosure note if restrictions desired

To DISCLOSE to:

To PHARMACY: I intend to disclose to the dispensing pharmacy to whom I present my prescription or to whom my prescription is called/sent/faxed, as well as to third party payers:

1. Any information needed to confirm the validity of my prescription and for submission for payment for the prescription.
2. Any information needed to assure the pharmacy of the validity of the prescription so that it can be legally dispensed.

To DISCLOSE to:

Person or Entity	Phone	Fax
Further Care PA/Dr. Rondon Vidal	***(603)294-4424***	***(603)319-1603***

330 Borthwick Ave Ste 111 Portsmouth, NH 03801

Address

Initials ____________

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INFORMATION AND DATES TO BE DISCLOSED: **I specifically intend this authorization to include the disclosure of any records or information concerning substance abuse, HIV, AIDS or mental illness including psychiatric care and psychological assessments.**

OR I would like to exclude the following records: (Requesting an exclusion may prevent us from sending the entire record as we are unable to edit a clinical note)

PLEASE EXCLUDE RECORDS THAT CONTAIN INFORMATION ABOUT: (Initial applicable exclusions)

[ ] Mental and behavioral health record and information maintained by licensed mental health treatment facilities or agencies, or related to mental health services provided by licensed mental health professionals.

[ ] Substance abuse program records and information.

[ ] HIV (Human Immunodeficiency Virus) records and information: I understand that authorizing the disclosure of HIV records and information could have adverse consequences, including the loss or denial of employment, health insurance benefits, life insurance benefits, and other forms of discriminatory treatment, whether lawful or unlawful.

The following healthcare records and information about me *(check all that apply)*: ***Unless otherwise indicated below, please include records for the 2 years prior to the date of this document.***

☐ My complete medical record

☐ My medical records for the dates / / – / /
FROM TO

☐ Other records (please specify) ______________________________

AUTHORIZATION DURATION: This authorization shall expire one (1) year from the date of my signature below, unless earlier revoked by me or I enter an earlier expiration date or event here:

__________________.

Initials ___________

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By signing below, I acknowledge that I have read this authorization and understand that:

- I may refuse to authorize the disclosure of the above healthcare information and Further Care PA will not condition treatment, payment for services, or eligibility for services on whether I sign this form but that my refusal may result in improper diagnosis or treatment, denial of coverage or a claim for health benefits or other insurance; or other adverse consequences.
- I may revoke this authorization at any time, either orally or in writing, by notifying Further Care PA in the manner described in Further Care PA's Notice of Privacy Practices (except to the extent that any person has already acted in reliance on it), but that my revocation may be the basis for the denial of health or other insurance coverage or benefits.
- I understand that PHI released pursuant to this authorization may include records generated by another healthcare provider or facility.
- There is the potential that information disclosed pursuant to this authorization may be redisclosed by persons or entities receiving the information and that, as a result, the information may no longer be protected.
- I have the right to a copy of this signed authorization.

Date: ________________ ____

Signature of Patient or Authorized Representative

If patient is unable to sign: ____

Printed Name of Authorized Representative

____

Legal Authority of Authorized Representative (e.g. Parent of minor, Health Care Power of Attorney, Guardian, Health Care Surrogate)

Notice of disclosure:
This information has been disclosed to you from records protected by Federal confidentiality rules (42 CFR Part 2). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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CONTROLLED MEDICATION CONTRACT:

1- Controlled medications will only be prescribed while you meet the diagnostic criteria for its indication. Once the syndrome has resolved genuine efforts will be made by you and your provider to decrease and if able stop the use of these medications.
2- You will only be prescribed controlled medications IF you maintain negative results for any non-prescribed substances on Random Urine Drug Screen Tests (RUDST). If you test positive for a RUDST, the controlled medications will be discontinued or tapered off over a short period depending on the substance.
3- Liver function tests that are suggestive of chronic or frequent alcohol abuse will be considered for all intents and purposes equal to a positive RUDST.
4- IF after testing positive for a RUDST you wish to restart the controlled medication for its recognized benefits in your case, then you may do so ONLY after 2 consecutive months of negative results on RUDST.
5- Positive RUDST includes any substance not prescribed by a Doctor. This includes Marijuana *even if you have obtained a marijuana decriminalization waiver (i.e. marijuana card)*. If you want to continue using the medication along with Marijuana, then you must request that the doctor that gave you the marijuana decriminalization waiver to prescribe the medications for you.
6- Controlled medications will not be renewed over a weekend.
7- Controlled medications will not be renewed before their expected renewal date.
8- Controlled medications may not be changed in dosage except during a face-to-face visit with the provider. They will not be started or changed on last minutes of a visit.
9- Controlled medications require follow-up visits per the schedule on the back of this form. If you have not seen a provider in our clinic within the required time, prescriptions may be withheld. Please plan accordingly.
10- If your medications are stolen, you will have to file a report with the police and bring this report to our office before early renewal can be accepted, if stolen a 2nd time, the medication will be discontinued as you cannot guarantee their safety.
11- The Prescription Monitoring Program (PMP) of your state will be periodically reviewed for discrepancies, and if found, they may limit the renewal of your medications.
12- Controlled substances will only be prescribed IF filled at prior agreed pharmacies or in states where PMP is active.(i.e. Maine and New Hampshire).
13- The Diversion Alert Program of your surrounding states will be periodically reviewed for evidence of diversion. If so, the use of controlled medications may be discontinued or changed by your provider.
14- When needed, controlled medications will be prescribed with bubble wrapping to avoid unexpected loss or damage.

I understand and agree with the above contract

______________________________ / ______________________________ ______/______/_______

Patient's NAME or representative/ Signature Date

The above contract is valid for all controlled medications, independent of signature. Starting controlled substances at this clinic and being presented with this contract even if unsigned is considered for all intents and purposes, as binding. We understand that unusual circumstances may affect all of the above and promise to treat each case individually while maintaining a close following of the above guidelines.

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CONTROLLED SUBSTANCE REQUIRED FOLLOW-UP SCHEDULE

(Actual patient appointment interval determined by provider not to exceed these maximum intervals.)

Drug	***Appointment and Lab Notes***
Alprazolam (Xanax)	A3, L12
Armodafinil (Nuvigil)	A3, L12
Buprenorphine and Naloxone (Suboxone)	A1, LW-M
Chlordiazepoxide (Librium)	A3, L12
Clonazepam (Klonipin)	A3, L12
Clozapine	A1, LW
Dextroamphetamine/Amphetamine (Adderall or Adderall XR)	A3, L12
Diazepam (Valium)	A3, L12
Eszopiclone (Lunesta)	A3, L12
Lisdexamfetamine (Vyvanse)	A3, L12
Lorazepam (Ativan)	A3, L12
Methylphenidate (Concerta or Methylin or Ritalin)	A1 then A3, L12
Methylphenidate ER (Metadate ER Methylin ER Ritalin LA or SR)	A1 then A3, L12
Modafinil (Provigil)	A3, L12
Oxazepam (Serax)	A3, L12
Suvorexant	A3, L12
Temazepam (Restoril)	A3, L12
Zaleplon (Sonata)	A3, L12
Zolpidem (Ambien)	A3, L12

A1 - appointment every month required
A3 - appoint every 3 months required
L12 - labs required once per year
L6 - labs required twice per year
LM - labs required every month
LW - labs required weekly

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