



Dear Patient:

Thank you for choosing the Dent Neurologic Institute, Western New York's premier Neurologic and Diagnostic Center.

**Patients are required to arrive 30 minutes prior to their appointment time for the initial consultation. This time will be used to complete the registration process. Thank you for your understanding!**

In order to ensure a positive experience, please be prepared with the following items on the day of your visit. Failure to comply may result in our need to reschedule your visit.

- ★ **Documents:** You must complete all the enclosed documents prior to your appointment time. **COMPLETION OF YOUR MEDICAL INTAKE FORMS IS CRITICAL IN ORDER FOR OUR PHYSICIANS APPROPRIATELY TREAT AND DIAGNOSIS.** If your visit is related to a work or motor vehicle accident, you must complete the application forms in their entirety.
- ★ **Payment:** If you have a co-pay or high deductible plan, you must bring payment with you; if you have a high deductible plan \$200 is required at the time of service; any remaining responsibility will be billed to you.
- ★ **Insurance Card:** You must provide us with your insurance card.
- ★ **Identification:** You must provide us with photo ID or two other forms of identification.
- ★ **Diagnostic Results:** Test results, diagnostic reports, films and CDs from all physicians treating you are **REQUIRED** at visit.

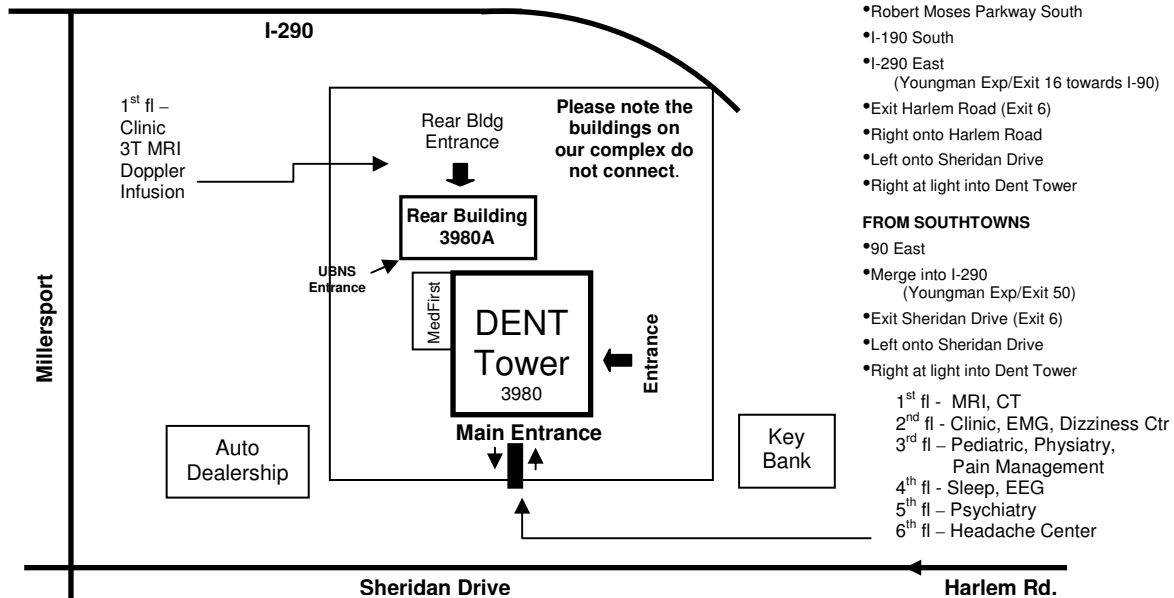
Be sure to visit our website at [www.dentinstitute.com](http://www.dentinstitute.com) for insurances we accept and access to your on-line secured medical record.

Once again, thank you for choosing the Dent Neurologic Institute. If you have any questions, please feel free to call our Center at 716-250-2000.

**Advance Notice is Required for all Cancellations**

***If you fail to cancel an appointment at least one business day prior; or you do not show for your scheduled appointment, you will be assessed a non-timely cancellation fee.***

**Amherst Location  
3980 Sheridan Drive**



**FROM NIAGARA FALLS/NORTHTOWNS**

- Robert Moses Parkway South
- I-190 South
- I-290 East (Youngman Exp/Exit 16 towards I-90)
- Exit Harlem Road (Exit 6)
- Right onto Harlem Road
- Left onto Sheridan Drive
- Right at light into Dent Tower

**FROM SOUTHTOWNS**

- 90 East
  - Merge into I-290 (Youngman Exp/Exit 50)
  - Exit Sheridan Drive (Exit 6)
  - Left onto Sheridan Drive
  - Right at light into Dent Tower
- 1<sup>st</sup> fl - MRI, CT  
 2<sup>nd</sup> fl - Clinic, EMG, Dizziness Ctr  
 3<sup>rd</sup> fl - Pediatric, Physiatry, Pain Management  
 4<sup>th</sup> fl - Sleep, EEG  
 5<sup>th</sup> fl - Psychiatry  
 6<sup>th</sup> fl - Headache Center

<p><b>Orchard Park</b>                  200 Sterling Drive                  Orchard Park, New York 14127</p> <p><b>FROM SOUTHTOWNS</b>                  Route 219 N to Milestrip Road East                  (1st Exit onto Milestrip Road)                  Left at traffic light onto Sterling Drive                  Left on Red Tail                  Left into parking lot</p> <p><b>FROM BUFFALO</b>                  Thruway (90) West to Route 219                  Exit Milestrip Road East                  (2nd Exit onto Milestrip Road)                  Left at traffic light onto Sterling Drive                  Left on Red Tail                  Left into parking lot</p> <p><b>FROM PENNSYLVANIA</b>                  Thruway (90) East to Exit 56                  Left onto Milestrip Road                  Left onto Sterling Drive                  Left on Red Tail                  Left into parking lot</p>	<p><b>Batavia</b>                  35 Batavia City Center                  Batavia, New York 14020</p> <p>Located in the                  Genesee Country Mall</p> <p>Note: Use entrance on Main Street between                  the Dental and Insurance offices.</p>
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**DENT NEUROLOGIC INSTITUTE 716.250.2000**

# DENT NEUROLOGIC INSTITUTE

## REGISTRATION FORM

<b>Today's Date:</b>						
<b>PATIENT INFORMATION</b>						
<b>Last Name:</b>	<b>Middle:</b>	<b>First:</b>	<input type="checkbox"/> Mr. <input type="checkbox"/> Mrs.	<input type="checkbox"/> Miss <input type="checkbox"/> Ms.	<b>Marital Status (circle one):</b> Single / Mar / Div / Sep / Wid	
<b>Former Name:</b>		<b>Birth Date:</b>	<b>Age:</b>	<b>Sex:</b>		<b>Transgender:</b>
				<input type="checkbox"/> M	<input type="checkbox"/> F	<input type="checkbox"/> T
<b>Street Address or P.O. Box:</b>		<b>E-mail Address:</b>		<b>Home Phone:</b> ( )		
				<b>Cell Phone:</b> ( )		
<b>City:</b>	<b>State:</b>	<b>Zip Code:</b>		<b>Social Security Number:</b>		
<b>Referring Physician:</b>		<b>Primary Physician:</b>				
<b>Occupation:</b>	<b>Employer:</b>			<b>Employer Phone:</b> ( )		
				<input type="checkbox"/> Full Time <input type="checkbox"/> Part Time		
<b>Race:</b>	<b>Ethnicity:</b>			<b>Language:</b>		
<b>Pharmacy Name:</b>	<b>Pharmacy Address:</b>			<b>Pharmacy Phone:</b>		
<b>CONTACT PERSON IN CASE OF EMERGENCY</b>						
<b>Name:</b>		<b>Relationship:</b>		<b>Home Phone:</b> ( )	<b>Work Phone:</b> ( )	
<b>INSURANCE INFORMATION</b>						
<b>You will need to give your insurance card to the receptionist</b>						
<b>Person Responsible for Bill (if not self):</b>		<b>Address (if different):</b>			<b>Home Phone:</b> ( )	
					<b>Cell Phone:</b> ( )	
<b>Birth Date:</b> /    /		<b>Occupation:</b>				
<b>Responsible Party's Employer:</b>	<b>Employer Address:</b>			<b>Employer Phone:</b> ( )		
<b>PRIMARY INSURANCE</b>						
<b>Insurance Plan:</b>						
<b>Policy No:</b>			<b>Group No:</b>			
<b>Subscriber's Name (if not self):</b>		<b>Subscriber's SSN:</b>			<b>Co-pay Amount:</b>	
		<b>Subscribers DOB:</b> /    /				
<b>Patient's Relationship to Subscriber:</b>	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		
<b>SECONDARY INSURANCE</b>						
<b>Insurance Plan:</b>						
<b>Policy No:</b>			<b>Group No:</b>			
<b>Subscriber's Name (if not self):</b>		<b>Subscriber's SSN:</b>				
		<b>Subscribers DOB:</b> /    /				
<b>Patient's Relationship to Subscriber:</b>	<input type="checkbox"/> Self	<input type="checkbox"/> Spouse	<input type="checkbox"/> Child	<input type="checkbox"/> Other		

**IF YOUR APPOINTMENT IS THE RESULT OF AN ACCIDENT OR INJURY,  
YOU MUST COMPLETE THE ENCLOSED NO-FAULT OR WORKERS COMP FORM**

# PLEASE READ

## Important Insurance Plan Information

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Before being seen, please review the following insurance participation information. Deductibles, co-insurances and co-pays are due at time of service. Estimated cost of an office visit ranges from \$75 - \$200; estimates for office procedures will be provided separately. If you have any questions or would like to receive an estimate for services, please call our Business Office at 250-2010.

### **DENT Participates with:**

- Blue Cross Blue Shield (including Align programs)
- Empire
- Fidelis (**Not Accepting New Adult Patients**)
- Independent Health
- MagnaCare (including Health Republic)
- MVP (excluding Individual Exchange plans)
- Nova
- RMSCO (aka Lifetime Benefits Solutions)
- United Healthcare (Commercial and Medicare plans only)
- Univera
- Medicare and Medicare Railroad
- NYS Medicaid
- Wellcare (**Not Accepting New Patients**)
- Excellus/Blue Cross Plans (does not include Medicare Blue Choice Value/ Optimum or Monroe Medicaid plans)
- Martin's Point (varies by doctor)
- YourCare

### **DENT does NOT Participate with:**

- Aetna (unless part of MultiPlan which varies by doctor)
- Cigna (unless part of MultiPlan which varies by doctor)
- Coventry/Health America
- Emblem Health/GHI -Imaging ONLY
- Excellus Plans (Premier Option)
- MVP (Individual Exchange plans)
- MultiPlan (varies by doctor)
- UPMC
- United Healthcare (Medicaid plans)
- Out of State Medicaid

In every case we will bill your insurance carrier on your behalf. Based on participation status you may have additional out-of-pocket expenses. We recommend you call your carrier directly to verify individual physician coverage.

Your insurance carrier may require you to utilize a specific laboratory testing facility. Please be sure to confirm this with the office staff.

Hospital Affiliations: Kaleida Health; Mercy Hospital of Buffalo

## PLEASE REVIEW AND SIGN OUR PRACTICE POLICIES

**Insurance Information/Assignment of Benefits.....** Patients are required to provide DENT with current and accurate insurance information at every visit. Your **FAILURE** to provide us with accurate information will result in a patient bill that you may be held responsible for. By signing below, you authorize DENT to furnish information to insurance carriers concerning your illnesses and treatments and hereby assign all payments for medical services rendered to you or your dependents to Dent Neurologic. Furthermore, you will be held responsible for any amount not covered by your insurance plan.

**Co-Pay, Deductibles, POS Plans, Private Payments and Unpaid Balances.....** In accordance with the provision of your insurance plan, you may be required to pay for a portion or all of your medical services. As a result, if you have a co-pay, deductible, or Point of Service Plan or you are a private paying patient, **payment is required at the time of service.** Should you need to discuss this payment policy, you may contact our Business Office at 250-2010 prior to your appointment. Please note it is within our discretion to take current payments and apply them to existing unpaid balances or move credit balances to future appointments. If for any reason, you maintain an unpaid balance on your account and fail to work out a payment arrangement with us, after 90 days your account will be turned over to a collection agency, proceedings will begin and you will be discharged from our care. Accounts sent to collections will have a 30% collection fee added to the balance along with applicable attorney fees.

**Identity Theft.....** The Federal Trade Commissions, “Red Flag” rule requires health care providers to establish a program to prevent identity theft. As a result we will be asking all patients to provide photo identification when checking in for their appointment and will be taking a photograph to be used for the sole purpose of identification. If you are unable to provide us with proper identification at the time of your visit, we will need to **RESCHEDULE** your appointment.

**Practice Communication Information.....** Patients in our practice may be contacted via phone, email, and/or text messaging to remind of appointments, payment, treatment, and/or other healthcare information. By entering information below, you consent to receiving these communications from us:

Send reminders/information ( <i>select all that apply</i> ):	<input type="checkbox"/> Voice ( ) -
	<input type="checkbox"/> SMS/text ( ) -
	<input type="checkbox"/> E-mail address: _____
	<i>Note: reminders not available via e-mail</i>
Preferred Phone Number ( <i>select one</i> ):	<input type="checkbox"/> Home <input type="checkbox"/> Cell <input type="checkbox"/> Work
Preferred Language ( <i>select one</i> ):	<input type="checkbox"/> English <input type="checkbox"/> Spanish
Best time to contact me ( <i>select one</i> ):	<input type="checkbox"/> Morning <input type="checkbox"/> Afternoon <input type="checkbox"/> Evening
<input type="checkbox"/> I do NOT wish to receive any reminders or communications from Dent as outlined above. I understand the cancellation and no show policy as outlined below.	

**Medical Photography.....** Medical photography taken for diagnostic purposes will become a part of your medical record and remain confidential in accordance with regulatory requirements and Dent Policy. From time to time we may use de-identified medical imaging or photography for research or academic purposes. Dent retains all ownership rights in these programs.

**Prescription Refills.....** Patients must contact their pharmacies to request any prescription refills for medications that DENT prescribes. In turn, the individual pharmacies will contact our organization with those requests. Please allow 5 business days for medications to be filled. Refills requiring a prior authorization take a minimum of 10 days.

**Appointment Cancellation and No Show Policy.....** Your scheduled appointment is time reserved especially for you. **We require a minimum of 24-hours advance notice for cancellation or rescheduling of an appointment to allow us to offer this time to other patients.** Rescheduling fees are: \$100-Imaging, VNG, Neuropsychology, Sleep Studies. \$50-All other appointments.

**General Consent to Treatment and Right to Refuse Treatment.....** By signing below, I (or my authorized representative on my behalf) authorize DENT Neurologic Institute and its staff to conduct any diagnostic examinations, tests and procedures and to provide any medications, treatment or therapy necessary to effectively assess and maintain my health, and to assess, diagnose and treat my illness or injuries. I understand that it is the responsibility of my individual treating healthcare providers to explain to me the reasons for any particular diagnostic examination, test or procedure, the available treatment options and the common risks and anticipated burdens and benefits associated with these options as well as alternative courses of treatment.

In giving my consent to treatment, I understand that I retain the right to refuse any particular examination, test, procedure, treatment, therapy or medication recommended or deemed medically necessary by my individual treating healthcare providers. I also understand that the practice of medicine is not an exact science and that no guarantees have been made to me as to the results of my evaluation and/or treatment.

**I have read and agree to all of the above policies. I understand that my failure to comply with any of these policies may result in discharge from the medical practice.**

Print Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
 Signature: \_\_\_\_\_ Date: \_\_\_\_\_

## Statement of Financial Responsibility

**Insurance Coverage.\*** The service(s) you have elected to participate in implies a financial responsibility on your part. The responsibility obligates you to ensure payment in full of DENT fees. You are ultimately responsible for payment of your bill.

Due to the increasing complexity of insurance plans, DENT requires you to contact your insurer's Member Services for information on your coverage and out-of-pocket costs. For some services, DENT will collect a fee from you before the service is rendered. That amount will be credited against the cost of that service, but in many cases will not cover the full amount. Your insurance plan is the best place to find information on the ultimate cost to you.

You are responsible for payment of any deductible and co-payment/co-insurance as determined by your contract with your insurance carrier. DENT expects these payments at the time of service. Many insurance companies have additional stipulations that may affect your coverage. If your insurance carrier denies any part of your claim, or if you or your physician elects to continue past your approved service period, you will be responsible for your balance in full.

Your signature below will also authorize your insurer to pay any benefits directly to DENT, the full and entire amount of the bill incurred by you or the named patient, or if applicable, any amount due after payment has been made by your insurance carrier.

**Co-Pay Policy.** It is expected that patients will pay co-pays at the time the service is rendered for each visit, typically during check-in.

**Cancellation / No Show Policy.** DENT understands there may be times when you miss an appointment due to emergencies or other obligations. However, patients who fail to provide adequate cancellation notice, at least 24 hours prior to the appointment time will be assessed a \$50 reschedule fee (NOTE: \$100 for Sleep Center, Neuropsychology testing and VNG testing appointments). All assessed fees are collected at the time of scheduling the next appointment. Patients will not be able to reschedule an appointment until all fees are paid.

By signing below, you acknowledge that you have read the above policies regarding financial responsibility to DENT for providing health care services to you or the named patient and that you understand and agree to the terms described.

Patient Name (please print): \_\_\_\_\_ DOB: \_\_\_\_\_

Patient or Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

\*Patients with No Fault or Workers Compensation coverage will be handled in compliance with New York State law with regard to payment and benefits.

**HEALTH INSURANCE PORTABILITY & ACCOUNTABILITY ACT (HIPAA)  
DENT NEUROLOGIC INSTITUTE  
Acknowledgement of Receipt of Privacy Notice  
And Restrictions/Permissions**

A copy of DENT Neurologic Institute's Notice of Privacy Practices detailing how my information may be used and disclosed as permitted under federal and state laws has been made available to me.

I understand the contents of the Notice and I request the following exceptions:

**RESTRICTIONS:**

Please restrict the use and disclosure of my protected health information as follows:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**PERMISSIONS:**

I give permission to the following individuals to view, discuss, exchange, and/or receive my protected health information:

Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_  
Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

I authorize DENT Neurologic Institute and the DENT Neurosciences Research Center (DNRC) to access my health data and use my protected health information for clinical research purposes.

\_\_\_\_\_ **Yes**, DENT and DNRC may use my information to conduct clinical research.

**Initial Here**

*This notice and consent will remain in effect until revoked in writing.*

Patient Name (print): \_\_\_\_\_ DOB: «DOB»  
**Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

If signed by a person other than the patient, please indicate relationship: \_\_\_\_\_

**NOTE: Power of Attorney and Legal Guardianship documents are required at the time of your appointment if you are signing on behalf of a patient over the age of 18.**

**DENT NEUROLOGIC INSTITUTE**  
**WORKERS COMPENSATION**  
 SUPPLEMENTAL INFORMATION FORM

Today's Date:		Date of Birth:	
Patient Name:		Social Security No:	
Date of Injury:			
Employer Name:		Employer Address:	
Employer Phone Number:  (    )	Your Job Title:	Are you out of work due to this injury:  <input type="checkbox"/> Yes <input type="checkbox"/> No	
<b>COMPENSATION INSURANCE CARRIER INFORMATION</b>			
Insurance Carrier Name:		Insurance Carrier Address:	
Carrier Claim Number:		WCB Case Number:	
Name of Case Manager:		Phone: (    )	
		Fax: (    )	
Briefly Describe the Injury you Sustained:			
Briefly Describe how Injury Occurred:			
<b>ATTORNEY INFORMATION</b>			
Attorney Name:		Attorney Address:	
Phone: (    )		Fax: (    )	
<b>Please bring all Insurance Carrier and Workers Compensation Board information with you to your appointment. We may need to reschedule your appointment should you fail to include critical information concerning your Carrier.</b>			



# DENT NEUROLOGIC INSTITUTE

## NO-FAULT

### SUPPLEMENTAL INFORMATION FORM

Patient Name:		Date of Birth:
		Social Security No:
Date of Accident:	Are You Currently Out of Work as a Result of this Accident: <input type="checkbox"/> Yes <input type="checkbox"/> No	
Injury Sustained:		
<b>INSURANCE CARRIER INFORMATION</b>		
Insurance Carrier Name:		Insurance Carrier Address:
Name of Adjuster:	Claim Number:	
Phone: (    )	Fax: (    )	
<b>ACCIDENT DETAILS</b>		
Location of Accident:		
Briefly Describe how the Accident Occurred:		
Were you a: <input type="checkbox"/> Driver <input type="checkbox"/> Passenger <input type="checkbox"/> Pedestrian		
If Driver or Passenger, were you: <input type="checkbox"/> Belted <input type="checkbox"/> Not-Belted		
Have you Filed a Claim with your Carrier: <input type="checkbox"/> Yes <input type="checkbox"/> No		Have you Completed and Returned your No-Fault Application: <input type="checkbox"/> Yes <input type="checkbox"/> No
<b>ATTORNEY INFORMATION</b>		
Attorney Name:		Attorney Address:
Phone: (    )	Fax: (    )	
<b>Signature:</b>		<b>Date:</b>
<b>FOR OFFICE USE ONLY</b>		
<b>PROVIDER:</b> DENT NEUROLOGIC GROUP PO Box 8000 Dept 057 Buffalo, NY 14267		<b>CLAIM#</b> _____ <b>DATE OF LOSS:</b> _____ <b>CARRIER:</b> _____
<b>Signature:</b> _____		

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**DNI Psychiatric Clinic  
Consent for Evaluation and/or Treatment**

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1. **Consent to Evaluate/Treat:** I voluntarily consent that I will participate in a mental health (e.g. psychological or psychiatric) evaluation and/or treatment by staff from DENT Neurologic Institute. I understand that following the evaluation and/or treatment, information will be provided concerning each of the following areas:
- a. The benefits of the proposed treatment
  - b. Alternative treatment modes and services
  - c. The manner in which treatment will be administered
  - d. Expected side effects from the treatment and/or the risks of side effects from medications (when applicable).
  - e. Probable consequences of not receiving treatment

The evaluation or treatment will be conducted by a psychiatrist, a psychologist, a physician assistant, a nurse practitioner, a licensed social worker or an individual supervised by any of the professionals listed.

2. **Benefits to Evaluation/Treatment:** Evaluation and treatment may be administered with psychological interviews, psychological assessment or testing, psychotherapy, medication management, as well as expectations regarding the length and frequency of treatment. It may be beneficial to me, as well as the referring professional, to understand the nature and cause of any difficulties affecting my daily functioning, so that appropriate recommendations and treatments may be offered. Uses of this evaluation include diagnosis, evaluation of recovery or treatment, estimating prognosis, and education and rehabilitation planning. Possible benefits to treatment include improved cognitive or academic/job performance, health status, quality of life, and awareness of strengths and limitations.
3. **Charges:** Fees are based on the length or type of the evaluation or treatment, which are determined by the nature of the service. I will be responsible for any charges not covered by insurance, including co-payments and deductibles.
4. **Release of Information Consent:** Specific description of information to be used or disclosed under this consent for the purpose of continuity of care to referring / primary care physician: diagnosis, presence in treatment, recent medical exam results, lab test results, treatment recommendations, prescribed medications, diagnoses, follow up recommendation, treatment plan and progress.
5. **Right to Withdraw Consent:** I have the right to withdraw my consent for evaluation and/or treatment at any time by providing a written request to the treating clinician. The withdrawing of my consent for this treatment will not prejudice my continued treatment relationship.
6. **Expiration of Consent:** This consent will remain valid as long as I am an active patient in the Psychiatry Clinic at the DENT Neurologic Institute.

**I have read and understand the above, have had an opportunity to ask questions about this information, and I consent to the evaluation and treatment. I also attest that I have the right to consent for treatment. I understand that I have the right to ask questions of my service provider about the above information at any time.**

\_\_\_\_\_  
**Print Name**

\_\_\_\_\_  
**Signature of Patient**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of Parent / Legal Guardian**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Signature of witness**

\_\_\_\_\_  
**Date**

# CONTROLLED SUBSTANCE AGREEMENT

## Purpose

The purpose of this agreement is to make you aware of our policy regarding controlled substances which exist in order to provide education regarding controlled substances and maintain compliance with state and federal laws and regulations. You are being asked to sign this agreement in the event that a controlled substance is prescribed for you.

## Definition of Controlled Substance

Controlled substances include, but are not limited to: opiate and opiate-like pain medications, sedative-hypnotics, benzodiazepines, barbiturate or barbiturate-like medications, stimulant and stimulant-like medications, some anti-seizure medications, and testosterone supplementation.

## Controlled Substance Education

- This treatment may increase my ability to function and/or reduce my pain.
- There are other types of treatments that do not involve controlled substances that include, but are not limited to non-pharmacological therapies, lifestyle changes, and non-controlled medications. I agree to pursue these alternatives if recommended, including treatment for chemical dependency.
- The long-term use of controlled substances is controversial because of uncertainty regarding the extent to which they provide long term benefit.
- I am aware that the following potential side effects of controlled substance medications may apply, but not to all classes of medications. I will inform my provider of any side effects that I have experienced.
  - a. Respiratory depression (breathing too slowly), overdose, or even death. Drugs may be hazardous or lethal to those who are not tolerant to their effects, especially children and animals, to which you must keep medications out of reach.
  - b. Increased Tolerance (require more medication to get the same effect).
  - c. Physical and/or psychological dependence (addiction) may develop. There is also risk of relapse occurring in a person with a prior addiction. Abruptly stopping the medication can trigger symptoms of withdrawal. The extent of this risk is not certain. I agree to inform my provider of any history of alcohol or drug addiction.
  - d. **If I am a female of childbearing age, I agree to inform my doctor immediately if there is a possibility that I might be pregnant.** Physical dependence of newborns whose mothers take these drugs during pregnancy and the possible can vary depending on the type of medication.
  - e. For male patients, low testosterone levels can occur. This may affect mood, stamina, sexual desire and physical/sexual performance.
  - f. Sedation (drowsiness). I agree to follow my providers instructions about engaging in activities that might be dangerous to me such as, operating heavy machinery, driving a motor vehicle, performing tasks on a ladder or any other unprotected height, and taking responsibility for another individual who is unable to care for themselves. I understand that driving while my ability is impaired could result in charges such as DUI or DWI.
  - g. Memory impairment and cognition.
  - h. Possibility that the medication will not provide complete relief. If relief is not provided, continuation is contingent on treatment plan.
  - i. Allergic reaction.
  - j. Taking more than prescribed, taking multiple controlled substances and/or taking controlled substances with alcohol or other illegal substances including, but not limited to: marijuana, cocaine, heroin, or other similar substances can intensify these risks.

## Patient Responsibilities

- I agree to conduct myself in a courteous manner with all of the staff in this office.

Print Name: \_\_\_\_\_

- I agree to provide a complete and accurate medical and legal history including current medical treatment, past medical treatment, medications I am currently taking and medications I have taken in the past (prescription, over-the-counter, and herbal supplements), any history of alcohol or drug addiction, or the possibility that I may become pregnant. I agree to complete a pregnancy test if required.
- I agree that I will not sell, trade, possess illegally, stockpile, share, or transport any controlled substances. I understand that if suspicion of this activity is observed or is suspected by my pharmacy, other treatment providers, or the NYS Prescription Monitoring Program, this will be reported to my provider and may result in termination of treatment.
- I agree to safeguard my controlled medication from theft, loss, damage.
- I agree to take my medications as prescribed, using them only for the intended purpose, as these may be highly sought after by others with chemical dependencies.
- I agree that I will not alter my paper prescriptions (if applicable).
- I will not accept any controlled medications from any other health care provider unless admitted to the hospital or with explicit approval of my treating provider as documented in my medical chart.
- I agree to submit to a blood, saliva, urine test, or pill count (medications should be brought in their original containers) whenever requested by my provider, including at appointments and within 48 hours of a phone call request. I agree that I am financially responsible for the cost of this testing, if not covered by my insurance. Consumption of poppy seeds may put me at risk of a false positive drug screen. This practice will consider this a positive for morphine regardless of poppy seed consumption. I will not tamper with this drug testing in anyway. I understand that drug tests may be witnessed. Evidence of non-compliance may result in discontinuation of medication and/or discharge from this practice.
- I agree to allow my provider to communicate openly with my other treating providers and pharmacists. I understand that the possible misuse, sale, or diversion of controlled substances may result in communication and investigation with NYS Board of Pharmacy, the Bureau of Controlled Substances, the Federal Drug Enforcement Agency, and any other city, county, state, and federal law enforcement agencies. I authorize my provider to issue a copy of this agreement to any of these agencies and to my pharmacy. I understand that I am waiving any applicable privilege, right of privacy or confidentiality concerning requests for my protected health information from these agencies.

### Medication Refills

- I agree to keep and to be on time for all of my scheduled appointments with my provider in order to receive refills of controlled substances. If an appointment cannot be kept, I agree to contact my provider 48 hours prior to my appointment. No refills will be granted if not seen within a maximum of 12 months.
  - Unless requesting medications during your office visit, all requests should be made to your pharmacy. If for some reason your pharmacy requests that you contact your provider, requests may be made only during regular office hours, Monday through Friday. Requests will not be honored on nights, weekends, or holidays.
  - I understand that I must contact my pharmacy or provider 3-7 days prior to running out of my medication. All prescriptions will be electronically prescribed. If a paper prescription is issued at provider discretion, my provider is not responsible for any lost or stolen prescriptions. A replacement prescription may or may not be granted at the discretion of the provider.
  - Early refills will generally not be granted for any reason including, but not limited to theft, loss, damage unless an exception is warranted by your provider.
  - I understand that if I am arrested and/or incarcerated my provider may no longer refill my controlled substances.
  - I agree to use one pharmacy only and to always inform my provider of any change in pharmacy.
- 

Print Name: \_\_\_\_\_

1. I understand that my compliance with the terms of this agreement is essential to the trust and confidence necessary in a provider/patient relationship and that my provider's treatment will be based on this agreement. Failure to comply with all of the conditions in this agreement may result in:
  - a. Danger to my life and health.
  - b. My doctor electing to decrease or to discontinue prescribing any controlled substances. If this occurs, my provider may choose to taper the medicine over a period of several days, to avoid withdrawal symptoms when discontinuing it.
  - c. Discharge from my provider's practice.
2. I understand that if I am no longer able to pay for the medication or treatment prescribed for me, I must not hold my provider or Dent Neurologic Institute responsible.
3. The terms and conditions of this agreement have been fully explained to me. All of my questions and concerns regarding both my treatment and this agreement have been answered to my satisfaction. I have been given a copy of this document.

This agreement is entered into on \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

Patient Name: \_\_\_\_\_

Patient Signature: \_\_\_\_\_

Provider Name: \_\_\_\_\_

Provider Signature: \_\_\_\_\_

Witness Name: \_\_\_\_\_

Witness Signature: \_\_\_\_\_

Today's Date: \_\_\_\_\_

**1. General Information:**

Name: \_\_\_\_\_ Sex: M / F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_  
SS #: \_\_\_\_\_ Marital Status: Single/Married/Separated/Divorced/Widowed  
Name of Referring Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Name of Primary Care Physician: \_\_\_\_\_ Phone #: \_\_\_\_\_  
Name of Therapist/Counselor: \_\_\_\_\_ Phone #: \_\_\_\_\_

**2. Problem: Please write the reason(s) you are seeing a psychiatrist:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have problems with sleep?  Yes  No

If so, what are they? *(mark all that apply)*

- Can't fall asleep  Interrupted sleep  Wake up tired  Sleep too much  
 Legs moving  Snoring  Nightmares

Do you have problems with any of the following? *(mark all that apply)*

- Appetite  Memory  Level of energy  Anxiety/Worry  
 Panic  Staying focused  Distractibility  Irritability  
 Impulsiveness  Racing thoughts

**3. PRIOR PSYCHIATRIC HISTORY:**

Have you ever seen a: *(mark all that apply)*

- psychiatrist  psychologist  therapist  counselor

If so, please list who and when:

Name: \_\_\_\_\_ Dates: \_\_\_\_\_  
Name: \_\_\_\_\_ Dates: \_\_\_\_\_  
Name: \_\_\_\_\_ Dates: \_\_\_\_\_  
Additional names: \_\_\_\_\_

**(PRIOR PSYCHIATRIC HISTORY CONTINUED)**

Have you ever been hospitalized for a psychiatric disorder?  Yes  No

If so, please list where and when:

Facility: \_\_\_\_\_ Dates: \_\_\_\_\_  
Facility: \_\_\_\_\_ Dates: \_\_\_\_\_  
Facility: \_\_\_\_\_ Dates: \_\_\_\_\_  
Facility: \_\_\_\_\_ Dates: \_\_\_\_\_

Additional information: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_





**5. MEDICAL HISTORY:**

Height: \_\_\_\_\_ft. \_\_\_\_\_in.      Weight: \_\_\_\_\_lb.       Left-handed    Right-handed

**Do you have any of the following medical conditions?**

- |   |  |  |                                       |
|---|--|--|---------------------------------------|
| <input type="checkbox"/> Diabetes             | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Migraines    |
| <input type="checkbox"/> Thyroid problems     | <input type="checkbox"/> Seizures/Epilepsy   | <input type="checkbox"/> IBS/IBD       | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Chronic Fatigue      | <input type="checkbox"/> Chronic Pain        | <input type="checkbox"/> Back injury   | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Rheumatoid arthritis | <input type="checkbox"/> Hypogonadism        | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Head injury  |

If yes to head injury, any loss of consciousness?       Yes      No

Longer than five minutes?       Yes      No

Have you ever had a DEXA scan?       Yes      No

Have you ever had a fracture?       Yes      No

Any parental history of a hip fracture?       Yes      No

Have you ever been on oral steroids for more than 3 months?       Yes       No

Have you ever been on an enzyme-inducing anticonvulsant?       Yes       No

Please list any additional medical conditions: \_\_\_\_\_

**Do you have any allergies?**       Yes       No

If yes, please list and include your reaction(s): \_\_\_\_\_

**(MEDICAL HISTORY CONTINUED)**

**Please list any surgeries:** \_\_\_\_\_

FOR WOMEN:    Date of your last period: \_\_\_\_\_

Any chance you could be pregnant?        Yes       No

Are you currently on birth control?       Yes       No

Are you currently on hormone replacement therapy?       Yes       No

**Please list all medications you are currently taking with dosages: (include vitamins/supplements)**

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Print Name: \_\_\_\_\_

**6. FAMILY PSYCHIATRIC HISTORY:**

Please describe any family history of psychiatric illness, mental health treatment, alcoholism, or drug use: (parents, siblings, extended family members)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has anyone:  been psychiatrically hospitalized  received psychiatric treatment  neither

If yes, who? \_\_\_\_\_

Has anyone attempted to commit suicide?  Yes  No If yes, who? \_\_\_\_\_

Has anyone committed suicide?  Yes  No If yes, who? \_\_\_\_\_

**7. FAMILY MEDICAL HISTORY (Diabetes, Stroke, Heart Disease, Cancer, etc.):**

Please list any medical conditions of the following family members:

Father: \_\_\_\_\_

Alive?  Yes  No If no, cause of death and/or illness: \_\_\_\_\_

Mother: \_\_\_\_\_

Alive?  Yes  No If no, cause of death and/or illness: \_\_\_\_\_

**8. SOCIAL HISTORY:**

Please list who you live with: \_\_\_\_\_

Do you have a good support system? (including family and/or friends)  Yes  No

If yes, please list who: \_\_\_\_\_

Please list names and ages of any children: \_\_\_\_\_

Have you fallen in the past 12 months?  Yes  No

Do you feel unsteady while standing or walking?  Yes  No

**9. LEGAL:**

Do you have any pending legal issues?  Yes  No

If yes, what are they? \_\_\_\_\_

Do you have any pending court appearances?  Yes  No

If yes, please list when and what for: \_\_\_\_\_

**10. WORK:**

**Are you currently employed?**  Yes  No

If yes, please complete the following:

Current title/position: \_\_\_\_\_ Employer: \_\_\_\_\_

Address of employment: \_\_\_\_\_

If no, when was your last day of employment? \_\_\_\_\_ Position/title: \_\_\_\_\_

**Are you currently on disability?**  Yes  No

If yes, date you became disabled: \_\_\_\_\_ Who put you on disability? \_\_\_\_\_

**Is your current condition due to a work related injury?**  Yes  No

If yes, please indicate when and where: \_\_\_\_\_

Print Name: \_\_\_\_\_

**11. INTERESTS/LEISURE:**

Please list any hobbies/activities you enjoy: \_\_\_\_\_  
\_\_\_\_\_

**12. DEVELOPMENT:**

Birth history:            Full term            Preterm

Delivery:                C-section            Vaginal

Complications:        Yes                No

If yes, please list: \_\_\_\_\_

How did you do in elementary school? \_\_\_\_\_

Did you have any delays in walking, talking, or reading?    Yes            No

If yes, what were they? \_\_\_\_\_

Were you in any special classes for people with disabilities?    Yes            No

If yes, what classes? \_\_\_\_\_

Highest grade or level of education completed: \_\_\_\_\_

Have you ever been abused: (*mark all that apply*)

Emotionally    Physically    Sexually

**13. Is there anything else you would like to add about yourself that has not been covered?**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Thank you.

Print Name: \_\_\_\_\_

Name: \_\_\_\_\_

DOB: \_\_\_\_\_

## Mood Disorder Questionnaire (MDQ)

**Instructions:** Please answer each question as best as you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got in trouble?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="checkbox"/>	<input type="checkbox"/>
...you felt much more self-confident than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you got much less sleep than usual and found you didn't really miss it?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more talkative or spoke much faster than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...your thoughts raced through your head or you couldn't slow your mind down?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="checkbox"/>	<input type="checkbox"/>
...you had much more energy than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more active or did many more things than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more interested in sex than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you did things that were unusual for you or that other people might have thought were excessive, risky, or foolish?	<input type="checkbox"/>	<input type="checkbox"/>
...spending money got you or your family in trouble?	<input type="checkbox"/>	<input type="checkbox"/>
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	<input type="checkbox"/>	<input type="checkbox"/>
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? <i>Please circle one response only</i>		
No problem    Minor problem    Moderate problem    Serious problem		
4. Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	<input type="checkbox"/>	<input type="checkbox"/>
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	<input type="checkbox"/>	<input type="checkbox"/>

**Please circle any of the following medications that you have previously tried. If possible, please add at what doses you tried the medication(s) and any side effects or adverse effects. Thank you.**

**SSRIs**

Zoloft / Sertraline  
 Prozac / Fluoxetine  
 Paxil / Paroxetine  
 Lexapro / Escitalopram  
 Celexa / Citalopram  
 Desyrel / Trazodone  
 Luvox / Fluvoxamine  
 Remeron / Mirtazapine  
 Viibryd  
 Brintellix

**SNRIs**

Effexor (XR) / Venlafaxine (ER)  
 Cymbalta / Duloxetine  
 Pristiq  
 Fetzima  
 Strattera

**OTHER ANTIDEPRESSANTS**

Wellbutrin (XL/SR/IR) / Bupropion  
 EMSAM / Selegiline  
 Elavil / Amitriptyline  
 Anafranil / Clomipramine  
 Tofranil / Imipramine  
 Pamelor / Nortriptyline  
 Norpramin / Desipramine  
 Sinequan / Doxepine

**MOOD STABILIZERS**

Lamictal / Lamotrigine  
 Depakote (ER) / Valproic acid  
 Trileptal / Oxcarbazepine  
 Tegretol / Carbamazepine  
 Topamax / Topiramate  
 Zonegran / Zonisamide  
 Lithium  
 Abilify / Abilify Maintena  
 Geodon / Ziprasidone  
 Risperdal / Risperidone  
 Seroquel (XR) / Quetiapine  
 Zyprexa / Olanzapine  
 Zyprexa Relprevv

Invega  
 Saphris  
 Fanapt  
 Latuda  
 Rexulti  
 Clozaril / Clozapine  
 Thorazine / Chlorpromazine  
 Haldol / Haloperidol  
 Prolixin / Fluphenazine  
 Trilafon / Perphenazine  
 Mellaril / Thioridazine  
 Navane / Thiothixene

**STIMULANTS**

Adderall (XR) / Amphetamine -  
 Dextroamphetamine  
 Ritalin / Methylphenidate  
 Concerta  
 Vyvanse  
 Focalin (XR)  
 Evekeo

**OTHER**

Ambien / Zolpidem  
 Sonata  
 Lunesta  
 Provigil / Modafinil  
 Nuvigil / Armodafinil  
 Xanax (XR) / Alprazolam  
 Ativan / Lorazepam  
 Valium / Diazepam  
 Klonopin / Clonazepam  
 Buspar / Buspirone  
 Vistaril / Hydroxyzine  
 Neurontin / Gabapentin  
 Lyrica  
 Horizant  
 Inderal / Propranolol

***I acknowledge that the above information is correct and co-relates with my psychiatric history.***

\_\_\_\_\_ **DOB: «DOB»**  
 Print Name

\_\_\_\_\_ **Date: \_\_\_\_\_**  
 Signature