Genesis Psychiatric Center
1380 Pantheon Way, Suite 310
San Antonio, Texas 78232
Office (210) 404-9696
Fax (210) 404-9466

Edmund P. "Ted" Williams, IV, M.D.
Gary Dunham, PA-C
Nicholas Gaultney, PMHNP, BC
Jennifer Harris, PA-C

PATIENT INFORMATION

Last Name:_____ First Name:_____ MI:____ Suffix:____ ☐Male ☐Female

Date of Birth:_____ Age:_____ Marital Status:_____ Occupation:_____

Social Security #:_____ Drivers License #/State:_____

Home Address:_____ Apt #:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____ Other:_____

E-mail:_____

What is the best way to reach you: ☐-Home☐-Cell ☐-Work ☐-Other May we contact you at work? Y N

Emergency Contact:_____ Relation:_____ Phone:_____

Preferred Pharmacy Name: _____Phone:_____

Primary Care Physician:_____ Phone:_____

Address:_____

Referred by:_____ Phone:_____

PARENT/GUARDIAN/RESPONSIBLE PARTY ☐SELF ☐ OTHER (Please complete if other)

Last Name:_____ First Name:_____ MI:____ Suffix:____ ☐Male ☐Female

Home Address:_____ Apt #:_____

City:_____ State:_____ Zip Code:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____ Other:_____

Social Security #:_____ Drivers License #/State:_____ DOB:_____

Employer:_____ Position/Title:_____

INSURANCE INFORMATION – Please present Insurance cards at EVERY visit.

PRIMARY Insurance Company: _____ Policy #:_____

Group #:_____ Effective Date: _____ Employer:_____

Policy Holder Name: _____ Policy Holder DOB:_____

Policy Holder Social Security #:_____ Relationship to patient:_____

SECONDARY Insurance Company: _____ Policy #:_____

Group #:_____ Effective Date: _____ Employer:_____

Policy Holder Name: _____ Policy Holder DOB:_____

Policy Holder Social Security #:_____ Relationship to patient:_____

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Patient Information, Consent, and Financial Policy

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Welcome to the Genesis Psychiatric Center. We appreciate the opportunity to work with you. The following information is provided for your benefit so that we may serve you better. Please read carefully and sign at the bottom of page 2. You will be given a copy for your records.

1. **PAYMENTS**: Fees for services: which include unpaid balances, deductibles; copayments and fees are due at the time of your visit. We accept cash, debit, and all major credit cards.

2. **APPOINTMENTS**: We ask that you arrive on-time for your appointments. This will facilitate our ability to see you as scheduled. Patients arriving past the appointment time may result in rescheduling.
NEW PATIENTS: A reservation fee of $125 is required to schedule your first appointment. For those with in-network insurance, this fee may be refunded to you at your first appointment (depending on your insurance plan/coverage); you will then be charged for your visit in accordance with your insurance plan/coverage. For private/self pay patients (including those with out-of-network insurance), the registration fee is applied to your New Patient appointment and the remaining balance is due at the time of your visit.

3. **CANCELLATIONS/MISSED APPOINTMENTS**: NEW PATIENTS: are asked to cancel their first appointment not less than 3 business days before their scheduled appointment by speaking with someone in our office directly. Late cancellation of your appointment will result in your $125 reservation fee not being refunded. EXISTING PATIENTS: patients are asked to cancel at least 24 hours in advance of the scheduled appointment time. There will be a $50 late cancel charge. The charge for not showing for an appointment is $100. This charge is not payable by insurance and I understand that this will be my responsibility.

4. **CHANGE OF INFORMATION:** Please provide us with any change regarding your address, phone number or insurance information as soon as possible.

5. **MEDICATION REFILLS**: Please contact your pharmacy first. They will contact our office for authorization of the refill. ***You must be seen regularly (usually not less than every 3 months) for proper monitoring of your condition and the medications prescribed.*** Controlled substances will not be filled after hours or weekends. There will be a $25 charge for filling a prescription after hours. Expedited refill request less than 2 business days will incur a $15. Charge. A $15 charge for lost or expired prescriptions.

6. **URINE PRESCRIPTION MONITORING:** Urine prescription monitoring will be conducted on all new patients and periodically on patients taking controlled substances. Patients with drug screens positive for illicit substances will not be prescribed medications that are potentially habit forming.

7. **AFTER HOURS CARE:** In a life-threatening emergency, please call 911. For urgent non-emergency matters please call our office number (210) 404-9696 and leave a message with the answering service. If needed the provider on call will return your call as soon as possible.

8. **MEDICAL RECORDS:** Request for copies of your medical records must be made in writing on a form provided by our office. Our office will respond within 15 business days to a properly completed written request. Fees: As per the rules adopted by the Texas State Board of Medical Examiners: $25.00 for the first 20 pages, $.50 cents for each page thereafter. No charge Doctor to Doctor/Hospital. Charges will be assessed for Letters and completion of forms.

9. **TERMINATION OF DOCTOR/PATIENT RELATIONSHIP:** The provider reserves the right to terminate the doctor/patient relationship at their discretion. Reasons for termination may include, but are not limited to: failure to comply with treatment plan, untimely unpaid balances, history of missed appointments, tampering or refusal of drug screen, verbal abuse of staff and lack of a good fit. The patient (or the patient's legal representative) has the right to terminate treatment at his/her discretion. Upon either party's decision to terminate the relationship, the provider will continue care for at least 30 days and recommend more appropriate resources.

10. **LEGAL AND COURT-RELATED MATTERS:** Dr. Williams and the providers with Genesis Psychiatric Center do not participate in court-related matters, such as divorce or child support cases. However, if court-related work is required, the practices' cost related to that work is the sole responsibility of the patient and/or their responsible party. These matters include but are not limited to: preparation, communication with involved parties, depositions, testimony, standby efforts, attorney fees, and other costs incurred as a direct result of the matter.

11. **EDUCATION:** Genesis Psychiatric Center is a teaching site for the University of Texas Health Science Center at SA (UTHSCSA). You may be asked to allow students to join your session. The choice is entirely yours. We appreciate your contribution to their medical education.

12. **PROMOTIONAL ACTIVITIES FOR PHARMACEUTICAL COMPANIES:** Dr. Williams has contracts with several pharmaceutical companies to educate other physicians about their products. These are promotional programs he is trained and paid to give.

13. **COLLECTION AGENCY:** In the event of a delinquent account balance, I will be responsible for all collection fees assessed by the collection agency onto the account.

14. **CONSENT TO TREATMENT:** I consent to evaluation and treatment of myself, my minor child or ward.

15. **ASSIGNMENT OF BENEFITS:** I hereby authorize my insurance benefits to be paid directly to Genesis Psychiatric Center and understand that I am financially responsible for non-covered services. I also authorize Genesis Psychiatric Center to release any information to my insurance company required to process claims.

Patient Name (please print) Patient or Authorized Representative Signature Date

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Authorization Form for Release of Protected Health Information with Family or Friends

Patient Name:_____ Date of Birth:_____

I grant permission for my healthcare provider and their representatives of Genesis Psychiatric Center to discuss my care using this disclosure form to share relevant information about my healthcare or discuss financial information for payment on my account with family or friends.

Release my protected health information to the following person(s)/entity:

Name:_____ Phone:_____ Relationship:_____

Name:_____ Phone:_____ Relationship:_____

The information you may release subject to this authorization is the following:

Appointment date/time ☐Yes ☐No Explanation of diagnosis and/or procedures ☐Yes ☐No

Lab Reports ☐Yes ☐No Billing Information ☐Yes ☐No

☐**I do not want any of my information shared with family or friends**

I consent to Genesis Psychiatric Center to leave a message on my voicemail regarding my lab test results:
☐Yes ☐No

I understand that my healthcare information at Genesis Psychiatric Center is protected. By signing this form, you are granting Genesis Psychiatric Center to disclose your protected health information for the purpose of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this information. The terms of our Notice may change, and if so, you may obtain a revised copy by contacting our office. The Notice is available on our website and in our lobby. If you would like a copy please see the front desk.

_____

Patient/Authorized Representative Signature Date

This consent will be considered valid until such time that I revoke it. I reserve the right to revoke it at any time. I understand that to revoke this consent, I must provide written notice to Genesis Psychiatric Center.

INITIAL PSYCHIATRIC EVALUATION

20180712

ADULT

Age 18 and older (after high school)

Genesis Psychiatric Center

Name: _____ **DOB:** _____ **Age:** _____ **Date:** _____

Name of others with you today: □ No one, I came alone today □ Spouse/Other: *Name, relationship to you:* _____

Are you ALLERGIC to any medicines? □ **No** □**Yes List:** _____ □ **NKDA**

Do you see a **therapist** for talk therapy? □No □Yes Name: _____

How did you hear about us? **If someone referred you, who?** _____

Check all that apply: □Insurance company □Therapist □Physician □Friend □Internet □ TV Commercial □Other _____

BACKGROUND INFORMATION

Tell us about your family & living situation

Names of those living in the same household and names of Children & Step Children *not* living with you:

□ No one lives with me. I live alone.

Living with you?	Name	Age	Relationship to you
□Yes □No			
□Yes □No			
□Yes □No			
□Yes □No			
□Yes □No			
□Yes □No			

Have you ever been divorced? □No □Yes How many times?_____

Have you ever been remarried? □No □Yes How many times?_____

Educational, Work, Legal & Religious History

Occupation: _____

Education: Current or highest grade level? _____

If in school, how are grades? _____

Legal – Have you had any legal problems or ongoing problems with custody issues? □ No □ Yes

Describe: _____

Spiritual History

Are you a Christian? □ No □ Yes □ Unsure

Other Religious beliefs? _____

How important to you is faith in God:

□ Important □ Somewhat Important □ Not Important

Do you now or have you ever met with others in religious or spiritual community? □No □Yes

How important is or was this to you?

□ Important □ Somewhat Important □ Not Important

THE PROBLEM WHICH BRINGS YOU HERE:

You may write on the other side if needed

Why are you here and What are your problems/concerns?

(Briefly explain the problem that brings you here now and what stressful circumstances have contributed to it.)

Patient Initials _____

COGNITION – Mental sharpness over the past month	**0** – Good (No problems)	**1** – Minimal problems	**2** – Moderate problems	**3** – Marked problems	*MG-CPFQ*
How has your *motivation/interest level/ enthusiasm* been over the past month?	□	□	□	□	
Your *wakefulness/alertness*?	□	□	□	□	
Your *energy level*?	□	□	□	□	
Your ability to *focus/sustain attention?*	□	□	□	□	
Your ability to *remember/recall information*?	□	□	□	□	Total:
Your ability to *find words*?	□	□	□	□	
Your *sharpness/mental acuity*?	□	□	□	□	

SUICIDAL THOUGHTS, ATTEMPTS, OR SELF-HARM

CURRENT THOUGHTS OF SUICIDE OR DEATH
□ I do not think of suicide or death – *if checked, skip this section*
□ No □ Yes - I feel that life is empty or wonder if it's worth living
□ No □ Yes - I have wished I were dead or wished I could go to sleep and not wake up.
□ No □ Yes - I Have been having thoughts of killing myself
□ No □ Yes - I have been thinking about how I might do this.
□ No □ Yes - I am thinking about acting on these thoughts
□ No □ Yes - I have started to work out or have worked out the details of how to kill myself.

PAST SUICIDE ATTEMPTS
□ NONE □ 1 □ 2 □ 3 or more
SELF MUTILATION
□ I have not ever hurt myself physically to distract myself from emotional pain – *if checked, may skip to next section*
□ I used to feel like cutting or hurting myself to deal with emotional pain, b t not any more
□ Recently I have felt like cutting or hurting myself
□ I think about cutting or hurting myself several times a day

Comments:

OTHER SYMPTOMS

SOCIAL ANXIETY SYMPTOMS	**POST-TRAUMATIC STRESS SYMPTOMS**
□ A persistent fear of being embarrassed or looking foolish,	□ You have experienced a very significant traumatic event.
especially around unfamiliar people, i.e. very shy	If YES, what?_____
□ You avoid situations in which you might be embarrassed so much	□ Distressing memories or nightmares
that it interferes significantly with your ability to function normally	□ Easily startled, always 'on guard'
	□ Feeling numb, unreal, or detached
OBSESSIVE-COMPULSIVE SYMPTOMS	□ You avoid situations reminding you of the trauma
□ Do you wash or clean a lot?	**EATING ISSUES**
□ Do you check things a lot?	□ Constantly dieting despite others saying you're thin
□ Is there any thought that keeps bothering you that you would like to get rid of but can't?	□ Binge eating or purging
□ Do your daily activities take a long time to finish?	**ANGER, & AGGRESSION**
□ Are you concerned about putting things in a special order or symmetry, or is very upset by mess?	Do you have (too frequently) sudden outbursts of anger? □Yes
□ Compulsive hair pulling (Trichotillomania)	With aggression? □Yes
□ Compulsive pornography	Are you having thoughts of hurting someone else? □Yes
□ Compulsive internet use	**OTHER SYMPTOMS**
□ Compulsive shopping	
□ Compulsive stealing	Are there times that you feel fine one minute and then become tearful (or laughing) the next minute over something small or for no reason at all. □Yes
□ Are you very concerned and preoccupied about the appearance of some part(s) of your body which you consider especially unattractive?	Do you detect hidden meanings in what people say or do? □Yes
	Do you often feel persecuted? □Yes
PHOBIAS/SPECIFIC FEARS	Feel that people can read or control your thoughts? □Yes
□ Fear of going out or going certain places	Hallucinations (hear voices or see things) □Yes
□ Other specific fears? If so, what?	

PATIENT INITIALS _____

DEVELOPMENTAL, ABUSE, & TRAUMA HISTORY

Was your childhood: □ Basically happy □ Painful Why? Were you a victim of past: □ Physical abuse? □ Neglect? □ Emotional abuse? □ Sexual abuse? Other? Explain briefly: _____ _____	□ No □ Yes Do you have any history of learning difficulties – dyslexia, being a slow learner, etc? Explain: _____ _____

FAMILY HISTORY

Please indicate whether any of your (blood) relatives have had any of these concerns:

	Parents	Brothers/Sisters	Children	Grandparents	Aunts/Uncles/Cousins
Diabetes	□	□	□	□	□
ADHD	□	□	□	□	□
Autistic Disorders	□	□	□	□	□
Suicide	□	□	□	□	□
Alcohol/Drug Problems	□	□	□	□	□
Mental hospital	□	□	□	□	□
Depression problems	□	□	□	□	□
Manic or Bipolar	□	□	□	□	□
Schizophrenia	□	□	□	□	□
Anxiety and/or panic	□	□	□	□	□
Obsessive-Compulsive	□	□	□	□	□

RELATIONSHIPS AND SOCIAL SUPPORTS

MARITAL ISSUES/ SIGNIFICANT OTHERS

Are you married? □ Yes □ No If NO, are you in a steady relationship? □ Yes □ No

How would you rate your relationship? □ Happy □ Fairly happy □ Just OK □ Fairly unhappy □ Very unhappy

If VERY UNHAPPY, please write briefly in the space provided below what the general nature of the problems are.

_____

_____

SOCIAL SUPPORTS

□ Yes □ No Do you experience a lot of loneliness?

□ Yes □ No Do you have a close confidant other than spouse? How often do you talk? _____

OTHER CONFLICTUAL RELATIONSHIPS

□ Yes □ No Are you having significant conflict or stress with anyone other than your spouse? If so, who? _____

About what? _____

JOB

How would you rate your work satisfaction? □ Very happy □ Fairly happy □ Just OK □ Fairly unhappy □ Very unhappy

If VERY UNHAPPY, please write briefly below what the general nature of the problems are.

_____

_____

PATIENT INITIALS _____

EXERCISE

In a typical week, how many times do you exercise at least 20-30 min (any type, or brisk walking or yoga)?

□ **None** □ **1 time** □ **2 times** □ **3 times** □ **4 times** □ **5 times** □ **6 times** □ **7 times**

SLEEP ISSUES

IN THE LAST TWO WEEKS:
Do you generally feel rested when you wake up in the morning? □ Yes □ No
What time do you typically go to bed? _____ What time do you typically fall asleep? _____
What time do you typically wake up? _____
Including naps during the day, how many hours, on average, do you sleep per 24-hour day? _____
If you awaken frequently through the night, how many times do you awaken, and how long does it take you to go back to sleep? If so, you awaken approximately times? _____ Time it takes to get back to sleep: _____
Do you struggle to stay awake when you should be awake? □Yes
Is your work, home, or social life negatively affected by excessive sleepiness, or, for example driving a car? □Yes
Do you have a tendency to snore? □Yes
Have you been told that you stop breathing briefly at times while you are sleeping at night? □Yes
Have you been prescribed CPAP? □Yes If Yes, do you use it regularly? □Yes
Do you work shifts or a nontraditional schedule (could include being a caregiver for infant or elderly)? □Yes

THE EPWORTH SLEEPINESS SCALE is used to determine the level of daytime sleepiness. *A score of 10 or more is considered sleepy.* How likely are you to doze off or fall asleep in the following situations, in contrast to feeling just tired? Use the following scale to choose the most appropriate number for each situation.

SITUATION	**CHANCE OF DOZING OR FEELING SLEEPY**
Sitting and reading	_____
Watching TV	_____
Sitting inactive in a public place (for example: a theater or a meeting)	_____
As a passenger in a car for an hour without a break	_____
Lying down to rest in the afternoon when circumstances permit	_____
Sitting and talking to someone	_____
Sitting quietly after a lunch without alcohol	_____
In a car, while stopped for a few minutes in traffic	_____

0 = **none**
1 = **slight**
2 = **moderate**
3 = **high**

Total Score

PROBLEMS WITH EMOTIONAL INSTABILITY

Having problems with emotional instability means having unstable relationships, low self-esteem, and problems with impulsive behavior, beginning by early adulthood. A common feature of this emotional instability is fear of being left alone (abandoned), even if the threat of being abandoned is not real. This fear may lead to frantic attempts to hold on to others and may cause them to become overly dependent on how others feel about them. Angry mood swings and erratic behavior can lead to troubled relationships in many areas of life.

Problems with emotional instability – do you tend to:

□ Make frantic efforts to avoid real or imagined abandonment.
□ Have a pattern of difficult relationships caused by alternating between extremes of intense admiration and hatred of others.
□ Have an unstable self-image or be unsure of his or her own identity.
□ Act impulsively in ways that are self-damaging, such as extravagant spending, sex with many partners, substance abuse, binge eating, or reckless driving.
□ Have recurring suicidal thoughts, make repeated suicide attempts, or cause self-injury through mutilation, such as cutting or burning oneself.
□ Have frequent emotional overreactions or intense mood swings, including feeling depressed, irritable, or anxious. These mood swings may only last a few hours at a time. In rare cases, they may last a day or two.
□ Have long-term feelings of emptiness.
□ Have inappropriate, fierce anger or problems controlling anger – or often display temper tantrums or get into fights.
□ Have temporary episodes of feeling suspicious of others without reason (paranoia) or losing a sense of reality.

CURRENT and PAST MEDICATIONS

List ALL CURRENT MEDICATIONS, VITAMINS, HERBAL, & SUPPLEMENTS that you are now taking:

Medication, Vitamin, or Herbal	Medication, Vitamin, or Herbal	Medication, Vitamin, or Herbal

List ALL PAST MEDICATIONS that you have taken:

√ if Taking Now or Past	Medication Have you *ever* taken any of these:	dose	When & Why Stopped	When	√ if Taking Now or Past	Medication Have you *ever* taken any of these:	dose	When & Why Stopped	When
□Now □Past	**Ritalin/Methylin**				□Now □Past	**Abilify**			
□Now □Past	**Metadate**				□Now □Past	**Aristada or Maintenna**			
□Now □Past	**Mydayis**				□Now □Past	**Rexulti**			
□Now □Past	**Aptensio**				□Now □Past	**Geodon**			
□Now □Past	**Concerta**				□Now □Past	**Risperdal/Invega**			
□Now □Past	**Focalin (or XR)**				□Now □Past	**Zyprexa**			
□Now □Past	**Daytrana**				□Now □Past	**Seroquel (or XR)**			
□Now □Past	**Adderall (or XR)**				□Now □Past	**Saphris**			
□Now □Past	**Vyvanse**				□Now □Past	**Fanapt**			
□Now □Past	**Other stimulant**				□Now □Past	**Latuda**			
□Now □Past	**Strattera**				□Now □Past	**Vraylar**			
□Now □Past	**Clonidine**				□Now □Past	**Clozapine**			
□Now □Past	**Guanfacine**				□Now □Past	**Lithium**			
□Now □Past	**Prozac**				□Now □Past	**Depakote**			
□Now □Past	**Zoloft**				□Now □Past	**Tegretol** (Carbamazepine)			
□Now □Past	**Paxil**				□Now □Past	**Trileptal**			
□Now □Past	**Luvox**				□Now □Past	**Lamictal** (lamotrigine)			
□Now □Past	**Celexa**				□Now □Past	**Topamax**			
□Now □Past	**Lexapro**				□Now □Past	**Valium** (Diazepam)			
□Now □Past	**Effexor XR**				□Now □Past	**Xanax** (Alprazolam)			
□Now □Past	**Pristiq**				□Now □Past	**Ativan** (Lorazepam)			
□Now □Past	**Cymbalta**				□Now □Past	**Klonopin** (Clonazepam			
□Now □Past	**Wellbutrin**				□Now □Past	**Lyrica**			
□Now □Past	**Remeron**				□Now □Past	**Neurontin**			
□Now □Past	**Buspirone**				□Now □Past	**Hydroxyzine**			
□Now □Past	**Trintellix**				□Now □Past	**Ambien (or CR)**			
□Now □Past	**Viibryd**				□Now □Past	**Lunesta**			
□Now □Past	**Fetzima**				□Now □Past	**Temazepam**			
□Now □Past	**Nefazodone**				□Now □Past	**Sonata**			
□Now □Past	**Amitriptyline**				□Now □Past	**Trazodone**			
□Now □Past	**Imipramine**				□Now □Past	**Rozerem**			
□Now □Past	**EMSAM**				□Now □Past	**Melatonin**			
□Now □Past	**Nardil**				□Now □Past	**Benadryl** (antihistamine)			
□Now □Past	**Parnate**				□Now □Past	**Other OTC sleep aid**			
□Now □Past	**Ketamine**				□Now □Past	**Buprenorphine**			
□Now □Past	**Provigil/Nuvigil**				□Now □Past	**Antabuse** (disulfiram)			
□Now □Past	**Aricept** (donepezil)				□Now □Past	**Campral** (acamprosate)			
□Now □Past	**Namenda** (memantine)				□Now □Past	**Naltrexone** (oral or injectable)			