Medication Management New Patient Paperwork

EXIMIOUS
INTEGRATED HEALTH SOLUTIONS

935 W. Exchange Pkwy, Ste. 110 Allen, TX 75013 PH# 972.985.7499 FAX# 972.985.7429

www.eximioustx.com info@eximioustx.com

Welcome to Eximious Integrated Health Solutions!

We would like to say thank you for considering and choosing us as your trusted provider for care and well being.

It is vital in a Provider/Patient relationship that you are absolutely upfront and forthcoming with all relevant information that pertains to your psychiatric health. Our goal is to obtain and maintain this wellbeing in coordination with **you** as our patient.

This will require YOU to :

- Follow all recommendations regarding medications, treatment plans and measures for safety and protection.
- Be responsible for keeping medications in a SAFE place and ensure that all medications are taken ONLY as prescribed by your practitioner.
- Inform us of any changes to insurance, personal contact information, medical treatment and/or changes that affect treatment with us, including:

  -Intensive Outpatient Treatment and Partial Hospitalization Programs;

  -Treatment Centers regarding addiction(s) and regular hospitalization ie, surgery.

Termination of Provider/Patient Relationship:

The following are situations that would cause us to sever this relationship:

- Continued missed / cancelled appointments.
- Non-payment of account.
- Non-adherence as a patient/not following recommended course of treatment.
- Misuse/abuse of prescribed medications/obtaining same medications from other prescribers, primarily controlled substances.
- Abusive or inappropriate behavior towards clinic staff and practitioners.

You will receive a certified letter stating the severing of our relationship should the need arise.

We reserve the right to invoke this option at any time. We will fill all non controlled substances for 30 days following the date of the letter.

Patient Signature : _____ Date: _____

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Date: _____

Patient Name: _____ DOB: _____

Social Security # _____ Sex: Male ____Female _____ Other _____

Ethnicity : Hispanic or Latino Non Hispanic or Latino Unknown

Race : American Indian Asian Black / African American White Native Hawaiian Other

Address: _____

City: _____State: _____ Zip: _____

Home phone # _____Cell # _____ Work # _____

Marital Status: _____ Email: _____

Employer _____

In Case of an Emergency, who can we contact?

Name: _____ Phone # _____

Relationship: _____ Cell # _____

Can we release ALL personal health information to the following? (Please provide names)

School Nurse / School Counselors: _____ PCP: _____

Employer / HR Department: _____ Counselor / Therapist: _____

Social Security Department _____ Doctor: _____

Texas Dept. of Family and Protective Services-CPS Other: _____

Attorney Office: If yes, please provide Attorney's name & phone # _____

Insurance Information:

Insurance company: _____ Member ID/ Policy # _____

Group # _____ Insurance phone # _____ Employer: _____

Name of Primary Policy Holder: _____ Primary Holder's DOB: _____

Primary Holder's SSN: _____ Relationship to Patient: _____

Is Primary Policy Holder the Responsible Party? Yes No (Adult patients are responsible for their own financials)

If No, Responsible Party / Guarantor's Information:

Responsible Party Name: _____Home/Cell Phone # _____

Address_____

City: _____State: _____ Zip: _____

Patient/Guardian Signature: _____ Date: _____

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Questionnaire for New Patients:

Name: _____ Date of Birth: __ /__ /__ Age: _____ Sex : ____

Phone Number: _____

Address: _____ City: _____ State: ___ Zip: _____

Referred by: _____ Phone Number: _____

Please state your view of your challenges/symptoms/reason for the visit:

_____

_____

_____

When did the problems begin: _____

What has been done so far to help alleviate the issue(s):

_____

_____

_____

Psychiatric History:

Has you ever been hospitalized for psychiatric care/needs? YES _____ NO _____

If so, Where and When: _____

Reason for Hospitalization: _____

Was treatment helpful/successful: _____

Have you had any other prior psychiatric providers, ie outpatient psychiatric medication management, behavioral counseling or therapy? YES _____ NO _____

If yes, please list provider: _____

_____

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Patient Health Questionnaire-9

(PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at all	Several Days	More than half of the days	Nearly daily
Please circle or mark the number or category of your answer:				
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 asleep, 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-feelings of failure and letting others down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper, books or watching television	0	1	2	3
8. Moving or speaking so slowly that other people have noticed? Or the opposite-so fidgety and restless, moving around a lot more than	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

For office coding: _____ + _____ + _____ + _____

Total = _____

_____

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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STOP BANG QUESTIONNAIRE (SLEEP STUDY QUALIFICATION)

PATIENT NAME: _____

DOB: _____

DATE: _____ Height: _____ Weight: _____

STOP	
S (snore) Have you been told that you snore?	YES / NO
T (tired) Are you often tired during the day?	YES / NO
O (obstruction) Do you know if you stop breathing or has anyone witnessed you stop breathing while you are asleep?	YES / NO
P (pressure) Do you have high blood pressure or on medication to control high blood	YES / NO
BANG	
B (BMI) Is your body index greater than 35?	YES / NO
A (age) Are you 50 years old or older?	YES / NO
N (neck) Are you a male with a neck circumference greater than 17 inches, or a female with a	YES / NO
G (gender) Are you a male?	YES / NO

For Office Use Only Procedure Order Form

□ YES to 3+ questions - patient qualifies for WatchPAT

Physician Order: Please provide patient with a WatchPAT for overnight testing. YES / NO

- Clinical Notes: I saw the patient in office today. Ordering a home sleep study to rule out sleep apnea due to the following clinical symptoms (circled): Excessive daytime sleepiness / Gastroesophageal reflux Nocturia / Morning Headaches / Difficulty concentrating / Memory problems or poor judgment / Personality changes or irritability / Loud snoring / Depression / Witnessed apnea events / Impotence
- Physician Signature _____ Date _____

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General Office Policies and Procedures

Financial Agreements

Appointments

It is the responsibility of the patient to schedule, reschedule, and cancel all appointments with our office.

Due to limited appointment availability we have implemented a No-Show policy. There is a $75.00 fee.

There will also be a $75.00 fee applied to all appointments that have been cancelled late, within 24 hours.

We require a minimum of a 24 hour notice for any appointment cancellation. Emergencies do arise, and we appreciate notice if you are unable to make your scheduled time. Please contact us as soon as possible.

Eximious Integrated Health Solutions/Premier Psychiatric will make every effort to contact our patients 2 business days before their appointment; this is a courtesy and it is the patient's responsibility to keep his/her appointment on his/her scheduled date. Should the clinic require the rescheduling of your appointment, we will contact you as soon as is possible to notify you of any changes due to unforeseen circumstances. Please be certain all contact numbers and email addresses are up to date.

Any patient arriving 15 minutes or later for their scheduled appointment time will be rescheduled.

NO EXCEPTIONS– When you are late, it causes other appointments to be late as well.

Repeated "no show" or "late cancelled" will result in being referred out of the practice to another practitioner.

We do not do phone appointments. In the case of an emergency, where you cannot make it into the clinic for your visit, there will be a fee of $150.00 for the phone appointment and that fee will be due in advance of your phone call. We cannot bill your insurance for this phone appointment, **it is your responsibility**.

Prescriptions and Samples

It is the responsibility of the patient to take or mail their prescriptions to their chosen pharmacy.

There are NO early refills

Mandatory urine toxicology screenings will be done on all patients that receive controlled substances or on Suboxone Therapy. You will NOT be seen or given a prescription for your medication without a urine sample and you will be subject for termination from our practice. If you are taking any type of Controlled Substances and you test positive for any type of pain medication you will be referred to your PCP or Pain Specialist to be tapered off of these medications. You will not get a prescription if you are taking pain medications along with your controlled medications. By doing so, you will receive only one warning and if discovered again, you will be subject to **termination** from our practice.

If refills are needed for an emergency purpose, please contact your pharmacy and ask them to fax a refill request to our office. We require at least a 48 hour notice.

If you are unable to keep your scheduled appointment, please be informed that you will not receive refills until you have been seen by your provider.

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General Office Policies and Procedures

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Medical Records and Forms

There is a $150.00 administrative fee for completing and filing all elective medical documentation; this includes all FMLA paperwork and Short Term/Long Term Disability Paperwork.

Please see our policy for this process once you are an established patient with the clinic. It is posted in the front

Please allow up to 7 days for the completion of your document. We will contact you once they are completed.

All requested letters for any reason will be charged a fee of $25.00 up to $150.00 depending on the need. Letters will need to be picked up in the office and must be paid for before we will release it to you.

Payment and Fees

Payment is due at the time of service rendered with no exceptions. This includes co-payments, co-insurance, and yearly deductible.

Past due balances and payment arrangements may be made with the office manager only.

We accept cash and credit card payments. We no longer accept personal checks.

Court Fees:

If a deposition or opinion in court is required, there is a $2000.00 fee that will be due upon the receipt of a subpoena and a fee of $450.00 per hour for our Nurse Practitioner , and $600.00 per hour fee for our MD to go to court, per day they are in court. If the Medical Assistant is subpoenaed to appear on your behalf, there will be a $500.00 fee due upon receipt of the subpoena. There will also be a $500.00 fee, per day that the medical assistant is due to be at the court. All court fees will be due no later than 10 business days after the court has been adjourned. All fees are your responsibility and will not be billed to your insurance. These fees are being charged for preparation time, travel time, any time spent with your attorney / clerk for preparation and cancelling of our staff's clinic schedule.

All fees including late cancellation and no show fees are not final, and are subject to change at any time without notice based on the discretion of the practice.

I have read, understood, and agreed to the policies listed above for :

Premier Psychiatric and Sleep Medicine Associates, Eximious Integrated Health Solutions. I accept the conditions for receiving services from Dr. Jawad Riaz, MD, Dr. Sabeen Riaz M.D., the Nurse Practitioners and/or the counselors/therapists.

_____ _____

Patient Signature Date

_____

Patient Printed Name

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NOTICE OF PRIVACY PRACTICES 11/29/2018

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

THIS NOTICE APPLIES TO ALL OF THE RECORDS OF YOUR CARE GENERATED BY THE PRACTICE, WHETHER MADE BY THE PRACTICE OR AN ASSOCIATED FACILITY. THE PRIVACY OF YOUR HEALTH INFORMATION IS IMPORTANT TO US.

This notice describes our Practice's policies, which extend to:

Any health care professional authorized to enter information into your chart; all areas of the Practice; all employees, staff and other personnel that work for or with our Practice; our business associates, on-call physicians, and so on.

The Practice provides this Notice to comply with the Privacy Regulations issued by the Department of Health and Human Services in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

We will make sure that the protected health information about you is kept private;

provide you with a Notice of our Privacy Practices and your legal rights with respect to protected health information about you; and

follow the conditions of the Notice that are currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU:

We use and disclose health information about you for treatment, payment and healthcare operations. For example:

Medical Treatment: We may use or disclose your health information to a physician or other healthcare provider providing treatment to you.

Payment: We may use and disclose your health information to obtain payment for services we provide to you.

Health Care Operations: We may use and disclose your health information in connection with our healthcare operations. Healthcare operations include quality assessment and improvement activities, reviewing the competence or qualifications of healthcare professionals, evaluating practitioner and provider performance, conducting training programs, accreditation, certification, licensing or credentialing activities.

Appointment and Patient Recall Reminders: We may use and disclose medical information to contact you as a reminder that you have an appointment for medical care with the Practice or that you are due to receive periodic care from the Practice. This contact may be by phone, in writing, e-mail, or otherwise which could (potentially) be received or intercepted by others.

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To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat either to your specific health and safety or the health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

Organ and Tissue Donation: If you are an organ donor, we may release medical information to organizations that handle organ procurement or organ, eye or tissue transplantation or to an organ donation bank as necessary.

Public Health Risks: Law or public policy may require us to disclose medical information about you for public health activities. These activities generally include the following:

to prevent or control disease, injury or disability; to report births and deaths; to report child abuse or neglect; to report reactions to medications or problems with products; to notify people of recalls of products they may be using; to notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition; to notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence. We will only make this disclosure if you agree or when required or authorized by law.

Investigation and Government Activities: We may disclose medical information to a local, state or federal agency for activities authorized by law. These activities include, for example, audits, investigations, inspections, and licensure.

Lawsuits and Disputes: If you are involved in a lawsuit or a dispute, we may disclose medical information about you in response to a court or administrative order or a subpoena, discovery request, or other lawful process by someone else involved in the dispute. We may also use such information to defend ourselves or any member of our Practice in any actual or threatened action.

Law Enforcement: We may release medical information if asked to do so by a law enforcement official:

In response to a court order, subpoena, warrant, summons or similar process about a victim of a crime; about a death we believe may be the result of criminal conduct; about criminal conduct at the Practice; and in emergency circumstances to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

Coroners, Medical Examiners and Funeral Directors: We may release medical information to a coroner, medical examiner or funeral director.

Inmates: If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

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CHANGES TO THIS NOTICE

We reserve the right to change this notice at any time and to make the revised or changed notice effective for medical information we already have about you as well as any information we may receive from you in the future. We will post a copy of the current notice in the Practice. Each time you visit the Practice for treatment or health care services, you may request a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with the Practice or with the Secretary of the Department of Health and Human Services. To file a complaint with the Practice, contact our office manager (903.892.6700), who will direct you on how to file an office complaint. All complaints must be submitted in writing, and shall be investigated, without repercussion to you. **You will not be penalized for filing a complaint**.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written authorization, unless those uses can be reasonably inferred from the intended uses above. You may revoke that authorization in writing, at any time. You understand that we are unable to take back any disclosures we have already made with your permission.

PATIENT RIGHTS

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. This includes your own medical and billing records, but does not include **psychotherapy notes**. Upon proof of an appropriate legal relationship, records of others related to you or under your care may also be disclosed. To inspect and copy your medical record, you must submit your request in writing to our Compliance Officer. We may charge a fee for the costs of copying, mailing or other supplies (tapes, disks, etc.) associated with your request. We may deny your request to inspect and copy in limited circumstances. If you are denied access to medical information, you may request that our Compliance Committee review the denial. Another licensed health care professional chosen by the Practice will review your request and the denial. We will comply with the outcome and recommendations from that review.

Right to Amend: You have the right to request that we amend your health information. Your request must be in writing and must explain why the information should be amended. We may deny your request under certain circumstances.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures." This is a list of the disclosures we made of medical information about you, to others. To request this list, you must submit your request in writing. Your request must state a time period not longer than six (6) years back and may not include dates before April 14, 2003. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

Right to Request Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We are not required to agree to these additional restrictions, but if we do, we will abide by our agreement (except in an emergency).

Right to Request Confidential Communications: You have the right to request that we communicate with you about your health information by alternative means or to alternative locations. You must make your request in writing. Your request must specify the alternative means or location and provide satisfactory explanation how payments will be handled under the alternative means or location you request.

Right to A Paper Copy of this Notice: You have a right to a paper copy of this notice at any time upon your request.

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, have received a copy of this office's

Notice of Privacy Practices._____ _____

(Signature) (Date)

AUTHORIZATION FORM FOR OTHER USES OF PROTECTED HEALTH INFORMATION

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you pursuant to our general Patient Consent Form. On occasion, the patient and the Practice may want to use PHI for reasons other than treatment, payment and health care operations. This form summarizes the anticipated use of information about you for which this authorization is required. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please list individuals who may receive and use the disclosed information:

_____

_____

_____

_____

___ All Information

___ Appointment information

___ Lab Work

___ Financial Information

___ Medical Records

___ Personal Identifying Information

___ Insurance Information

Other (Specify) : _____

_____ _____

Patient Signature **Date**

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Medication Consent Form

I have received education regarding the medication that has been prescribed to me, my child, or a person for whom I am the legal guardian by and I consent to the administration of this medication. I have been educated regarding the possible side effects of this medication, possible drug and/or food interactions that may occur while taking this medication. I have also been informed of the reason or intended purpose for which this medication is prescribed. I am aware that the U.S. Food and Drug Administration (FDA) may not have approved this medication to be prescribed for this particular condition or for a patient of this age. I understand this medication education.

It is recommended that women who are or may become pregnant, or are breastfeeding, discuss this with their practitioner ***before*** taking ***any*** medication and to notify their practitioner ***immediately*** upon becoming pregnant.

If prescribed benzodiazepines or psychostimulants DO NOT USE with alcohol or operate an automobile/heavy machinery.
In addition, DO NOT take within 3 hours of narcotic pain medications.

If the patient experiences any side effects from the medication prescribed, it is recommended that patient notify their practitioner immediately.

During the patient's appointment, the practitioner will obtain a thorough patient history. Please let the practitioner know about the following:
Current medications (prescription, over-the-counter, herbs, etc.) the patient is taking
Food and drug allergies of the patient
Any medical conditions of the patient

_____ _____

Patient Signature Date

Patient Name _____

Date of Birth _____

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MEDICATION HISTORY

The medicines you take are part of your health information. Please fill out this form (or have your caregiver complete it) and discuss it with your medical provider. If you need more space to list your medicines, please use the back side.

Patient Name:	Today's Date:

ALLERGIES

Name of Substance (Drug or Food)	Type of Reaction

CURRENT MEDICATIONS

Drug Name (pills, creams, drops) Please include herbal and natural Remedies and	Strength (such as 50mg)	Directions (as in 2 tablets in the am) Check box if taken only as needed	Prescribed by (Name of prescribing physician)

PHARMACY INFORMATION

***List the ONE Pharmacy you will be using to fill prescriptions for yourself.**

Pharmacy Name	Phone #

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REVIEW OF SYSTEMS

REVIEW OF SYMPTOMS-CHECK "YES" OR "NO" AS THEY RELATE TO YOUR/THE PATIENTS HEALTH

General: No complaints / fevers / chills / sweats / anorexia / fatigue / sleepiness / sleep problems / malaise / weight gain / weight loss / speech delay.

Eyes: No complaints / eye pain / vision loss / excessive tears / blurring / diplopia / irritation / discharge / photophobia.

Ears: No complaints / ear pain / discharge / tinnitus / decreased hearing.

Nose: No complaints / obstruction / discharge / nosebleeds.

Throat: No complaints / sore throat / hoarseness / dysphagia.

Cardiovascular: No complaints / chest pains / palpitations / syncope / dyspnea on exertion / orthopnea / PND / peripheral edema

Respiratory: No complaints / cough, dyspnea, excessive sputum, hemoptysis, wheezing

Gastrointestinal: No complaints / nausea / vomiting / diarrhea / constipation / change in bowel habits / abdominal pain / melena / hematochezia / jaundice.

Genitourinary: No complaints / vaginal discharge /sores / menstrual irregularity.

Musculoskeletal: No complaints / back pain / joint pain / joint swelling / muscle cramps / muscle weakness / stiffness.

Skin: No complaints / rash / itching / ulcers/ growths / excess scarring / bleeding problem / dryness / suspicious lesions.

Neurologic: No complaints / transient paralysis / weakness / paresthesia / seizures / syncope / tremors / vertigo.

Psychiatric: No complaints / depression / anxiety / memory loss / suicidal ideation / homicidal ideation / hallucinations (audio / visual / command) / paranoia / delusions / mood swings / difficulty sleeping / irritability / attention/concentration difficulty / appetite changes / medication side effects, non-adherence / low energy /low motivation / feelings of worthlessness, hopelessness, guilt / anhedonia / apathy / chronic stress / crying episodes / isolation / panic / euphoria / grandiosity / flight of ideas / impulsivity / risky behaviors or spending sprees / non-epileptic seizures / nervousness and restlessness

Endocrine: No complaints / cold intolerance / heat intolerance / polydipsia / polyphagia / polyuria / weight change

Heme/Lymphatic: No complaints / abnormal bruising or bleeding / enlarged lymph nodes

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REVIEW OF SYSTEMS

REVIEW OF SYMPTOMS-CHECK "YES" OR "NO" AS THEY RELATE TO YOUR/THE PATIENTS HEALTH

Allergic/Immunologic: No complaints / urticaria / hay fever / persistent infections / HIV exposure / STI or STD

Health Screening / Treatment Team Providers: Primary care / Dentist / Neurologist / Pain management / Cardiologist / Other _____

Additional comments for your practitioner: _____

_____

PAST PSYCHIATRIC HISTORY
Prior outpatient psychiatric treatment in the past? (Y/N) Comments _____
Prior outpatient alcohol/substance abuse treatment? (Y/N) Comments _____
Prior outpatient treatment was helpful? (Y/N) Comments _____
Number of prior psychiatric hospitalizations: _____
Date of last psychiatric hospitalization: _____
Number of prior alcohol or substance abuse hospitalizations: _____
Date of last alcohol/substance abuse treatment: _____
Involuntary hospitalizations in past?(Y/N) Comments _____
Prior History of non-suicidal injury (scratching, cutting, burning)? (Y/N)
Prior History of suicide attempt? (Y/N)
Number of attempts: _____
Last attempt was: _____
Method of self-harm: _____
Attempt resulting in medical hospitalization: (Y/N)
Prior History of Aggression or Violence? (Y/N)
Aggression towards: _____
Legal charges stemming from aggression: (Y/N)
Incarceration stemming from aggression: (Y/N)
Prior Psychiatric medications tried: _____

_____

SUBSTANCE USE HISTORY (circle as they apply to you / the patient):
Alcohol: (beer, wine, liquor, other)
Cannabinoids: (marijuana, hashish, other)
Opioids and Morphine Derivatives: (codeine, morphine, heroin, opium, other)
Stimulants: (cocaine, amphetamines, methamphetamines, other)
Club Drugs: (MDMA, GHB, Flunitrazepam, other)
Dissociative Drugs: (Ketamine, PCP, Dextromethorphan, Salvia, other)
Depressants: (barbiturates, benzodiazepines, other)
Hallucinogens: (LSD, Psilocybin, Mescaline, other)
Anabolic steroids: (depo-testosterone, anadrol, other)

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REVIEW OF SYSTEMS

REVIEW OF SYMPTOMS-CHECK "YES" OR "NO" AS THEY RELATE TO YOUR/THE PATIENTS HEALTH

Inhalants: (huffing, glue, solvents, other)
Intravenous drug use: (Y/N) / single-use equipment / shared equipment

Have you experienced tolerance to substance(s) of choice (increased amount of substance required to obtain initial effect of the drug)? (Y/N)
Have you experienced withdrawal symptoms from substance(s) of choice (physiologic or psychological distress upon stopping or reducing the amount of drug used) ? (Y/N)
Has your consumption exceeded the intended amount? (Y/N)
Have you experienced challenges in your efforts to reduce/control consumption? (Y/N)
Have you spent excessive time related to substance use, leading to disruption of daily functioning? (Y/N)

Additional comments for your provider: _____
_____

PSYCHIATRIC SOCIAL HISTORY

Childhood
Were you adopted? YES / NO
Did your biological parents separate or divorce during your childhood? YES / NO
Loss of parent by death prior to age 18? YES / NO
Would you consider your childhood: happy / average / unhappy?
Was socio-economic upbringing: lower / middle / upper?
During childhood, were you ever concerned about any form of trauma / abuse, including:
Emotional (YES / NO) / Physical (YES / NO) / Sexual (YES / NO)?

Education
Highest Grade: _____
High School Diploma? YES / NO
College Degree: _____
Graduate Degree: _____
Special Educational Circumstances? YES / NO / Comments: _____
Special Education Classes: YES / NO / Comments: _____
GED earned: YES / NO
Vocational/Trade School: YES / NO / Comments: _____
Current Occupation: _____

Relationships – please circle:
Current Relationship Status: single / married / divorced / widowed
Have you ever been divorced? (Y/N)
Current relationship is: poor / fair / good

EXIMIOUS
INTEGRATED HEALTH SOLUTIONS

935 W. Exchange Pkwy, Ste. 110 Allen, TX 75013

PH# 972.985.7499 FAX# 972.985.7429 premierpsychiatric1@gmail.com

REVIEW OF SYSTEMS

REVIEW OF SYMPTOMS-CHECK "YES" OR "NO" AS THEY RELATE TO YOUR/THE PATIENTS HEALTH

Are you currently sexually active? (Y/N)
Sexual Preferences? opposite sex / same sex / bisexual / pan-sexual
Do you have any concerns or difficulties with sexual functioning? (Y/N)
Number of children: _____
Spirituality: none / active / non-active / comments _____

Females only: Are you pregnant? (Y/N)
Are you trying to get pregnant? (Y/N)

Legal Issues
Prior difficulties with the legal system ever? (Y/N)
Prior incarceration? (Y/N)
Current legal issues? (Y/N)
Currently on disability? (Y/N)
Currently seeking disability? (Y/N)

HISTORIES & HABITS

Patient Medical History – if present, (1) when did condition start? and (2) who is treating the condition?

Alcoholism (Y/N) _____/_____ Allergic rhinitis (Y/N) _____/_____
Anemia (Y/N) _____/_____ Anxiety (Y/N) _____/_____
Arthritis (Y/N) _____/_____ Asthma (Y/N) _____/_____
A-fib (Y/N) _____/_____ Autism spectrum (Y/N) _____/_____
Bipolar d/o (Y/N) _____/_____ Bulimia nervosa (Y/N) _____/_____
Chest pain (Y/N) _____/_____ Circulatory system d/o (Y/N) ____/_____
CHF (Y/N) _____/_____ Delusional d/o (Y/N) _____/_____
Dementia (Y/N) _____/_____ Depression (Y/N) _____/_____
Diabetes (Y/N) _____/_____ Eating d/o (Y/N) ____/_____
Emphysema (Y/N) _____/_____ Gout (Y/N) _____/_____
Headache (Y/N) _____/_____ Hearing loss (Y/N) _____/_____
Heart attack (Y/N) _____/_____ Heartburn(Y/N) _____/_____
Herniated disc (Y/N) ____/_____ High cholesterol(Y/N) _____/_____
High lipids(Y/N) _____/_____ Hypertension(Y/N) _____/_____
Hypothyroidism(Y/N) _____/_____ Insomnia(Y/N) _____/_____
IBS (Y/N) _____/_____ Kidney failure (Y/N) _____/_____
Migraine (Y/N) ____/_____ Mitral valve insufficiency (Y/N) ____/_____
OCD (Y/N) _____/_____ Osteoporosis (Y/N) ____/_____
PTSD (Y/N) _____/_____ Schizophrenia(Y/N) _____/_____
Sinusitis (Y/N) _____/_____ Skin disorder (Y/N) _____/_____
Smoking(Y/N) _____/_____ Social phobia (Y/N) _____/_____
Stroke (Y/N) _____/_____ Visual impairment (Y/N) _____/_____

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Surgical History – if YES, (1) date of procedure; (2) name of provider; (3) hospital/facility where procedure was completed.

Adenoidectomy (Y/N) _____/_____/_____
Appendectomy (Y/N) _____/_____/_____
Cholecystectomy (Y/N) _____/_____/_____
Hernia repair (Y/N) _____/_____/_____
Hysterectomy (Y/N) _____/_____/_____
Tonsillectomy (Y/N) _____/_____/_____
Adenoidectomy (Y/N) _____/_____/_____
Wisdom teeth (Y/N) _____/_____/_____
Other (Y/N) _____/_____/_____

Family Medical History – if present, who in the patient's family has/had the condition?

Alcoholism (Y/N) _____ Allergic rhinitis (Y/N) _____
Anemia (Y/N) _____ Anxiety (Y/N) _____
Arthritis (Y/N) _____ Asthma (Y/N) _____
A-fib (Y/N) _____ Autism spectrum (Y/N) _____
Bipolar d/o (Y/N) _____ Bulimia nervosa (Y/N) _____
Chest pain (Y/N) _____ Circulatory system d/o (Y/N) _____
CHF (Y/N) _____ Delusional d/o (Y/N) _____
Dementia (Y/N) _____ Depression (Y/N) _____
Diabetes (Y/N) _____ Eating d/o (Y/N) _____
Emphysema (Y/N) _____ Gout (Y/N) _____
Headache (Y/N) _____ Hearing loss (Y/N) _____
Heart attack (Y/N) _____ Heartburn(Y/N) _____
Herniated disc (Y/N) _____ High cholesterol(Y/N) _____
High lipids(Y/N) _____ Hypertension(Y/N) _____
Hypothyroidism(Y/N) _____ Insomnia(Y/N) _____
IBS (Y/N) _____ Kidney failure (Y/N) _____
Migraine (Y/N) _____ Mitral valve insufficiency (Y/N) _____
OCD (Y/N) _____ Osteoporosis (Y/N) _____
PTSD (Y/N) _____ Schizophrenia(Y/N) _____
Sinusitis (Y/N) _____ Skin disorder (Y/N) _____
Smoking(Y/N) _____ Social phobia (Y/N) _____
Stroke (Y/N) _____ Visual impairment (Y/N) _____

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IMMUNIZATION HISTORY – records up to date – (Y/N)

SOCIAL HISTORY

Tobacco use (Y/N)
Current every day smoker (Y/N)
Current some day smoker (Y/N)
Former smoker (Y/N)
Packs per day _____

Alcohol use (Y/N)
Beer (Y/N)
Liquor (Y/N)
Wine (Y/N)
Mixed (Y/N)
How many drinks / ounces per day? _____ Per month? _____ Per year? _____
Frequency of alcohol use (please circle as applicable to you / patient):
Socially / Minimally / Infrequently / Frequently

Drug useSexually active (Y/N)

PREGNANCY STATUS
Pregnant (Y/N)
Due date _____
Last menstrual period date _____
PRIOR BIRTH(S)
Birth date(s) / Gender _____ Birth date(s) / Gender _____
Birth date(s) / Gender _____ Birth date(s) / Gender _____

PSYCHIATRIC EXAM

VITAL SIGNS
Height _____ Weight _____
Pulse _____ Blood pressure _____/_____
PHQ-9 _____
(Y/N)

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INTEGRATED HEALTH SOLUTIONS

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www.eximioustx.com info@eximioustx.com

Premier/Eximious Stimulant Medication Policy:

Patient Name : _____ DOB : _____

You have elected to start yourself or your (minor) child on a Schedule II (CII) medication, a medication deemed by the FDA to have a high abuse potential with severe psychological or physical dependence liability, potentially leading to diversion or to recreational use. In an attempt against abuse and diversion, the following policies have been created by Premier Psychiatric/Eximious. Individuals will be asked to read, adhere to and sign this policies statement:

- Prescriptions can only be issued at a regularly scheduled appointment, after submitting to a urine drug screening. Individuals who test positive for marijuana (THC) or other illicit substances will be counseled and a decision made about continued prescription of the stimulant. In extenuating circumstances requiring a prescription outside of an appointment, there will be a $30 self pay fee for the prescription. There are no early fills except in extenuating circumstances, subject to approval by the prescribing psychiatrist.

- You must present for a face to face assessment at least once every 90 days in order to have this medication prescribed. Individuals are expected to keep regular appointments and to give 24 hours' notice if cancelling to avoid a separate no show fee. Prescriptions will be written for up to 30 days. Per DEA regulations, there are no refills; you must submit to urine drug screening prior to receiving a new script.

- The prescription expires 21 days from the date written on your script. You agree that if you allow a script to expire, you will bring it to your next appointment. Please do not destroy it as Premier/Eximious providers are require to be accountable for all controlled prescriptions that leave this office. There will be a $15 self pay fee to rewrite the prescription. This courtesy will only be offered once. It is your responsibility to assure you fill your prescriptions on time.
- Lost prescriptions/medication will not be replaced. Stolen prescriptions/medication will only be replace if the individual presents a police report documenting the theft.
- You agree not to have any stimulants prescribed by another provider wile you are being treated by Premier/Eximious provider. You agree not to share or sell this medication to anyone, or to use this medication in any manner other than how it is prescribed to you.
- The final determination about whether to prescribe a stimulant medication rests with Premier/Eximious's prescribing psychiatrist.

_____ I have read, understood, and agreed to the stimulant medication policies listed above for Premier Psychiatric/ Eximious integrated health solutions.

_____ I have read and understood the Premier Psychiatric and Sleep Medicine Associates/Eximious Integrated Health Solutions

_____ _____

Signature of patient/legal guardian Date

_____ _____

Signature of Premier/Eximious provider Date