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DEMOGRAPHIC INFORMATION

First Name: _____ **Last Name:** _____

DOB: _____ **SEX:** Male / Female / Transgender / _____ **Pronoun(s):** _____

MARITAL STATUS: Single / Married / Divorced / Widowed / Separated **VETERAN:** Yes / No

Street Address:_____City:_____State: ___Zip: _____

Cell Phone:_____ Ok to Text Reminder Y/N Work Phone _____

Email Address:_____ Employer Name: _____

EMERGENCY CONTACT

Name:_____Phone :_____Relationship: Parent/Guardian/Spouse/Child

Name:_____Phone :_____Relationship: Parent/Guardian/Spouse/Child

PARENT / LEGAL GUARDIAN (If Applicable)

Last Name:_____First Name:_____DOB: _____
Phone Number:_____Living with Child ? Yes_____No_____
Street Address:_____City:_____State:___ Zip Code: _____
If Applicable, Circle One: Child is Adopted Under Guardian Care Under Foster Care

PRIMARY INSURANCE

Insurance Name:_____Insurance Phone: _____
Policy Number:_____Group Number: _____
Policyholder Name:_____Policyholder DOB: _____
Relationship to Patient: Self/Parent/Guardian/Spouse Employer: _____

SECONDARY INSURANCE

Insurance Name:_____Insurance Phone: _____
Policy Number:_____Group Number: _____
Policyholder Name:_____Policyholder DOB: _____
Relationship to Patient: Self/Parent/Guardian/Spouse Employer:_____

REFERRAL SOURCE

Who Referred You To Our Services? _____

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SSPC - GENERAL CONSENT

I (Print Name)_____hereby authorize: ☐ release of information ☐ exchange of information

Health Care Provider		Relative, Facility, Agency, Healthcare Provider	
Name:	Stepping Stones Psychiatric Care	**Name:**	
Address:	1370 Washington Pike, Ste LL8	**Address:**	
City/State/Zip:	Bridgeville PA 15017	**City/State/Zip:**	
Phone / Fax :	412-221-7770 / 412-221-7773	**Phone / Fax :**	

I authorize and request the disclosure of all protected information for the purpose of review and evaluation to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

__Admission & Intake Data __ Clinical Needs Continuing Care Recommendations __ Dates of Treatment __ Diagnosis
__Discharge Plans Evaluation Summary __ Lab Reports Medication Management Progress Notes Psycho-Social
__Telephone & Written Communication Treatment Plans

This protected health information is disclosed for the following purposes:

__Referral to other services __ Coordination of Care Verbal Communication __ Transfer of Care Consultation
__Other: _____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse.

_____I authorize the release or disclosure of this type of information._____DO NOT RELEASE

By signing below, I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation. I understand that SSPC will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

This consent is valid between the following dates: _____until_____.
I have been offered a copy of this form and I ☐ ACCEPT or ☐ REJECT receiving a copy:

Patient Signature (if age 14 or older)	Date	Parent or Legal Guardian Signature	Date
		OR	
Print Name of Witness or Staff	Date	Print Name & Relationship (if applicable)	Date

☐ An individual who cannot write has provided verbal consent, and two individuals have witnessed consent.

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SSPC - PRIMARY CARE PHYSICIAN (PCP)

I (Print Name)_____hereby authorize: ☐ release of information ☐ exchange of information

Health Care Provider		Primary Care Physician	
Name:	Stepping Stones Psychiatric Care	**Name:**	
Address:	1370 Washington Pike, Ste LL8	**Address:**	
City/State/Zip:	Bridgeville PA 15017	**City/State/Zip:**	
Phone / Fax :	412-221-7770 / 412-221-7773	**Phone / Fax :**	

I authorize and request the disclosure of all protected information for the purpose of review and evaluation to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I acknowledge that I request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

__Admission & Intake Data __ Clinical Needs_Continuing Care Recommendations_Dates of Treatment_Diagnosis
__Discharge Plans_Evaluation Summary_Lab Reports_Medication Management_Progress Notes_Psycho-Social
__Telephone & Written Communication_Treatment Plans

This protected health information is disclosed for the following purposes:

__Referral to other services __ Coordination of Care_Verbal Communication_Transfer of Care_Consultation
__Other: _____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse.

_____I authorize the release or disclosure of this type of information. _____DO NOT RELEASE

By signing below, I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation. I understand that SSPC will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization. I acknowledge that SSPC will coordinate with my PCP to facilitate the appropriate delivery of health care services.

This consent is valid between the following dates: _____ until _____.
I have been offered a copy of this form and I ___ **ACCEPT** or ____ **REJECT** receiving a copy.

_____ _____ _____ _____
Patient Signature (if 14 or older) Date Parent or Legal Guardian Signature Date

_____ _____ _____ _____
Print Name of Witness or Staff Date Print Name & Relationship (if applicable) Date

****An individual who cannot write has provided verbal consent, and two individual have witnessed consent**

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SSPC - PHARMACY

I (Print Name)_____hereby authorize: ☐ release of information ☐ exchange of information

Health Care Provider		Pharmacy	
Name:	Stepping Stones Psychiatric Care	**Name:**	
Address:	1370 Washington Pike, Ste LL8	**Address:**	
City/State/Zip:	Bridgeville PA 15017	**City/State/Zip:**	
Phone / Fax :	412-221-7770 / 412-221-7773	**Phone / Fax :**	

I (Print Name)_____hereby authorize: ☐ release of information ☐ exchange of information

Health Care Provider			
Name:	Stepping Stones Psychiatric Care	**Name:**	
Address:	1370 Washington Pike, Ste. LL8	**Address:**	
City/State/Zip:	Bridgeville PA 15017	**City/State/Zip:**	
Phone / Fax :	412-221-7770 / 412-221-7773	**Phone / Fax :**	

I (Print Name)_____hereby authorize: ☐ release of information ☐ exchange of information

Health Care Provider		Pharmacy	
Name:	Stepping Stones Psychiatric Care	**Name:**	
Address:	1370 Washington Pike, Ste. LL8	**Address:**	
City/State/Zip:	Bridgeville PA 15017	**City/State/Zip:**	
Phone / Fax :	412-221-7770 / 412-221-7773	**Phone / Fax :**	

I authorize and request the disclosure of all protected information for the purpose of review and evaluation to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

__Admission & Intake Data __ Clinical Needs Continuing Care Recommendations Dates of Treatment Diagnosis
__Discharge Plans Evaluation Summary Lab Reports Medication Management Progress Notes Psycho-Social
__Telephone & Written Communication Treatment Plans

_____ _____ _____ _____
Patient Signature (if age 14 or older) Date Parent or Legal Guardian Signature Date

_____ _____ _____ _____
Print Name of Witness or Staff (if minor) Date Print Name & Relationship (if applicable) Date

This protected health information is disclosed for the following purposes:
__Referral to other services __ Coordination of Care Verbal Communication Transfer of Care Consultation
__Other: _____

This consent is valid between the following dates: _____until_____.

I have been offered a copy of this form and I _____ ACCEPT or _____ REJECT receiving a copy.

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SSPC - INSURANCE COMPANY

I (Print Name)_____hereby authorize: ☐ release of information ☐ exchange of information

Health Care Provider		Insurance Company	
Name:	Stepping Stones Psychiatric Care	**Insurance:**	
Address:	1370 Washington Pike, Ste LL8	**ID # :**	
City/State/Zip:	Bridgeville PA 15017	**Group # :**	
Phone / Fax :	412-221-7770 / 412-221-7773	**Phone / Fax :**	
		Cardholder Name/DOB:	

I authorize and request the disclosure of all protected information for the purpose of review and evaluation to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. I request that the designated record custodian of all covered entities under HIPAA identified above disclose full and complete protected medical information including the following:

__Admission & Intake Data __ Clinical Needs_Continuing Care Recommendations_Dates of Treatment_Diagnosis
__Discharge Plans_Evaluation Summary_Lab Reports_Medication Management_Progress Notes_Psycho-Social
__Telephone & Written Communication_Treatment Plans

This protected health information is disclosed for the following purposes:

__Referral to other services __ Coordination of Care_Verbal Communication_Transfer of Care_Consultation
__Other: _____

I understand the information to be released or disclosed may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV), and alcohol and drug abuse.

_____I authorize the release or disclosure of this type of information. _____DO NOT RELEASE

By signing below, I acknowledge that I am aware of the confidential and/or privileged nature of the information being disclosed, and understand the benefits and/or disadvantage of disclosing such information. I hereby release above Facility, its affiliates and its agent and representatives, (including collection agencies) from all legal liabilities that may result from the release of this information according to this request. I may revoke this authorization at any time. Revocations to this authorization must be presented in writing. Revocation will not apply to information disclosed prior to receiving a written revocation. I understand that SSPC will not condition my treatment, payment, enrollment or eligibility for benefits on whether I provide this authorization.

This consent is valid between the following dates: _____until_____.
I have been offered a copy of this form and I _____**ACCEPT** or _____ **REJECT** receiving a copy:

_____ _____ _____ _____
Patient Signature (if age 14 or older) Date Parent or Legal Guardian Signature Date

Place sticker

FINANCIAL AGREEMENT

MS Legacy & Stepping Stones Psychiatric Care is a private psychiatric practice that accepts most major insurance companies and self-pay patients. It is the responsibility of the patient to verify outpatient mental health coverage for your specific policy to ensure coverage for your services.

Highmark – Blue Cross Blue Shield – UPMC – Self Pay

- Co-payment or balances are due in full at time of service.
- Special financial arrangements must be discussed prior to your appointment.
- Parents/Guardians are financially responsible for payment for services provided to minors, or other legal dependents.

Payment for Services:
Every effort is made to ensure your insurance company makes payment. However, they make the final determination. I agree that I will be responsible for any services received that are not covered or denied by my insurance plan._____[initials]
I will provide full and accurate insurance information in advance of my appointment and bring my insurance card at the time of my appointment. I understand that insurance billing is provided by my healthcare provider as a courtesy, but I remain the responsible party. I understand that if my insurance company has not responded after 90 days, I will receive a statement. I agree to pay my balance in full at that time. I understand that I will be reimbursed promptly if and when the insurance payment arrives. I understand that I am responsible for payment of any balances on my account. If payment is not received within 90 days, your account will be turned over to collections. We have the option to pursue all lawful collection procedures available and the patient/parent will be responsible for all the reasonable costs of collection, including attorney's fees incurred, if any. The minimum collection fee will be 50% of the total account balance. Unwillingness to pay may result in termination of services.

Fee Scale:

Psychotherapy	$90
Medication Check	$110
Psychiatric Diagnostic Evaluation	$220
Therapy Initial Assessment	$110
Document/Record Preparation	$ 60
Return Check Fee	$25
No Show Fee	$40

Policy for Missed Appointments and Cancellations:
Appointment times are reserved exclusively for you; if you do not cancel your appointment, you will be charged $40.00 for the scheduled time. To avoid any missed appointment or cancellation fees, please call 24 hours in advance to make any changes to your appointment. I understand that I must give proper notification to cancel an appointment to avoid any late cancellation or missed appointment fees. **I agree to call at least 24 hours in advance to cancel or change my appointment.** For Monday appointments, I will call the previous Friday by noon.

Your signature verifies your understanding of the financial responsibility you may have for services rendered during your course of treatment.

_____ _____
PRINTED name of Patient or Authorized Parent/Guardian Date

_____ _____
SIGNATURE of Patient or Authorized Parent/Guardian Date

_____ _____
Staff Signature Date

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Consent for Treatment

Please read the following information regarding the agreement between the healthcare provider, and the patient. Please initial each section, your initials constitute that you accept the policy in this agreement.

I,_____, (Patient/Guardian) request treatment for myself or for the individual for whomI am the legal representative at MS Legacy which may include diagnostic evaluation, psychotherapy, medication management, and treatment for any medical, emotional, and behavioral problems which may be found to exist. The treatment was explained to me in detail and I understand that I must communicate freely with my psychiatrist and/or counselor and not withhold pertinent information regarding my health so that the best course of treatment can be prescribed.

Patient Rights

I certify that I have reviewed a copy of my rights as a patient of Stepping Stones Psychiatric Care. Any questions regarding those rights have been address with staff. **_____ Initial Here**

Liability

In consideration of services rendered, Client agrees to hold MS Legacy, blameless for any liability due to an accident, illness, injury, or incident, which may occur to Client while receiving outpatient services. Client also agrees to hold MS Legacy free from all liability for any losses through fire or theft. Client agrees, if hospitalization or extensive medical care is needed, MS Legacy is not required to assist the client in obtaining appropriate medical attention. Further, the family, guardian, or Client will assume all liability for any medical expenses, hospital care, or other expenditures without liability to MS Legacy. **_____ Initial Here**

Request for Records

Requests for records are received from various sources. Attention to these requests will only occur when we have received a signed (by patient or parent) release of information form. **Records are copied at $25 plus postage and billed directly to you.** Please allow two weeks for this request to be processed. **_____ Initial Here**

Letters

Letters and forms are often requested by patients (or their parents) to be sent to schools, employers, etc. We do not complete formsfor Disability. **_____ Initial Here**

Prescriptions & Refills

MS Legacy requires 7 calendar days of notice for medication refills due to special circumstances; as our Benzodide Agreement states, patients need to be seen to receive medication refills . Without notification within 7 days, MS Legacy cannot guarantee that refills will be received by the pharmacy in time to prevent the medication from running out. MS Legacy will not provide new prescriptions if the originals are reported lost, stolen, or are not filled before the expiration date. **_____ Initial Here**

Confidentiality

I have further been assured that any information, knowledge, or records associated with said Client are subject to release only by my informed and written consent or by a court order, except in instances of medical emergency, suspected child or elder abuse or neglect, or risk of harm to self or others. Your confidentiality and privacy are protected by the following Federal guidelines: Code of Federal Regulations (CFR 42 Part2) and the Health Insurance Portability and Accountability Act (HIPAA). **_____ Initial Here**

Discrimination Policy

No person will be discriminated upon based on gender, race, religion, age, national origin, disability (mental or physical), sexual orientation, sexual preference, medical condition, including HIV diagnosis or because an individual is perceived as being HIV infected, or any other characteristic. Consent for treatment is made with informed consent, and as such, consent may be revoked and services discontinued at any time. **_____ Initial Here**

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Permission to Leave Voice Messages
Initialing here gives permission for MS Legacy to leave voicemail message regarding appointments and other necessary information. Discretion will be used in disclosing sensitive materials through voicemail communication. Please initial here to give permission to leave voicemail messages. _____ **Initial Here**

Involuntary Termination of Treatment
Multiple causes for involuntary discharge exist. Causes for involuntary termination include, but are not limited to: verbal/physical aggression towards staff members or other patients, harassment of staff members or other patients, threats towards others, illegal activity related to treatment, and destruction of property. If MS Legacy receives information that a patient is receiving prescriptions by other doctors than those with MS Legacy, MS Legacy reserves the right to terminate treatment immediately and involuntarily. If a patient misses any 3 appointments (with the therapist or psychiatrist) within any 4 month span of time, MS Legacy reserves the right to terminate treatment. All patients that receive an involuntary termination of treatment will be provided with written notice and referrals for continued treatment. _____ **Initial Here**

Consent for Treatment and Consultation
I authorize and request that Muhammad I. Shaikh, M.D. and MS Legacy to carry out behavioral health treatments, and/or diagnostic procedures that now or during the course of my care as advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement. I also understand that while the course of treatment is designed to be helpful, it may at times be difficult and uncomfortable.

Your signature below indicates that you have read this agreement and agree to its terms and also serves as an acknowledgement that you have received the HIPPA notice form described above.

I have been offered a copy of this form and I ☐ ACCEPT or ☐ REJECT a copy:

_____ _____
PRINTED name of Patient or Authorized Parent/Guardian Date

_____ _____
SIGNATURE of Patient or Authorized Parent/Guardian Date

_____ _____
Staff Signature Date

Place sticker

BILL OF RIGHTS

As a client receiving services from MS Legacy, your Client Bill of Rights will include:

You have a right to be treated with dignity and respect.

1. You have the right to unrestricted and private communications inside and outside this facility including the right to make complaints and have your complaints heard and adjudicated promptly.
2. You have the right to participate in the development and review of your treatment plan.
3. You have the right not to be subjected to any harsh or unusual treatment.
4. You have the right to be informed of diagnostic and treatment procedures, their risks and their costs, that are available to you and which would aid in your recovery from mental illness. You have the right to be informed of the reasons and factors involved in recommending a procedure of choice.
5. You have the right to be informed of the nature of material about to be released to others (or obtained) when you are requested to sign a release of information.
6. You have a right to have your records treated in a confidential manner in compliance with the laws of the Commonwealth of Pennsylvania.
7. You have the right to courteous treatment from staff at all times.
8. You have the right to be kept safe from injury while in the auspices of the practice.
9. You have the right to voice complaints or appeals about the insurance company or the care provider.

I (we) have received from MS Legacy staff a clear explanation of my (our) rights in simplest terms.
I (we) have received a written copy of these rights. I (we) acknowledge a clear understanding of my (our) rights.

PRINTED name of Patient or Authorized Parent/Guardian _____ Date _____

SIGNATURE of Patient or Authorized Parent/Guardian _____ Date _____

Staff Signature _____ Date _____

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Patient Agreement Form

AGREEMENT FOR LONG TERM CONTROLLED SUBSTANCE PRESCRIPTIONS

The use of _____(names of medication(s) may cause addiction and is only one part of the treatment for (name of _____ condition-e.g., anxiety, depression, etc.).

The goals of this medication (s) is/are to improve my ability to work and function at home and to assist with managing symptoms.

I have been informed that:

1. If I drink alcohol or use street drugs, I may not be able to think clearly, and I could become sleepy and risk personal injury or death.
2. I may get addicted to this medication.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher risk of addiction.
4. If I need to stop this medication, I must do so slowly, or I may get very sick.

I agree to the following:

I am responsible for my medications. I will not share, sell or trade my medication. I will not take anyone else's medications.
I will not increase my medication until I speak with my doctor.
My medication will not be replaced if it is lost, stolen, or used up sooner than prescribed.
I will keep all appointments set up with my doctor and other healthcare providers (e.g. therapist, and substance abuse treatment).
I will bring the pill bottles with any remaining pills of my medication to each visit with the doctor.
I agree to give a urine sample, if asked, to test for drug use.

Refills

Refills will be made only during regular office hours - Monday through Thursday, 9:00AM-6:00PM and Fridays 9:00AM-3:00PM. No refills will be made on nights, holidays or weekends. I must call at least three [3] working days ahead (M-F) to request a refill on my medication. **No exceptions will be made.**
I must keep track of my medication. No early or emergency refills will be made.

Prescriptions from Other Doctors

If I see another doctor who gives me a controlled substance medication (e.g. a dentist, E R doctor or a hospital) I must inform the doctor as soon as possible.

Privacy

While I am taking this medication, my doctor may need to contact other doctors or family members to get information about my care and/or use of this medication. I will be asked to sign a release for consent to collaborate.

_____ _____
Patient's Signature Date

_____ _____
Physician's Signature Date

_____ This document has been discussed with and signed by the physician and patient. (A signed copy has been given to the patient).

Name: _____ Date: _____ **Please complete before your next visit.**

In general, how are you feeling? ❑ Better ❑ Same ❑ Worse [explain] _____

On the rating scale below, **CIRCLE** the level of each symptom (ex): 1 2 3 4 (5) 6 7 8 9 10 **Mild** **Moderate** **Severe**

Have you been feeling…?	**Check the symptoms that you currently have:**		
Depressed? ❑ Better ❑ Same ❑ Worse ❑ No Symptoms Rating Scale: 1 2 3 4 5 6 7 8 9 10 ❑ Daily ❑ Few days/week ❑ Occasionally	❑ Sad most of the time ❑ Less interest in activities/hobbies ❑ Decreased appetite ❑ Increased appetite ❑ Trouble concentrating/thinking	❑ Sleeping more ❑ Sleeping less ❑ Fatigued/Tiredness ❑ Lack of energy ❑ Hopelessness	❑ Worthlessness ❑ Feelings of guilt ❑ Thinking about death ❑ Suicidal thoughts
Manic? ❑ Better ❑ Same ❑ Worse ❑ No Symptoms Rating Scale: 1 2 3 4 5 6 7 8 9 10 ❑ Daily ❑ Few days/week ❑ Occasionally	❑ Inflated self-esteem ❑ Decreased need for sleep ❑ More talkative ❑ Racing thoughts	❑ Distracted ❑ Increase in activity ❑ Increase in reckless/ risky behavior ❑ Spending too much money	
Psychotic? ❑ Better ❑ Same ❑ Worse ❑ No Symptoms Rating Scale: 1 2 3 4 5 6 7 8 9 10 ❑ Daily ❑ Few days/week ❑ Occasionally	❑ Difficulty thinking/understanding ❑ Disorientation ❑ Racing thoughts ❑ Paranoia ❑ Thought disorder	❑ Unwanted thoughts ❑ Hearing voices ❑ Delusions ❑ Unusual behaviors ❑ Inappropriate behaviors	❑ Visual hallucinations ❑ Incoherent speech ❑ Rapid speech ❑ Disorganized speech ❑ No emotion
Anxious? ❑ Better ❑ Same ❑ Worse ❑ No Symptoms Rating Scale: 1 2 3 4 5 6 7 8 9 10 ❑ Daily ❑ Few days/week ❑ Occasionally	❑ Excessive worry ❑ Restlessness ❑ Easily Fatigued ❑ Muscle tension	❑ Irritability ❑ Difficulty sleeping ❑ Blank mind / Difficulty Concentrating	
Social Anxiety? ❑ Better ❑ Same ❑ Worse ❑ No Symptoms Rating Scale: 1 2 3 4 5 6 7 8 9 10 ❑ Daily ❑ Few days/week ❑ Occasionally	❑ Fear of social situations ❑ Fear of embarrassment ❑ Fear of humiliation ❑ Avoids social situations	❑ Social situations cause anxiety/panic	
Panic Attacks? ❑ Better ❑ Same ❑ Worse ❑ No Symptoms Rating Scale: 1 2 3 4 5 6 7 8 9 10 ❑ Daily ❑ Few days/week ❑ Occasionally	❑ Palpitations/heart racing ❑ Sweating ❑ Trembling/shaking ❑ Nausea/vomiting	❑ Shortness of breath ❑ Feeling of choking ❑ Chest pain/discomfort ❑ Hot/cold flashes	❑ Dizziness ❑ Fear of losing control ❑ Fear of dying
Traumatic Stress? ❑ Better ❑ Same ❑ Worse ❑ No Symptoms Rating Scale: 1 2 3 4 5 6 7 8 9 10 ❑ Daily ❑ Few days/week ❑ Occasionally	❑ Ongoing recollections ❑ Distressing dreams ❑ Acting/feeling event again ❑ Distress to seeing resemblances ❑ Attempts to avoid thoughts ❑ Difficulty feeling happy	❑ Irritability/anger ❑ Reckless behavior ❑ Hypervigilant ❑ Less interest ❑ Feeling detached	❑ Startled responses ❑ Neg. beliefs self/others/world ❑ Attempts to avoid reminders ❑ Attempts to avoid reminders of the event
Focusing Issues? ❑ Better ❑ Same ❑ Worse ❑ No Symptoms Rating Scale: 1 2 3 4 5 6 7 8 9 10 ❑ Daily ❑ Few days/week ❑ Occasionally	❑ Lack of attention to detail ❑ Doesn't listen when spoken to ❑ Not finishing tasks ❑ Disorganized ❑ Avoids tedious tasks	❑ Loses things ❑ Easily distracted ❑ Forgetful ❑ Fidgets/squirms ❑ Unable to play quietly	❑ Often "on the go" ❑ Talks excessively ❑ Blurts out answers ❑ Difficulty waiting turn ❑ Interrupts others
Behavior Issues? ❑ Better ❑ Same ❑ Worse ❑ No Symptoms Rating Scale: 1 2 3 4 5 6 7 8 9 10 ❑ Daily ❑ Few days/week ❑ Occasionally	❑ Loses temper ❑ Argues with adults ❑ Defiant ❑ Annoys others	❑ Blames others ❑ Easily annoyed ❑ Angry/resentful ❑ Spiteful/vindictive	
Aggressive? ❑ Better ❑ Same ❑ Worse ❑ No Symptoms Rating Scale: 1 2 3 4 5 6 7 8 9 10 ❑ Daily ❑ Few days/week ❑ Occasionally	❑ Severe temper ❑ Temper outbursts ❑ Frequently irritated ❑ Verbal aggression ❑ Physical aggression	❑ Property destruction ❑ Hitting ❑ Kicking ❑ Biting ❑ Throwing objects	❑ Explosive anger ❑ Easily triggered ❑ Frequently angry

Taking medication regularly? ❑ Yes ❑ Irregular ❑ Stopped ❑ Refused

Medication Side Effects: _____

Sleep: ❑Good ❑Difficulty falling ❑Difficulty staying ❑Early wakening ❑Excessive

Recent stressors: ❑ Employment ❑Relationship ❑Grief/loss ❑Physical health ❑Financial ❑Other: _____

Thoughts of harming self? ❑Yes ❑No If **YES**, since last visit? ❑Yes ❑No

Thoughts of harming others? ❑Yes ❑No If **YES**, since last visit? ❑Yes ❑No

Office use only: ❑ C-SSRS ❑New ❑ 120
Staff Signature:_____

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Random Drug Screen Policy

Effectively immediately, SSPC will be conducting random drug screenings on all patients at a minimum of two times per year as per insurance guidelines.

PLEASE NOTE: Patients with commercial insurance may receive a bill from Quest Labs as per individual insurance plans.

Drug screens are not optional. If selected, a patient will be required to provide a urine sample prior to being seen by the physician. SSPC has the right to discharge a patient refusing to participate in random drug screenings.

Drug screening results that are inconsistent with current medications, either prescription medications are absent or medications that are not prescribed are present, may lead to one of the following:

- **Patient may be subject to additional random drug screenings.**
- **Patient may be asked to perform a drug screening at each visit.**
- **Patient may be discharged, depending upon nature of results.**

Your signature verifies your understanding of the practice drug screening policy.

PRINTED name of Patient or Authorized Parent/Guardian	Date
SIGNATURE of Patient or Authorized Parent/Guardian	Date
Staff Signature	Date

stepping stones psychiatric care

1370 Washington Pike Ste. LL8
Bridgeville, PA. 15017

SSPC TELEHEALTH SERVICES

In response to providing optimal **Telehealth** services, **Stepping Stones Psychiatric Care** continues to implementing measurements to protect your privacy and follow through with HIPAA regulations.

Our service providers: Psychiatrist, PA's & Therapists, **will send a link to your email or a text message to your "best" phone number in the system** to connect with you via our HIPAA compliant **ICANotes** computer service. This will allow access to video/voice communication and ensure a confidential and protected session appropriately.

- The Psychiatrist, Physician Assistants & Therapists will reach out to you from our current office location in Bridgeville, to ensure privacy and client information protection & confidentiality.
- We know that life is busy, and you are important to us! We recommend that you find a quiet, private and confidential area where you can actively participate and engage in your session and make the best of it without being disrupted or bothered by onlookers, kids, coworkers, etc.!
- It is also recommended that you ensure that any updates in your computer, cellphone or any other devices that you might use for the session have been completed so that they do no attempt to update in the middle of the session while you are talking.
- **Only the service provider and the patient [and guardian in case of a minor] should be present.**
- **By scheduling, answering the call or connecting via the link sent to your email you are consenting to actively participating in the session.**
- **Because technology can be unpredictable at times -** If the video service is not available, signal isn't optimal, we can't hear you, etc., a regular phone call will be attempted. If neither service is successful [possible delays in service, need to travel, or risks associated with not having the services] the appointment can be rescheduled for another day as a **Telehealth** appointment or an **In-person** appointment.
- **As a patient it is your right to accept or decline participating in Telehealth services in each session. If that was the case, we do have the option of In-person appointments to facilitate interaction and avoid technology disruptions.**

_____ _____

Patient's Signature Date

_____ _____

Parent or Legal Guardian [if a minor] Date

Place sticker

Scribe Consent

Here at ***Stepping Stones Psychiatric Care*** our psychiatrist works with a scribe that assists in documenting your sessions. The following is consent that you are willing and okay with a scribe being present during your sessions both in person and telehealth. **You are able to revoke this consent either verbally or in writing at any time with any staff member.**

*****Patient has been informed of the use of a scribe during their treatment session(s) and has provided verbal agreement to participate in treatment. These sessions can be offered either **"IN PERSON" or "TELEHEALTH"** and this consent will be applicable to both services.*

_____ _____

Patient's Name / Signature Date

_____ _____

[If a minor] Parent / Legal Guardian / Signature Date

1370 Washington Pike Ste. LL8 Bridgeville, PA. 15017 I Phone: 412.221.7770 I Fax: 412-221-7773

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Client Assessment for Adults/Adolescents/Children

Presenting Information and Current Symptoms:

What are the main reasons you are seeking psychiatric treatment?

_____

_____

When did the problem(s) first begin?

_____

_____

Please list your current symptoms that you feel are problematic or inhibit you from living your daily life.

_____

_____

Please indicate if any of the following medical and psychiatric symptoms are present (P), or not present (NP):

Convulsions/Seizures	P	NP	Allergies	P	NP	Sadness/Moodiness	P	NP
Vision Problems	P	NP	Chronic Pain	P	NP	Anxiety	P	NP
Nausea/Vomiting	P	NP	Dizziness/Fainting	P	NP	Hyperactivity	P	NP
Constipation/Urinary problems	P	NP	Thyroid Problems	P	NP	Inattentiveness	P	NP
Arthritis	P	NP	Sexually Transmitted Disease	P	NP	Obsessive/Compulsive Behavior	P	NP
Hallucinations	P	NP	Asthma	P	NP	Irritability/Anger	P	NP
Social Discomfort	P	NP	Cough/Asthma	P	NP	Homicidal/Suicidal Thoughts	P	NP
Poor Memory/Confusion	P	NP	Hearing Problems	P	NP	Sleep Problems	P	NP
Panic Attacks	P	NP	Diabetes	P	NP	Paranoia	P	NP
Addiction	P	NP	Headaches	P	NP	Mood Swings	P	NP

Does the patient have any allergies?

Food: _____

Drug: _____

Seasonal/Environmental Allergies: _____

Other Allergy (please explain): _____

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Personal Medical/Surgical History:

Do you have any **current** or **past** medical conditions? Please explain.

Please list any surgeries the patient has had in their lifetime, and indicate dates if possible.

Have you experienced any traumatic injuries/accidents? If yes, please explain and include dates if possible.

Please indicate if the patient has taken any of the following psychoactive medications or is currently being prescribed them by another practice. In the blank box next to the medications, please indicate an "H" for Helpful, and "NH" for not helpful, for each medication the patient has previously tried. If the medication has not been tried by the patient, please leave the box blank.

Mood Stabilizers	**Currently Taking (C) Past Medication (P)**	**Helpful (H) Not Helpful (NH) Please circle**	**Medication Dose**	**Side Effects Experienced or circle "None"**
Geodon	C P	H NH		None
Abilify	C P	H NH		None
Depakote	C P	H NH		None
Risperdal	C P	H NH		None
Seroquel	C P	H NH		None
Lithium	C P	H NH		None
Tegretol	C P	H NH		None
Haldol	C P	H NH		None

Anti-Depressants	**Currently Taking (C) Or Past Medication (P)**	**Helpful (H) or Not Helpful (NH) Please circle**	**Medication Dose**	**Side Effects Experienced or circle "None"**
Trazodone	C P	H NH		None
Zoloft	C P	H NH		None
Prozac	C P	H NH		None
Cymbalta	C P	H NH		None
Celexa	C P	H NH		None
Lexapro	C P	H NH		None

Stimulants	**Currently Taking (C) Or Past Medication (P)**	**Helpful (H) or Not Helpful (NH) Please circle**	**Medication Dose**	**Side Effects Experienced or circle "None"**
Ritalin	C P	H NH		None
Adderall	C P	H NH		None
Concerta	C P	H NH		None
Vyvanse	C P	H NH		None
Straterra	C P	H NH		None

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Other Psychiatric Medications				

Please list all non-psychiatric medications currently taken by the patient:

Does the patient have a family history of any medical conditions? Please explain.

Family Psychiatric History:

Are the following members of your family currently or have previously been treated for any psychiatric conditions?

Mother:

Father:

Siblings:

Is there a family history of suicide or attempted suicide? Yes ☐ No ☐ If yes, please explain:

Are you experiencing conflict within your family? Yes No (Please circle) If yes, please explain:

Patient Psychiatric History:

Are you currently participating in any psychiatric care at another facility? Yes ☐ No ☐
If yes, where and what service?

Do you have a previous history of psychiatric care that you are no longer participating in? Yes ☐ No ☐
If yes, please explain:

Please list any previous Psychiatrists, Psychologists, or Therapists that the patient has seen:

Name or Facility	Dates Seen (mm/yy-mm/yy)	Medications Prescribed	Hospitalized? (yes/no, location)

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Social History:

Please detail the Patient's circumstances for the following:

Gender Identity: ☐Female ☐Male ☐ Transgendered ☐ Other:_____

Sexual Orientation: ☐Gay ☐Lesbian ☐Queer ☐Bisexual ☐Heterosexual ☐Pansexual ☐Other:_____

Marital History: ☐ Married ☐ Single ☐ Divorced ☐ Widowed

Children: ☐No Children ☐Children

Living Situation: ☐ Living Dependently ☐ Living Independently ☐ Homeless

Support System (Family, friends, etc.): _____

Military History: ☐Never in Military ☐Military Experience If yes, what branch?_____Do you have combat related trauma?_____

Are you financially secure (do you have food, shelter, water, clothes, ect)? Yes No (If no, please explain:_____
_____)

Are you employed? Please circle one: Full-time Part-time Disability Retired In school Recently lost job
Other:_____

If employed, what do you do for a living? _____

Do you have any current legal charges? ☐No ☐Yes
If yes, are you:
Currently on Probation? ☐No ☐Yes
Court ordered for Psychiatric Treatment? ☐No ☐Yes
Have an upcoming hearing? ☐No ☐Yes
Registered on Megan's Law? ☐No ☐ Yes

Education (Level achieved/performance) Please circle one: Elementary Highschool Trade School Some College College Degree

If the patient is enrolled in elementary school, middle school, or high school, please answer the following questions. If the patient is not enrolled in any of the above, please skip this section and move on to "History of Abuse and Traumatic Events".

Marital status of parents: _____If parents are separated/divorced, how old was child at time of separation? _____

With whom does the child live? _____

Custody: ☐Lives in one home with both legal parents. ☐Mother has physical custody.
☐Father has physical custody. ☐Physical custody is shared. ☐Other: _____

List all people living in household:

Name	Age	Relationship to child

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Please mark next to any behavior or problem that your child currently exhibits.

_____Has difficulty with speech
_____Has difficulty with hearing
_____Has difficulty with language
_____Has difficulty with vision
_____Has difficulty with coordination
_____Prefers to be alone
_____Does not get along well with other children
_____Is aggressive
_____Is shy or timid
_____Has poor bowel control (soils self)
_____Is more interested in things (objects) than in people
_____Engages in behavior that could be dangerous to self (describe) _____

_____Has frequent tantrums
_____Has frequent nightmares
_____Has trouble sleeping (describe) _____
_____Has blank staring spells
_____Rocks back and forth
_____Bangs head
_____Holds breath
_____Eats poorly
_____Is stubborn
_____Is much too active

How do you describe the child's friendships:
☐No Friends ☐Only Acquaintances ☐Both acquaintances and close friends

School: _____Grade: _____
Place a check mark next to any educational problem that your child currently exhibits:
Check -
_____Has difficulty with reading
_____Has difficulty with arithmetic list) _____
_____Has difficulty with spelling _____
_____Has difficulty with writing
_____Does not like school
Is your child in a special education class? Yes _____No _____
If yes, what type of class? _____

Has your child been held back in a grade? Yes _____No _____
If yes, what grade and why? _____

Has your child ever received special tutoring or therapy in school? Yes _____No _____
If yes, please describe: _____

Has your child ever been suspended or expelled? Yes _____No _____
If yes, please describe: _____

Has, or is, your child experiencing bullying? Yes_____ No_____ If yes, please explain:_____

History of Abuse and Traumatic events (Please circle Y or N):

Physical Abuse: Yes No

Emotional Abuse: Yes No

Sexual Abuse: Yes No

Domestic Violence: Yes No

Witnessed Domestic Violence: Yes No

Witnessed a traumatic event: Yes No

Neglect: Yes No

Experienced a death of a loved one: Yes No

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If yes to any of the above, is the abuse (please circle): In the past or Current or Both

Do you feel safe in your current living situation? Yes No If you answered no, please explain:_____

If you answered "yes" to any of the above abuse questions, please answer the following questions.

* Have you had any unwanted memories of the traumatic event while you were awake? Yes No
* Have you experienced any unpleasant dreams about the traumatic event? Yes No
* Have there been times when you suddenly acted or felt as if the traumatic even were actually happening again? Yes No
* Have you gotten emotionally upset when something reminded you of the event? Yes No
* Have you had strong negative beliefs about yourself, other people, or the world? Yes No
* Have you blamed yourself for the traumatic even or what happened as a result of it? Yes No
* Have you had any strong negative feelings, such as fear, horror, anger, guilt, or shame? Yes No
* Have you been less interested in activities that you used to enjoy? Yes No
* Have you been especially alert of watchful, even when there was no specific threat or danger? Yes No
* Have you had any strong startle reactions? Yes No
* Have you had any problems with concentration? Yes No
* Have you had any problems falling asleep? Yes No

Have you experienced a recent loss? Yes No
If yes, please briefly explain the loss:_____

If there anything else that you feel I should know regarding your trauma history: Yes No
If yes, please explain: _____

History of Substance Abuse:

Has the patient **previously or is the patient currently** abusing any of the following substances? Please note, this information is protected and will not be shared without written consent from the patient.

Substance Type	**Current Use (Last 6 Months)**			**Past Use**		
	Y	N	Frequency/Amount	Y	N	Frequency/Amount
Alcohol						
Tobacco						
Marijuana						
K2/Spice						
Cocaine/Crack						
Ecstasy						
Methamphetamines						
Pain Medication/Rx Meds						
Inhalants						
Heroin						
Xanax/Valium/Klonopin						
PCP/LSD						
Steroids						
Tranquilizers						
Other:						

Do you use tobacco? Yes No (If yes, what do you use and how often:_____)
Do you have a history of overdose? Yes No (If yes, when and with what substance:_____)

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Do you have a history of withdrawal symptoms? Yes No (If yes, what substance and what symptoms:_____
_____)
Do you have a history of withdrawal seizures? Yes No (If yes, when:_____)
Do you have a history of sharing needles? Yes No
Have you ever been to an inpatient detox unit? Yes No (If yes, where and when:_____)

Does anyone important to you believe you a problem with substances? Yes No (If yes, please briefly explain:_____
_____)

Have you ever participated in outpatient drug and alcohol tx? Yes No (If yes, where and when:_____)
Have you ever been to an inpatient rehab? Yes No (If yes, where and when:_____)

Developmental History:

Has the patient ever been diagnosed with a learning disability? ☐ Yes ☐ No
If yes, please explain:

_____

_____

Does the patient have problems reading and/or writing? ☐ Yes ☐ No

If yes, please explain:

_____

_____

Are the patient's motor skills inhibited in any way? If yes, please explain:

_____

Did the patient reach all developmental milestones at age appropriate at appropriate times (i.e.: crawling, talking, toilet training)?

_____

Is there anything else that you feel I should know about you before engaging in treatment? Yes No
If yes, please explain:_____
_____
_____

The patient/authorized parent or guardian authorizes that the information provided in this document is true to the best of my knowledge, but also retain the ability to modify my response at any time. The clinician understands that this information may change at any time.

_____ _____
PRINTED name of Patient or Authorized Parent/Guardian Date

_____ _____
SIGNATURE of Patient or Authorized Parent/Guardian Date

_____ _____
SIGNATURE of Therapist Date