VITALITY PSYCHIATRY GROUP PRACTICE

3125 US Route 9W Suite-204 New Windsor, NY 12553
3 Pine West Plaza Suite 305 Albany, NY 12205
Tel # (914)-502-3998) / (518)-691-0732
Fax # (518)-708 -6889
LIFE@VPGP.ORG
WWW.VITALITYPSYCHIATRY.ORG

NEW PATIENT REGISTRATION

Patient Name: _____ Date Of Birth: _____

Guardian Name & Relationship to Patient: _____
Address: _____
Phone: _____ Email: _____
Emergency Contact Name & Phone: _____
SSN: _____ Insurance Company: _____
Member ID Number: _____ Group Number: _____
Primary Policyholder's Name, DOB, SSN, & Relationship to Patient: _____
_____

Allergies: _____

Surgical History: _____
_____

Psychiatric Hospitalizations: _____
_____
Current Medications: _____
_____
Primary Care Physician and/or Additional Therapist/Psychiatrist: Please list your pharmacy name, address, and phone number: Current Psychiatric Symptoms: (check all that apply) _____
_____

Low or Sad Mood		Panic Symptoms	
Difficulty Concentrating		Difficulty Sleeping or Excessive Sleeping	
Difficulty with Appetite		Experiencing Nightmares	
Increased Anxiety		Frequent Headaches and/or Body Aches	
Decreased Energy		Decreased Interest in Pleasurable Activities	
Feelings of Loss or Guilt		Hearing Voices	
Suicidal Thoughts		Strange Visual Experiences	
Feeling Others are There to Harm You		Irritability or Mood Swings	

*Please present a valid photo ID along with a valid insurance card at your initial appointment. *Please note that we will take a current photo of you for your chart at your initial appointment.

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PATIENT TREATMENT CONTRACT

As a participant in treatment at Vitality Psychiatry Group Practice for medication management and/or therapy, I freely and voluntarily agree to accept this treatment contract as follows:

1. I agree to keep and be on time to my scheduled appointments. If I cannot keep my appointment at its scheduled time, I will call the office to cancel at least 24 hours prior to my scheduled appointment. Failure to give 24 hours notice of a cancelled appointment with result in a $40.00 fee that will be assessed to me, the patient, at my following visit.
2. I agree to conduct myself in a courteous manner while in the physician's office, as well as through any phone, email, or other forms of communication with all office staff.
3. I agree to adhere to the payment policies outlined by this office. Payments must be made via cash, credit, debit, certified check, cashier check, or money order. Personal checks are NOT an acceptable form of payment. If for some reason a personal check is accepted and it is returned for ANY reason, you are subject to the original check amount, an additional $50.00 returned check fee from Vitality, as well as any fees associated with your bank.
4. I agree to give a minimum of 48 hours notice for any medication refill requests. Refill requests that have been granted by your physician, will be subject to a $25.00 fee per incident.
5. I agree not to sell, share, or give any of my medications to another person. I understand that such mishandling of my medications is a serious violation of this agreement and would result in my treatment being immediately terminated without any recourse for appeal.
6. I agree not to conduct any illegal or disruptive activities in or on Vitality property.
7. I understand that any illegal or disruptive activities I am party to which happen outside of Vitality and are reported to Vitality may lead to termination of services from Vitality.
8. I agree that my medications/prescriptions can only be given to me at my scheduled office visits. A missed appointment may result in I, the patient, being unable to receive my medications/prescriptions until my next scheduled visit.
9. I agree that my medications are my responsibility. I agree to keep my medications in a safe, secure place. I agree that my medications will NOT be replaced unless a police report is given to Vitality.
10. I agree not to obtain medications from any doctors, pharmacies, or other sources without informing my physician at Vitality.

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11. I will make my physician aware of all medications I am currently prescribed, including those given by other treatment providers.
12. I agree to take my medications as instructed by my physician, without altering how I take my medications without first consulting with my physician.
13. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in counseling as discussed and agreed upon with my physician and specified in my treatment plan. Regular participation in counseling services is REQUIRED to maintain medication management services at Vitality.
14. Vitality does not take any responsibility for any failure of insurance reimbursements.
15. **I UNDERSTAND THAT VIOLATION OF ANY OF THE ABOVE MAY BE GROUNDS FOR TERMINATION OF TREATMENT AT THE DISCRETION OF VITALITY.**

Patient Signature: _____

Patient Name (Printed): _____Today's Date: _____

By initialing here, I acknowledge that I have received a copy of Vitality's Notice of Privacy Practices: _____

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HIPAA AUTHORIZATION FORM

I_____, whose date of birth is_____, , authorize Vitality Psychiatry Group Practice to: (check all that apply)

Name: _____ Phone:_____

Fax: _____ Email: _____

Information to be Received and/or disclosed: (check all that apply)

Psychiatric Records	Psychotherapy Records	Inpatient Records
Discharge Summary	Consultation Notes	Lab Reports
Alcohol/Drug Treatment	Medication List	Scheduling Rights

Other:_____

This protected health information is being disclosed for the following purposes: (check all that apply)

Coordination of Care	
At My Request	
Other:	

This authorization expires 1 year from the date it is signed. If the person or entity receiving this information is not a healthcare provider or health plan covered by federal privacy regulations (HIPAA), the information described above may be disclosed to other individuals or institutions and no longer protected by these regulations.

You have the right to revoke this authorization in writing at any time by sending written notification to Vitality Psychiatry Group Practice. A revocation of this authorization is not effective to the extent that action has been taken in reliance on the authorization.

Patient Signature: _____

Guardian Signature:_____

Patient Name: _____ Today's Date:_____

Staff Witness Signature: _____

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last 2 *weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself—or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite — being so figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
	add columns		+	+

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

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

A2663B 10-04-2005

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GAD-7

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3

(For office coding: Total Score T____ = ____ + ____ + ____)

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

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CREDIT/DEBIT CARD AUTHORIZATION

I, authorize Vitality Psychiatry to store my credit/debit card information and automatically charge my credit/debit card listed below for payment of _____

_____

In the amount of:	$		
Up to the amount of:	$		
VISA		MASTERCARD	
AMEX		DISCOVER	

Card Number: _____

Cardholder: _____

Expiration Date: _____ CVV Code: _____

Billing Address: _____

Phone: _____ Email: _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Vitality Psychiatry Group Practice PC in writing of any changes in my account information or termination of this authorization. It is expressly understood that the amount charged does not include or constitute any additional fees related to our acceptance of credit cards as a form of payment, permitted by law. I understand that patient services will only be issued upon receipt of payment for any amount due. I certify that I am an authorized user of this credit/debit card and will not dispute these scheduled transactions with my bank or credit card Company; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE: _____ DATE: _____

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FINANCIAL POLICY/WAIVER

We are committed to providing you with the best possible care. If you have medical insurance, we are anxious to help you receive your maximum allowable benefits. In order to achieve these goals, we need your assistance and your understanding. We will file your insurance claims for you, however, we ask that you pay any copayments at the time services are rendered, and the balance in full if your insurance company has not paid your claim within 60 days. We accept cash, credit, debit, certified check, cashier's check, or money order for any payments. A personal check is NOT an acceptable form of payment.

We will do everything in our power to expedite insurance reimbursement, but you must know that:

1. Your insurance policy is a contract between you, your employer, and the insurance company. If we participate with your insurance plan, we are under contract to only charge what your company allows. Since each carrier's "usual and customary" fees differ, we will take the appropriate discount when your insurance company pays our practice.
2. Not all services are covered benefits in all insurance contracts. Some insurance companies arbitrarily select certain services in which they will not cover. These non-covered services are your responsibility.

We must emphasize that as medical care providers, while the filing of insurance claims is a courtesy we extend to our patients, that all charges are your responsibility from the date services are rendered. We realize that temporary financial problems may affect payment of your account. If such problems arise, we encourage you to contact us promptly for assistance in management of your account. If you have any questions or concerns, please do not hesitate to ask, we are here to help you.

Below is a list of fees, which may be charged to your account (if applicable). These charges are NOT billable to your insurance company. By signing this contract you agree that you are responsible for these charges, should they be charged to your account.

1. Missed Appointment Fee: $40.00 each incident
2. Returned Check Fee: $50.00 each incident
3. Calling/Mailing Rx to Pharmacy: $25.00 each incident
4. Late Fee for Outstanding Patient Account Balances: $15.00 per mailed statement
5. Copying Patient Records: $0.75 per page
6. One Page Letter/Report: $40.00 per page
7. Case Conferencing: $40.00 per call
8. Case Management: $40.00 per call
9. Postage: at current USPS rates
10. Missed Psychiatric or Therapy Intake Appointment Fee: $100

I authorize the direct payment of any medical benefits for services rendered to Vitality Psychiatry Group Practice. I understand that I am responsible for any and all usual and customary charges not paid as a result of this assignment. If my account is turned over to a third party, collection agency, or attorney, I understand a 10% service charge (minimum of $15.00) will be added to the balance, and I understand that I will be responsible to pay all litigation expenses, court costs, and reasonable attorney fees.

Personal/Guarantor's Signature:_____
Patient Name & DOB:_____
Relationship to Patient: _____ Today's Date: _____

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NOTICE OF PRIVACY PRACTICES

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.

Uses and Disclosures of Protected Health Information:
Your protected health information may be used and disclosed by your physician, our office staff, and others outside of our office that are involved in your care and treatment for the purpose of providing healthcare services to you, to pay your healthcare bills, to support the operation of the physician's practice, and any other use required by law.

We will use and disclose your protected health information to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party. For example, your protected health information may be provided to a physician to whom you have been referred, DME vendors, surgery centers/hospitals, referring physicians, family practitioner, physical therapists, home health providers, laboratories, workers comp adjusters, and nurse care managers, etc. to ensure that the healthcare provider has the necessary information to diagnose and treat you.

Your protected health information will be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a hospital stay, surgery, MRI, or other diagnostic test, injection procedures, injection series, physical therapy, etc., may require that your relevant protected health information be disclosed to the health plan to obtain approval for the procedures.

We may use or disclose, as-needed, your protected health information in order to support the business activities of our physician's practice. These activities include, but are not limited to, quality assessment, employee review, training of medical students, licensing, fundraising, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical students that see patients at our office. In addition, we may use a sign-in sheet at the registration desk were you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment, and inform you about treatment alternatives or other health-related benefits and services that may be of interest to you. If we use or disclose your protected health information for fundraising activities, we will provide you the choice to opt out of those activities. You may also choose to opt back in.

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We may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, FDA requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, worker's compensation, inmates, and other required uses and disclosures.

Under the law, we must make disclosures to you upon your request. Under the law, we must also disclose your protected health information when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements under section 164.500.

Uses and Disclosures that Require Your Authorization:
Other permitted and required uses and disclosures will be made only with your consent, authorization, or opportunity to object unless required by law. Without your authorization, we are expressly prohibited to use or disclose your protected health information for marketing purposes. We may not sell your protected health information without your authorization. We may not use or disclose most psychotherapy notes contained in your protected health information. We will not use or disclose any of your protected health information that contains genetic information that will be used for underwriting purposes. You may revoke the authorization at any time, in writing, except to the extent that your physician or the physician's practice has taken action in reliance on the use or disclosure indicated in the authorization.

Your Rights:
You have the right to inspect a copy of your protected health information (fees may apply) – pursuant to your written request, you have the right to inspect or copy your protected health information whether in paper or electronic format. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or used in, a civil, criminal, or administrative action or proceeding, protected health information restricted by law, information that is related to medical research in which you have agreed to participate, information whose disclosure may result in harm or injury to you or another person, or information that was obtained under a promise of confidentiality.

You have the right to requests a restriction of your protected health information. This means you can ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific requested restriction except if you request that the physician not disclose protected health information to your health plan with respect to healthcare for which you have paid in full out of pocket.

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You have the right to request to receive confidential communications from us by alternative means or at tan alternative location. You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice alternatively i.e. electronically. You have the right to request an amendment to your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. You have the right to receive an accounting of certain disclosures, paper or electronic, except for disclosures: pursuant to an authorization, for purposes of treatment, payment, healthcare operations; required by law, that occurred prior to April 14, 2003, or 6 years prior to the date of the request. You have the right to receive a notice of a breach. We will notify you if your unsecured protected health information has been breached. We reserve the right to change the terms of this notice and will notify you of such change on the following appointment.

You may file a complaint with our compliance officer, Erin Waite (518-691-0732 x11), or to the Secretary of Health and Human Services if you believe your privacy right have been violated by us. We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. Law also requires us to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA compliance officer in person or by phone.

Patient Signature: _____

Patient Name (Printed): _____ Today's Date: _____

By initialing here, I acknowledge that I have received a copy of Vitality's Notice of Privacy Practices: