211 E. Butler Rd., Suite C1
Mauldin, SC 29662
P: 864-305-1662
F: 864-603-2067
www.GreenvilleADHD.com

Patient Registration Packet

Thank you for choosing Greenville ADHD Specialists! We are happy to have you as a patient, and are committed to providing you with the best possible care. Please follow the directions below.

Directions for completing paperwork:

1. Please complete all paperwork in its entirety. It is important for us to obtain a complete medical history.
2. Please have the last page of the intake forms, the Adult ADHD Symptom Checklist, completed by a family member or close friend.
3. The following records are also needed, if applicable. From the past 12 months, any test results, psychological assessments, medical records, or therapy notes regarding ADHD and other related problems. We are happy to obtain medical records for you, just complete the enclosed Release of Information Form.
4. Read each section carefully, especially our business policies. We want to be sure you understand our policies and charges. Please don't hesitate to ask questions.
5. Return your completed paperwork to our office as soon as possible. Once we receive all completed documents, we will contact you within 2-3 business days to schedule an appointment.
6. You may return documents by fax or email, or simply drop them by our office. You may also mail the documents if you wish, but we strongly recommend making copies first as mail is not always reliable.

   Fax: 864-603-2067

   Email: frontdesk@greenvilleadhd.com

   Mail: Greenville ADHD Specialists
   Attn: New Patient Coordinator
   211 E. Butler Rd., Ste C1
   Mauldin SC, 29662

On the day of the appointment:

1. No caffeine or nicotine (if applicable) at least 2 hours prior to your appointment for accurate testing results. You are welcome to take a break after the Qb test is performed.
2. Bring your insurance card(s) and photo ID with you. We will also take a patient photo for your chart.
3. Bring a list of all current medications and supplements with dosage, or the original bottles.
4. Please remember that testing is an out-of-pocket expense of $206 due at time of service. Depending on your insurance coverage, you may also be responsible for co-payments, co-insurance, deductible amounts or non-covered services as well.
5. If you live with a spouse or significant other, it can be beneficial to bring them to the appointment with you. We also suggest using a voice recording device or app on your phone to record your conversation with the doctor. It can be very helpful to go back and listen, as you will be receiving a lot of information.
6. The time needed for your first appointment is about 2-3 hours, so plan accordingly.

Thank you for your time and patience. Please let us know if you have any questions.

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PATIENT INFORMATION

All information disclosed is strictly confidential and will become part of your medical record. Please print clearly; sign and date the bottom.

Patient Name:	☐ Male ☐ Female	**DOB:**
Preferred Name:	**Social Security Number:**	
Mailing Address:		**Zip Code:**
Primary Phone #:	☐ Home ☐ Cell ☐ Work	**Contact Name:**
Secondary Phone#:	☐ Home ☐ Cell ☐ Work	**Contact Name:**
Email:		
Please select your preferred method of contact for **automated appointment reminders**: ☐ Email ☐ Text **Please remember: DO NOT REPLY to automated appointment reminders, you MUST CALL THE OFFICE to change or cancel your appointment.		
Referral Source: ☐ Physician ☐ Therapist ☐ Family ☐ Friend ☐ School ☐ Facebook ☐ Internet/Website ☐ Other:		

EMERGENCY CONTACT INFORMATION

Name:	**Relationship to Patient:**	
Phone #:	**Email:**	
Mailing Address:		**Zip Code:**

GUARANTOR INFORMATION

Who is financially responsible for account? ☐ Self (patient) ☐ Other If Other, please complete the following.		
Name of Parent/Spouse/Legal Guardian:		DOB:
Relationship to Patient:	Social Security Number:	
Phone #:	Email:	
Mailing Address:		**Zip Code:**

INSURANCE INFORMATION

Insurance Company:	**Group#:**
Member ID#:	**Effective date:**
Primary Policy Holder Name:	**Date of Birth:**
Social Security Number:	**Relationship to Patient:**
Claims Mailing Address (on back of card)**:**	
Does the patient have Secondary Insurance? ☐ Yes ☐ No If yes, please provide information below.	
Insurance Company:	Group#:
Member ID#:	Effective date:
Policy Holder Name:	Date of Birth:
Social Security Number:	Relationship to Patient:
Claims Mailing Address (on back of card):	

PRIMARY CARE PHYSICIAN

Doctor's Name:	**Practice Name:**	
Phone:	**Fax:**	**Address:**

REFERRING MEDICAL PROFESSIONAL (REFERRAL IS NOT REQUIRED)

Name:	**Practice Name:**	
Phone:	**Fax:**	**Address:**

Signature of Patient/Guardian/Guarantor: _____ **Date:** _____

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CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I understand that if I want to receive treatment from Greenville ADHD Specialists, P.A. ("the Practice"), I must give consent for them to use and disclose protected health information ("PHI") among themselves and with other individuals for treatment, payment and other health care operations. I also understand that all reasonable efforts will be made to protect the privacy of my health information, whether it is maintained on paper or electronically, and regardless of the method by which it is communicated.

I understand that the Practice has a Notice of Privacy Practices ("Notice") that describes in detail (1) how my PHI is used and disclosed, (2) when I need to give further approval for the Practice to use and disclose my PHI, (3) when my permission is not needed for the Practice to use and disclose my PHI, (4) my rights regarding my PHI, and (5) grievance procedures if I believe my privacy rights have been violated.

I understand that I have the right to receive a copy of the Notice and that I have the right to read the Notice before signing this Consent. I understand that Greenville ADHD Specialists, P.A. reserves the right to change the Notice at any time. I may obtain a current copy of the Notice by contacting the Practice at (864) 305-1662.

By signing below, **I agree that Greenville ADHD Specialists, P.A. may**:

1. Use my PHI, on a need to know basis, to give me treatment.
2. Disclose my PHI and correspond with others who are involved with my care either in or outside of the Practice. Including, but not limited to: referring providers, primary care physicians, other healthcare providers, therapists, counselors, teachers or school representatives.
3. Use my PHI for billing purposes.
4. Disclose my PHI with health insurance companies, government agencies, or other payers that request information related to benefits, claims filed, and other billing matters.
5. Disclose my PHI with outside parties who contract with the practice to perform services on behalf of our patients. (ie: Qb Tech, CNS Vital Signs, Lab companies)
6. Disclose my PHI and communicate confidential information (ie: appointment and medication/prescription information, invoices for services) to the address, email, and phone number(s) provided and leave a message on voicemail or with someone who answers if I am not available.
7. Use my PHI to obtain my medication history from the pharmacy database.
8. Disclose my PHI to specified family member(s) or person(s) involved in my care. I give consent to the following family member(s) or person(s), allowing them involvement in treatment, payment, and health care operations including picking up prescriptions:

Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____
Name: _____ Relationship: _____

I understand that I may request restrictions on the uses and disclosures of my PHI. The Practice is not legally required to accept my request, but if it does, it is bound by this agreement and will abide by the restrictions except in emergency situations, or where required by law.

I understand that I may revoke this consent, in writing, except to the extent that the Practice has already made disclosures in reliance upon my prior consent. I also understand that if I revoke this consent, the Practice has the right to refuse to provide further treatment to me.

I consent to the uses and disclosure of my protected health information as described above.

Signature of Patient or Legal Guardian/Representative:_____

Printed Name: _____ Date: _____

Relationship to Patient: _____

Print Patient Name: _____ Date of Birth: _____

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NOTICE OF PRIVACY PRACTICES

Effective April 1, 2014

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review this notice carefully.

Protected health information ("PHI") is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services. This Notice of Privacy Practices describes how we may use and disclose your PHI to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI, and to notify affected individuals following a breach of unsecured protected health information.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, calling the office to request that a revised copy be sent to you by mail or email, or asking for one at the time of your next appointment.

How we may use and disclose your PHI:

· **For Care or Treatment**: Your PHI may be used and disclosed to those who are involved in your care for the purpose of providing, coordinating, or managing your services. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who referred you to us, or will provide services that we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test.

Your authorization is required to disclose PHI to any other provider not currently involved in your care.

· **For Payment**: Your PHI may be used and disclosed to any parties that are involved in payment for care or treatment. For example, your insurance may require copies of your PHI during the course of a medical record request, chart audit or review.

If you pay for your care or treatment completely out-of-pocket with no use of any insurance, you may restrict the disclosure of your PHI for payment.

· **For Business Operations**: We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging other business activities. Or we may use and disclose this information to get your health plan to authorize services or referrals.

We will share your PHI with third party "business associates" that perform services (for example, billing or testing services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we have a written contract that contains terms to protect the confidentiality and security of your PHI.

We may use and disclose PHI to contact you with appointment reminders or prescription information by phone or email. If you are not home, we may leave this information on your voicemail or with the person answering the phone. We may also use and disclose PHI by having you sign a sheet for prescription pick-up. At an appointment, we may call out your name when we are ready to see you.

· **Required by Law**: As required by law, we will use and disclose your PHI, but we will limit our use or disclosure to the relevant requirements of the law. For example, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule, if so required.

· **Without Authorization**: Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. Examples of some of the types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as the health department)
- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

· **Verbal Permission**: We may use or disclose your information to family members that are directly involved in your receipt of services with your verbal permission.

· **With Authorization**: Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked. Your explicit authorization is required to release notes and PHI for the purposes of marketing, subsidized treatment communication and for the sale of such information.

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Your PHI Rights:

To exercise any of these rights, please submit your request in writing to our Practice at the address listed above:

· **Right of Access to Inspect and Copy**. You have the right, which may be restricted only in exceptional circumstances or with documents released to us, to inspect and copy PHI that may be used to make decisions about service provided. This means you may inspect and obtain a copy of your PHI for so long as we maintain the PHI. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice use for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

· **Right to Request Restrictions**. You have the right to request a restriction or limitation on the use or disclosure of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or health care operations. You may also request that any part of your PHI 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 restriction requested and to whom you want the restriction to apply. We are not required to agree to your request.

· **Right to Request Confidential Communication**. You have the right to request that we communicate with you about PHI matters in a specific manner (e.g. telephone, email, postal mail, etc.) We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact.

· **Right to Amend**. If you feel that the PHI we have about you is incorrect or incomplete, you have a right to request that we amend the information. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. However, we are not required to agree to the amendment or change your information.

· **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain disclosures that we make of your PHI. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

· **Right to Receive Notification in the Event of a Breach.** You have a right to receive notification if there is a breach of your PHI. After learning of a breach, we must provide notice to you without unreasonable delay and in no event later than 60 calendar days after discovery of the breach, unless a law enforcement official requires us to delay the breach notification

· **Right to a Copy of this Notice**. You have the right to a copy of this notice.

Website Privacy:

Any personal information you provide us with via our website, including your e-mail address, will never be sold or rented to any third party without your express permission. If you provide us with any personal or contact information in order to receive anything from us, we may collect and store that personal data. We do not automatically collect your personal e-mail address simply because you visit our site. In some instances, we may partner with a third party to provide services such as newsletters, surveys to improve our services, health or company updates, and in such case, we may need to provide your contact information to said third parties. This information, however, will only be provided to these third-party partners specifically for these communications, and the third party will not use your information for any other reason.

Our site may contain links to other outside websites. We cannot take responsibility for the privacy policies or practices of these sites and we encourage you to check the privacy practices of all internet sites you visit. While we make every effort to ensure that all the information provided on our website is correct and accurate, we make no warranty, express or implied, as to the accuracy, completeness or timeliness, of the information available on our site. We are not liable to anyone for any loss, claim or damages caused in whole or in part, by any of the information provided on our site. By using our website, you consent to the collection and use of personal information as detailed herein. Any changes to this Privacy Policy will be made public on this site so you will know what information we collect and how we use the information.

Complaints:

If you believe we have violated your privacy rights, you have the right to file a complaint in writing to Greenville ADHD Specialists at the address listed above. If you have questions and would like additional information, you may contact our office.

I acknowledge by signing below that I have received the Notice of Privacy Practices and Notice of Individual Rights.

Signature of Patient or Legal Guardian/Representative:_____

Print Name: _____ Date: _____

Relationship to Patient: _____

Print Patient Name: _____ Date of Birth: _____

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BUSINESS POLICIES

Greenville ADHD Specialists is committed to providing you with the best possible care. Letting you know in advance of our business policies allows for a good flow of communication. If you have any questions, do not hesitate to ask a member of our staff.

Please read each section carefully, and initial each paragraph acknowledging that you understand.

Appointment Policy

We value the time we have set aside to see and treat you. In general, new patient appointments take about 2 hours and follow-up appointments can vary from 30 minutes to 1.5 hours. Please plan accordingly to allow the time needed to properly manage your care.

Please help us serve you better by **keeping scheduled appointments**. If you are unable to keep your scheduled appointment, please call our office as soon as possible to reschedule. This will allow time to provide that time slot to another patient.

_____ 1. We **require at least a 24-hour notice** if you need to reschedule or cancel your appointment. There is a charge for missed or late cancelled appointments. Multiple missed or cancelled appointments may result in dismissal from the practice.

- **No Show/Late Cancellation Fee- New Patient Appointment $100**
- **No Show/Late Cancellation Fee- Follow-Up Appointment $30**

_____ 2. You must CALL THE OFFICE to cancel or reschedule your appointment. **Do not reply to automated appointment reminders.** Monday appointments must be cancelled by the previous business day, during business hours (typically Friday between 8 am – noon, unless Friday is a holiday). The same applies to Tuesday appointments when Monday is a holiday.

_____ 3. As a courtesy we will notify you by phone or email of your upcoming appointment. However, **we do not guarantee notification** and may not be able to notify you 24 hours in advance. You are responsible for keeping track of your appointment date and time.

_____ 4. The appointment time we give you is your **required arrival time**, it is not the time you are scheduled to see the doctor. This allows our staff the time needed to gather all information necessary for the doctor. We strive to minimize any wait time; however, circumstances do occur that may delay your appointment. We appreciate your understanding.

_____ 5. **If you are late** for your appointment, we will do our best to accommodate you. However, on certain days it may decrease your time with the doctor or be necessary to reschedule your appointment and the **cancellation fee applies**.

_____ 6. If the patient is a minor, they must be accompanied by their parent or legal guardian at every visit. **We must have a signed consent on file prior to appointments** for a minor unaccompanied by parent or legal guardian. Please ask us for this form if needed.

Insurance Policy

We participate with most local and national insurance plans and wish to help you receive your maximum allowable benefits. Our office will file medical claims to a patient's health insurance company. We require presentation of a valid health insurance card and accurate demographic information to properly file these claims.

_____ 1. It is your responsibility to understand whether we are a **preferred provider within your network**. You are responsible for all charges or out of network benefits that apply.

_____ 2. It is your responsibility to know if your plan **requires pre-authorization or a referral** from your primary care physician, and to obtain any required information prior to your appointment. You will be responsible for all charges if any claims are denied because authorization or referral was not received.

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_____ 3. Our **services may or may not be covered** by your particular policy. It is your responsibility to understand your benefit plan and contact your carrier to determine if services are covered prior to the date of service. All non-covered services are your responsibility and must be paid at the time of service.

_____ 4. Depending on your insurance coverage, you may be responsible for **co-payments, co-insurance, deductible amounts or non-covered services** due at the time of service.

_____ 5. **Testing is an out-of-pocket expense** and will not be submitted to your insurance company.

_____ 6. It is the patient's responsibility to provide us with current insurance information and to keep us updated with your correct insurance information, including a copy of your card. **If the insurance company you designate is incorrect, you will be responsible for payment and you will have to submit the charges to the correct plan yourself.**

Financial Policy

For an estimate of what you will owe on the date of service, the administrative assistants at the front desk are happy to assist you with any payment questions.

_____ 1. **Payment <u>in full</u> is required at the time of service**. We accept cash, check, credit/debit card.

_____ 2. If special circumstances make immediate payment in full impossible, payment arrangements must be approved and agreed upon by Greenville ADHD Specialists **prior to receiving services**. There is a **$15.00 non-payment fee** if payment is not made at time of service, and a payment arrangement has not been approved prior to visit.

_____ 3. While the filing of insurance claims is a courtesy, all charges not covered by your insurance company are your responsibility.

_____ 4. For patients with **no insurance coverage,** full payment is required at the time of service.

_____ 5. If we do not participate with your insurance plan, payment in full is expected from you at the time of service. We will supply you with a detailed receipt that you can submit to your insurance for reimbursement.

_____ 6. Patient balances are billed immediately on receipt of your insurance plan's explanation of benefits. Your **remittance is due within 30 days** of your receipt of your bill.

_____ 7. **<u>Out-Of-Pocket Fees and Charges</u>:**

• **Qb Test**	**$206**
• **CNS Vital Signs Test**	**$128**
• **Rating Scales**	**$14 each**
• **Returned Check**	**$35**
• **Accommodation Requests**	**$10 - $50**
• **Drug Screens**	**$25 - $45**
• **Patient Records Printed** (first 30 pages)	**$25**
• **Prescription Replacement**	**$15**
• **Mail Prescription(s)**	**$5**
• **Failed Auto-Draft Transaction**	**$5**
• **Non-Payment Fee**	**$15**

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_____ 8. **Overdue balances**, including family accounts, must be paid prior to or on the day of your next appointment, and/or before a prescription may be picked up or mailed out.

_____ 9. Bills unpaid for more than 90 days may be **turned over to a collection agency** unless other arrangements have been made. Accounts that are turned over to a collection agency will have a 25% processing fee attached to the balance, and will result in dismissal from the practice.

Prescription Policy

_____ 1. Patients must be seen in our office at least **every 3 months** in order to receive prescriptions for controlled substances.

_____ 2. For medication refills, we ask that you contact us **2-3 days prior to running out of your medication**. All refills are authorized by your physician, so we must have ample time to communicate with the physician for authorization. It may take up to 72 hours to complete your request.

_____ 3. Please request refills during regular business hours. We do not refill medication after hours or on weekends.

_____ 4. Any refill request made after 3:00 pm will not be addressed until the following business day.

_____ 5. If prescriptions are misplaced, lost, stolen, or expired, we may only replace them one time at the discretion of the provider. There is a **$15 prescription replacement fee**. After that one prescription replacement, you will have to wait until you are due for another refill or a follow up appointment.

_____ 6. You must obtain ADHD medication from Greenville ADHD Specialists only. We will check the pharmacy database regularly for compliance.

_____ 7. **Random drug screens may be performed** at the discretion of the provider. The fee for these screens is nonrefundable, and the responsibility of the patient.

_____ 8. If there is any type of abuse or misuse of medication, you will be discharged from the practice immediately.

_____ 9. All prescriptions for controlled substances must be picked up in person and signed for. We **cannot call in or fax prescriptions for controlled substances** to the pharmacy.

_____ 10. If the patient is a minor or the patient is not the one picking up the prescription, the person picking up the prescription **must be listed on the patient's consent form** and present a photo ID at pick up.

_____ 11. We can mail prescriptions to you upon request for a **$5 fee**.

_____ 12. All outstanding **balances must be paid in full** before a prescription may be picked up or mailed out, unless a payment arrangement is already in place.

_____ 13. If a patient is a **NO SHOW** (miss a scheduled appointment without prior notification), the physician will no longer provide another prescription until the patient is seen for an appointment. Please note that typically the next available appointment is usually several months out.

By signing below, I acknowledge that I have read and understand these business policies and agree to comply and accept responsibility as outlined above. I understand that this is a legal and binding document.

Signature of Patient or Legal Guardian/Representative: _____

Print Name: _____ Date: _____

Relationship to Patient: _____

Print Patient Name: _____ Date of Birth: _____

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NEW PATIENT INTAKE FORM: ADULT

Patient Name: _____

Date of Birth: _____

1. **What are your main concerns?** For example, inattention, distractibility, impulsivity, work performance, academic/school-related problems, etc. Please describe.	

2. Have you ever been formally diagnosed with ADHD?		☐ Yes	☐ No
If yes, when were you diagnosed?	And by whom?		
Do you have documentation of the diagnosis?		☐ Yes	☐ No
Are you currently under a provider's care for ADHD?		☐ Yes	☐ No
Are you currently taking medication for ADHD?		☐ Yes	☐ No
3. Have you ever received IQ or Academic testing for learning problems?		☐ Yes	☐ No
If yes, what were the results?			
4. When do you think your problems with ADHD started?			

5. How are/were grades in:	Elementary school?	☐ Below Average	☐ Average	☐ Above Average	☐ N/A
	Middle school?	☐ Below Average	☐ Average	☐ Above Average	☐ N/A
	High school?	☐ Below Average	☐ Average	☐ Above Average	☐ N/A
	College?	☐ Below Average	☐ Average	☐ Above Average	☐ N/A
	Grad school?	☐ Below Average	☐ Average	☐ Above Average	☐ N/A
6. How difficult is/was homework and studying?					
7. Do/Did you have any behavioral/discipline problems in school?		☐ Yes	☐ No		
8. Do you procrastinate?		☐ Yes	☐ No		
9. Are you late getting places?		☐ Yes	☐ No		
10. Are you organized at home?		☐ Yes	☐ No		
11. Are you organized at school/work?		☐ Yes	☐ No		
12. Do you avoid talking on the phone?		☐ Yes	☐ No		
13. Are you sensitive to:	Noises?	☐ Yes	☐ No		
	Light?	☐ Yes	☐ No		
	Touch?	☐ Yes	☐ No		

14. **Do you have any medication allergies?** ☐ **Yes** ☐ **No** If yes, please list below.

Name of Medication	Describe the Reaction

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Patient Name: _____ DOB: _____

List all CURRENT prescribed medications and over-the-counter drugs, such as vitamins and inhalers	
Name of Medication and Strength	Frequency Taken

List any <u>past</u> ADHD medication trials	
Name of Medication and Strength	Dates Tried, Benefits and/or Side Effects

MEDICAL HISTORY							
Have you ever experienced any of the following? If yes, please describe and include dates if applicable.							
Hospitalizations	☐ Yes	☐ No					
Surgeries	☐ Yes	☐ No					
Concussion	☐ Yes	☐ No					
Traumatic Brain Injury	☐ Yes	☐ No					
Headaches	☐ Yes	☐ No					
Obstructive Sleep Apnea	☐ Yes	☐ No					
Restless Legs Syndrome	☐ Yes	☐ No					
Asthma	☐ Yes	☐ No					
Seizures	☐ Yes	☐ No					
Anemia	☐ Yes	☐ No					
Thyroid Disease	☐ Yes	☐ No	Diabetes	☐ Yes	☐ No		
Heart Disease	☐ Yes	☐ No	Cardiac Abnormalities	☐ Yes	☐ No		
Elevated Blood Pressure	☐ Yes	☐ No	Elevated Lipids	☐ Yes	☐ No		
Constipation	☐ Yes	☐ No	Diarrhea	☐ Yes	☐ No		
Heartburn	☐ Yes	☐ No					

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Patient Name: _____ DOB: _____

MENTAL HEALTH HISTORY				
Have you ever experienced any of the following? If yes, please describe any treatments or medications tried.				
ADHD	☐ Yes	☐ No		
Anxiety / OCD / Panic	☐ Yes	☐ No		
Depression	☐ Yes	☐ No		
Bipolar Disorder	☐ Yes	☐ No		
Autism Spectrum Disorder	☐ Yes	☐ No		
LD- Other Developmental Learning Difficulties	☐ Yes	☐ No		
ODD- Oppositional Defiant Disorder	☐ Yes	☐ No		
Tic Disorder	☐ Yes	☐ No		
Other Psychiatric Disorder	☐ Yes	☐ No		
Have you ever worked with an ADHD coach?	☐ Yes	☐ No	When/Who:	
Counseling/Therapy	☐ Yes	☐ No	Last visit:	Therapist:

SOCIAL HISTORY						
Marital Status	☐ Single	☐ Married	☐ Separated	☐ Divorced	☐ Widowed	☐ Domestic Partner
Do you have children?	☐ Yes	☐ No	If yes, how many?			
With whom do you live?						
Highest level of education?						
If you have a degree, what is it in?						
What type of work do you do? For what company?						
What is your general stress level?	☐ High	☐ Medium	☐ Low			
List activities that you enjoy doing						
Exercise	☐ Sedentary (No exercise)					
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)					
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)					
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)					
Diet	Are you dieting?				☐ Yes	☐ No
	If yes, are you on a physician prescribed medical diet?				☐ Yes	☐ No
	# of meals you eat in an average day?					
	Rank salt intake	☐ High	☐ Medium	☐ Low		
	Rank fat intake	☐ High	☐ Medium	☐ Low		
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	☐ Energy Drinks	
	# of cups/cans per day?					

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Patient Name: _____ DOB: _____

Alcohol	Do you drink alcohol?		☐ Yes	☐ No
	If yes, what kind?			
	How many drinks per week?			
	If you drank in the past, when did you quit?			
Tobacco	Do you use tobacco?		☐ Yes	☐ No
	☐ Cigarettes – pks./day?	☐ Chew - #/day?	☐ Pipe - #/day?	☐ Cigars - #/day?
	Number of years?	If you formerly smoked, number of years and year quit?		
Nicotine	Do you use nicotine without tobacco? (e.g. e-cigarettes, gum, patches, lozenges)		☐ Yes	☐ No
	☐ Electronic Cigarettes (Vape)	☐ Nicotine Gum	☐ Nicotine Patch	☐ Nicotine Lozenges
	How long have you used?	Approximately how many mg of nicotine do you use per day?		
Drugs	Are you currently using any recreational or street drugs?		☐ Yes	☐ No
	→ If yes, list drug(s) and describe use (frequency, quantity, how long you have used, etc.): → Do you have any desire to reduce or eliminate the use of a substance?			
	In the past, have you ever used or experimented with drugs or smoked marijuana?		☐ Yes	☐ No
	→ If yes, list drug(s) and describe use:			
	Have you ever had an addiction/abuse problem with prescribed or recreational drugs?		☐ Yes	☐ No
	→ If yes, list drug(s), describe use, and when stopped:			
	Have you participated in any type of rehab program or substance abuse counseling?		☐ Yes	☐ No
	→ If yes, when and where?			

CURRENT PHARMACY INFORMATION			
	Name	Address – Street name is fine for local address	Phone
Local			
Mail Order			

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Patient Name: _____ DOB: _____

FAMILY MEDICAL HISTORY

Check the box next to any medical condition below that has affected any of your immediate family members (parents, brothers, sisters) and state your relationship.

Initial if none _____	Relationship
☐ High Blood Pressure	
☐ High Cholesterol	
☐ Heart Disease	
☐ Stroke	
☐ Migraines	
☐ Seizures/Convulsions	
☐ Diabetes	
☐ Bleeding/Blood-clotting Disorder	
☐ Allergies	
☐ Asthma	
☐ Thyroid Problems	
☐ Osteoporosis	
☐ ADHD	
☐ Psychiatric Disorder/Mental Illness	
☐ Alzheimer's/Dementia	
☐ Substance Abuse/Addiction or Alcoholism	
☐ Cancer- type:	
☐ Other:	

OTHER INFORMATION

Anything you would particularly like us to know about you which would help us give you the best treatment possible?

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INSTRUCTIONS: Please have family member or close friend complete

Patient Name: _____ Today's Date: _____

Name of person completing the form: _____ Relationship: _____

Adult ADHD Symptom Checklist Please answer the questions below, rating the patient on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you felt the patient conducted themselves over the past 6 months.	Never	Rarely	Sometimes	Often	Very Often
1. How often does the patient have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often does the patient have difficulty getting things in order when they have to do a task that requires organization?					
3. How often does the patient have problems remembering appointments or obligations?					
4. When the patient has a task that requires a lot of thought, how often do they avoid or delay getting started?					
5. How often does the patient fidget or squirm with their hands or feet when they have to sit down for a long time?					
6. How often does the patient seem to feel overly active and compelled to do things, like they were driven by a motor?					
					Part A
7. How often does the patient make careless mistakes when they have to work on a boring or difficult project?					
8. How often does the patient have difficulty maintaining attention when they are doing boring or repetitive work?					
9. How often does the patient have difficulty concentrating on what people say to them, even when they are being spoken to directly?					
10. How often does the patient misplace or have difficulty finding things at home, school, or work?					
11. How often is the patient distracted by activity or noise around them?					
12. How often does the patient leave their seat in meetings or other situations in which they are expected to remain seated?					
13. How often does the patient seem restless and fidgety?					
14. How often does the patient have difficulty unwinding and relaxing when they have time to themselves?					
15. How often does the patient talk too much in social situations?					
16. When the patient is in a conversation, how often do they finish the sentences of the people they are talking to before that person can finish it themselves?					
17. How often does the patient have difficulty waiting their turn in situations where taking turns is required?					
18. How often does the patient interrupt others when they are busy?					
					Part B

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REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Please complete this form in order for Greenville ADHD Specialists to obtain previous records from, or release and send records to another provider (i.e. primary care physician, therapist, counselor, testing center, etc.).

Patient's Name: _____ **Date of Birth:** _____

Previous Name: _____ SSN (last four digits) _____

I request and authorize Greenville ADHD Specialists to obtain and/or release the information or records specified for the patient named above. Please request records from, or release records to: (Fill in information below)

Name of Individual/Organization:			
Address:	City:	State:	Zip:
Phone:	Fax:		

INFORMATION AUTHORIZED TO BE RELEASED:

- ☐ Latest Encounter Note
- ☐ Mental Health Notes (Past 12 months)
- ☐ Psychological or Educational Test Results
- ☐ ADHD/Behavioral
- ☐ Therapy Notes
- ☐ Lab Reports
- ☐ Well Checks (Past 12 months)
- ☐ Growth Chart
- ☐ Other: _____

PURPOSE/USE OF REQUESTED INFORMATION:

- ☐ Sharing with other health care providers
- ☐ Personal use by patient
- ☐ Other (please describe) _____

By signing below, I agree that I have read and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I understand that I may revoke this authorization at any time, except to the extent that action based on this authorization has already been taken. Greenville ADHD Specialists' Notice of Privacy Practices explains the process for revocation, which includes a request in writing. I understand that, if this information is disclosed to a third party, the information may no longer be protected by state, federal regulations and may be re-disclosed by the person or organization that receives the information. I understand authorizing the disclosure of information identified above is voluntary and this authorization is not intended to alter the patient's ability to receive medical care from any health care provider. This authorization will be valid for the duration of the patient's treatment or until rescinded in writing. I release Greenville ADHD Specialists from any legal responsibility or liability for the disclosure of the above information to the extent indicated and authorized herein. I hereby, knowingly and voluntarily authorize Greenville ADHD Specialists to use or disclose my health information in the manner described above.

_____ _____

Signature of Patient or Legal Representative | Date

_____ _____

Name of Representative (print) | Relationship to Patient

CIOX HEALTH CUSTOMER # 2019347