Cordova Psychiatric Associates
Office Policies and Financial Responsibility Agreement

- **Please read this carefully** and feel free to ask questions regarding any of the following. Your signature indicates your consent and agreement to these conditions.
- **Copayments** are required in full prior to services rendered. Your appointment will be rescheduled if you are not able to provide payment.
  - We accept Visa, MasterCard, Discover, or cash. We **do not** accept checks or American Express.
- **Our office will charge a $75.00 fee for "No Show" appointments or for appointments canceled without 24 hours of notice.**
  - **Email and text reminders are a courtesy provided by the office; however, the patient is still responsible for keeping the appointment or the "no-show" fee will apply.**
- If you are more than 10 minutes late to your appointment, our office will reschedule you to the next available appointment time.
- The following policies regarding prescription refills will be strictly enforced:
  - **24 HR NOTICE IS REQUIRED, REFILLS MAY NOT BE DONE THE SAME DAY.**
  - **Requests for refills due to no-show appointments, cancelled appointments, or failure to make an appointment will be subject to a $75,00 charge.** This charge is not covered by your insurance company. Payment is due upon receiving the prescription refill.
  - **No request is guaranteed.**
- Office hours are Monday through Thursday 8:00am till 4:30pm. Friday is 8:00am till 12:30pm. The office closes daily for lunch 11:45am till 1:00pm. We are closed on all major holidays, Saturday & Sunday. Hours are subject to change. There is not a 24-hour service provided outside of regular business hours.
- Allow 24 hours for providers and staff to process any messages. Calls after 3pm will be processed the next business day.
- This office is solely an outpatient practice. If you have a medical emergency, please go to the nearest emergency room. If you need to be seen or admitted for mental health concerns after hours, please contact Lakeside Behavioral Health, Parkwood, St Francis Hospital, or Delta Medical Center.
- As a courtesy to our patients, our office will file insurance claims for you. Please know that benefits quoted by your insurance company are not a guarantee of coverage or payment.
  - Any charges not paid by your insurance company, within 90 days of the date of service, are the **responsibility of the patient.**
  - **You are responsible** for providing our office with all insurance information, knowing the terms and limits of your insurance coverage, and informing the front office staff of any changes with your insurance coverage.
- There is a fee of $50.00 for completing any type of **forms or written correspondence (FMLA etc.)**
  - This charge is not reimbursed by your insurance company and is **due prior to** the completion of the forms or letter.
  - Please allow a minimum of one week for completion of these materials.
  - You must be an established patient who has been seen in the past 12 months and has been seen more than once.
  - Our office **DOES NOT** initiate paperwork to establish or continue disability. If you choose to file for disability, you will be referred to another provider and your care here may be terminated.
- Please refrain from using your cell phone in the lobby out of respect for other patients.
- Please leave all food and drinks (except water) in your car; we do not allow them in the office.
- No pets allowed in the office.

Having read the foregoing information fully and completely, I have discussed any questions I had about this information with the staff at Cordova Psychiatric Associates, and I understand my financial responsibility and the office policies. Failure to comply with these policies will result in having to postpone any appointments until I can fulfill my responsibilities. I also acknowledge that Mark Hesselrode, APN; Brandi Beard, DNP; Renee Mathis, APN, Scot Canfield, PhD. Are psychiatric nurse practitioners and that I have received or declined a copy of the "Notice of Privacy Practices" in accordance with HIPAA requirements.

Patient/Guardian Signature

Date

Cordova Psychiatric Associates
REGISTRATION FORM

Today's Date:					
PATIENT INFORMATION					
Patient's last name:	First:		M.I.:	Preferred Name:	
Address:	City:	State:	Zip Code:	DOB:	Age:
	Marital Status:		Sex: **M** **F**		
Email address:					
Social Security #:	Cell phone #:		Other phone #:		
Pharmacy:	Location:		Can we leave a message with theses phone numbers?		
Phone #:			**YES** **NO**		
Primary Care Dr & Phone #:					
INSURANCE INFORMATION					
(Please give your insurance card to the receptionist.)					
Person responsible for bill:		DOB:	SSN:	Phone no.:	
Address:					
Primary Insurance Company:					
Subscriber's name:	Subscriber's SSN:	DOB:	Policy ID:	Group ID:	Relation:
Secondary Insurance Company (if applicable):					
Subscriber's name:	Subscriber's SSN:	DOB:	Policy ID:	Group ID:	Relation:

The above information is true to the best of my knowledge. I have checked with my insurance company and have verified that the provider I am seeing is a participating provider on my insurance plan. If a referral is required in order to see this provider, I agree that it is my responsibility to obtain such referral. I authorize my insurance benefits be paid directly to the Cordova Psychiatric Association. I understand that I am financially responsible for any balance unpaid by my insurance company. I also authorize Cordova Psychiatric Associates to release information requested to process my claims.

Patient/Guardian signature _____ Date _____

COORDINATION OF CARE

In case of emergency, who can we call?	Relationship to patient:	Cell phone no.:	Other phone no.:
Other Healthcare Providers we can communicate with:	Name:	Type of care:	Phone no.:
Family members, friends, etc. we may communicate with:	Name:	Relationship:	Phone no.:

I authorize Cordova Psychiatric Associates to release healthcare information to the above mentioned parties. I understand that I may revoke this authorization by written letter and also understand that Cordova Psychiatric Associates may have already released information about me after I gave permission.

_____ _____

Patient/Guardian Signature Date

NAME_____ DATE_____

ANXIETY DISORDERS
ASSESSMENT QUESTIONNAIRE

Category/Rating	None 0	Sometimes 1x/week	Frequently 2-3x/week	A Lot 4-5x/week
Increased Heart Rate				
Excessive Sweating				
Trembling/Shaking				
Shortness of Breath				
Choking Feeling				
Chest Pain				
Abdominal Distress				
Feeling Dizzy/Light Headed				
Fear of Losing Control				
Fear of Dying				
Numbness/Tingling Sensations				
Chills/Hot Flashes				
Fear of Being in Crowded Places				
Racing Thoughts				
Restless/On the Go				
Unable to Relax				
Excessive Worry				
On Edge				
Avoidance Behavior				
Somatic Symptoms (sleeping)				
Other:				

_____
Clinician/Date

NAME_____ DATE_____

MOOD DISORDER QUESTIONNAIRE (MDQ)

Has there ever been a period of time when you were not your usual self and…	YES	NO
…you felt so good or so hyper that other people thought you were not yourself or you were so hyper that you got in to trouble?	❑	❑
…you were so irritable that you shouted at people or started fights or arguments?	❑	❑
…you felt much more self-confident than usual?	❑	❑
…you got much less sleep than usual and found you didn't really miss it?	❑	❑
…you were much more talkative or spoke much faster than usual?	❑	❑
…thoughts raced through your head or you couldn't slow your mind down?	❑	❑
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?	❑	❑
…you had much more energy than usual?	❑	❑
…you were much more active or did many more things than usual?	❑	❑
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	❑	❑
…you were much more interested in sex than usual?	❑	❑
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	❑	❑
…spending money got you or your family into trouble?	❑	❑

If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ❑ ❑

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?
Please circle one response only:

No Problem Minor Problem Moderate Problem Serious Problem

Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder? ❑ ❑

Has a health professional ever told you that you have manic-depressive illness or bipolar disorder? ❑ ❑

Cordova Psychiatric
ASSOCIATES PLLC

Adult Self-Report Scale (ASRS) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, circle the correct number that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often	Score
1. How often do you make careless mistakes when you have to work on a boring or difficult project?	0	1	2	3	4	
2. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	0	1	2	3	4	
3. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	0	1	2	3	4	
4. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	0	1	2	3	4	
5. How often do you have difficulty getting things in order when you have to do a task that requires organization?	0	1	2	3	4	
6. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	0	1	2	3	4	
7. How often do you misplace or have difficulty finding things at home or at work?	0	1	2	3	4	
8. How often are you distracted by activity or noise around you?	0	1	2	3	4	
9. How often do you have problems remembering appointments or obligations?	0	1	2	3	4	
					Part A – Total	
10. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	0	1	2	3	4	
11. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	0	1	2	3	4	
12. How often do you feel restless or fidgety?	0	1	2	3	4	
13. How often do you have difficulty unwinding and relaxing when you have time to yourself?	0	1	2	3	4	
14. How often do you feel overly active and compelled to do things, like you were driven by a motor?	0	1	2	3	4	
15. How often do you find yourself talking too much when you are in social situations?	0	1	2	3	4	
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	0	1	2	3	4	
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	0	1	2	3	4	
18. How often do you interrupt others when they are busy?	0	1	2	3	4	
					Part B – Total	

CORDOVA PSYCHIATRIC ASSOCIATES – PATIENT QUESTIONNAIRE

NAME_____AGE_____DATE_____
PRIMARY CAE PHYSICIAN_____PHONE_____
PHYSICIAN ADDRESS_____

WHAT IS THE CHIEF COMPLAINT AND HOW LONG HAVE YOU EXPERIENCED THIS PROBLEM?_____
_____
HAVE YOU EVER BEEN TREATED OUTPATIENT OR INPATIENT FOR PSYCHIATRIC CARE OR ATTEMPTED SUICIDE?_____
HAS ANYONE IN YOUR FAMILY BEEN TREATED FOR PSYCHIATRIC CARE?
_____
HAS ANYONE IN YOUR FAMILY BEEN HOSPITAIZED FOR PSYCHIATRIC CARE, ATTEMPTED OR COMPLETE SUICIDE?_____
HAVE YOU HAD PREVIOUS EPISODES: ___MANIC___PANIC ATTACK
___MAJOR DEP___PSYCHOSIS___ADHD

OTHER CURRENT SYMPTOMS

___THOUGHTS OF SUICIDE/HOMICIDE___PLAN
___SLEEP DISTURBANCE ___DEPRESSION
___APPETITE CHANGE ___OBSESSIONS/COMPULSIONS
___ANXIETY ATTACKS ___LACK OF INTEREST
___POOR CONCENTRATION___HOPELESS
___CRYING SPELLS ___ENERGY CHANGES
___WORTHLESS

LIST CURRENT MEDS
WHO PRESCRIBED MEDICATION?

HAVE YOU EVER USED THE BELOW? (include how much and how long used)

_____alcohol _____sedatives
_____cocaine _____caffeine
_____stimulants _____tobacco
_____marijuana _____other
_____hallucinogens

LIST PREVIOUS MEDS
WHO PRESCRIBED MEDICATIONS?

DO YOU HAVE ALLERGIES TO FOOD OR DRUGS?_____
HAVE YOU HAD SERIOUS INJURIES, ILLNESS, BROKEN BONES, ETC?_____
_____
HAVE YOU HAD SURGERY?_____
HAVE YOU HAD BLOOD TRANSFUSIONS? WHEN?_____
LAST DATE OF MENSTRUAL PERIOD, ARE THEY REGULAR, DATE OF ONSET?_____
MEDICAL PROBLEMS FOR WHICH YOU ARE CURRENTLY BEING TREATED?_____
_____
_____

NAME_____DATE_____

FAMILY HISTORY

Relative	**Living?**	**How many?**	**Current Age?**	**Present Health orCause of Death**
Father	Y / N		_____	_____
Mother	Y / N		_____	_____
Spouse	Y / N		_____	_____
Brothers	Y / N	_____ ___	_____	_____
Sisters	Y / N	_____ ___	_____	_____

Children Living: list names, ages, and state of health (Include#children deceased, ages, cause of death)

_____

_____

Are you married? Y / N How many years? _____ Spouse's name _____
How many previous marriages? _____

BELOW – OFFICE USE ONLY

MSE: WITHDRAWN PHYSICAL DISTRESS ALERT ORIENTATION_____
SLEEP _____
SUICIDAL/HOMICIDAL THOUGHTS _____PLANS _____NO HARM CONTRACT _____
JUDGEMENT/INSIGHT _____NORMAL
THOUGHT FLOW: FL OF IDEA _____LOOSE ASSOC_____HALLUCINATIONS_____
DELUSIONS_____PSYCHOSIS_____TANGENTIAL_____
AFFECT: BROAD _____CONSTRICTED _____FLAT _____EXPANSIVE_____LABILE
BEHAVIOR:CALM____COOPERATIVE_____GUARDED_____HOSTILE_____
SPEECH:____LOGICAL_____COHENT_____PRESSURED_____SLOWED_____
SOCIAL HISTORY:

_____

_____

DIAGNOSTIC IMPRESSION: **NEW MEDICATION** **Preg warn_____**
AXIS I: **Side effect_____**

AXIS II:

AXIS III:

AXIS IV: STRESSORS: **TARGET SYMPTOMS/TRTMT PLAN**

AXIS V: GAF current (1-90) highest (1-90)

SIGNATURE_____DATE_____

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Stimulant and Controlled Substance Policy:

- In compliance with the DEA guidelines, Cordova Psychiatric Associates specifies to select one provider to fill these types of medications. For example, if a benzodiazepine is written by this office, do not go to another provider to have the same medication filled. If this happens, it is a direct violation of this practice and we will no longer be able to fill that medication.
- Patient education related to stimulants and benzodiazepines over long term use: memory cognition impairments, addictive properties and decreased seizure threshold.
- Stimulants will be sent to one pharmacy of your choice.
- In the event the pharmacy is out of the stimulant, we will only transfer and/or send to another location one time.
- Compliance of regimen to controlled medications will be monitored with drug screens (urine or saliva) taken twice annually or as appropriate. The patient is responsible for the cost of drug screens.
- Guidelines for controlled medications require follow-up appointments no less than once every 3 months or as appropriate.

_____
Print Name

_____
Signature and date