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

☐**<u>I do not want any of my information shared with family or friends</u>**

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

CHILD & ADOLESCENT

Genesis Psychiatric Center

Age 17 and under (through high school)

Name: ______________________ **DOB:** ________ **Age:** _____ **Date:** ________

Name(s) of parent/guardian accompanying patient: ____________________ Relationship to patient ______________

Who is filling out this form? ______________________________

ALLERGIES to any medicines? □ No □Yes List:__________________________________ □ NKDA

Does your child 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 Siblings & Step Siblings *not* living with you:

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

Have child's parents separated or divorced? □Yes □No When: ________

Has either remarried? Name of step parent: ______________

What contact does child have with other biological parent? __________

____

Educational, Work, Legal & Religious History

Education: Current or highest grade level? ____________

If in school, how are grades? ______________________

Has child had any history of **learning difficulties** – dyslexia, being a slow learner, etc? □ No □ Yes: ______________

Is child in special education, or '504'? □ No □ Yes

Peer Relationships – Does child/adolescent have close friends? □Yes □ No

Has the family moved recently? □ No □Yes: ______________

Are you concerned about influences of certain peers? □ No □Yes:

Legal – Has the child/adolescent had any legal problems or Are there any ongoing problems with custody issues? □ No □ Yes

Describe:______________________________

Spiritual History

Are your child's beliefs Christian? □ No □ Yes □ Unsure

Other Religious beliefs?______________________

How important to your child is faith in God:

□ Important □ Somewhat Important □ Not Important

Does your child meet with others in religious or spiritual community?

□No □Yes

THE PROBLEM WHICH BRINGS YOUR CHILD/TEEN 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.)

____

____

____

____

____

____

OTHER SYMPTOMS

POST-TRAUMATIC STRESS SYMPTOMS
□ Has your child has experienced a very significant traumatic event. If YES, what?________________________
□ Has distressing memories or nightmares
□ Is easily startled, always 'on guard'
□ Seems to feel numb, unreal, or detached
□ Avoids situations reminding him/her of the trauma

OBSESSIVE-COMPULSIVE SYMPTOMS
□ Does your child/teen wash or clean a lot?
□ Does your child/teen check things a lot?
□ Does your child/teen have a thought that bothers them that they can't get rid of?
□ Does your child/teen, because things have to be done a certain way, take a long time to finish things?
□ Is your child concerned about putting things in a special order or symmetry, or is very upset by mess?
□ Compulsive hair pulling (Trichotillomania) or skin-picking

PHOBIAS/SPECIFIC FEARS
□ Fear of going out or going certain places
□ Other specific fears? If so, what?

SELF MUTILATION
□ Teen has not ever hurt self physically to distract self from emotional pain – *if checked, may skip to next section*
□ In the past teen has hurt self physically but does not do so any more
□ Recently child/teen has hurt self physically
□ Teen thinks about cutting or hurting self several times a day

EATING ISSUES
□ Constantly dieting despite others saying you're thin
□ Binge eating or purging

TANTRUMS, OUTBURSTS
Severe, frequent tantrums, anger outbursts □Yes □No
With aggression? □Yes □No Explain:

OTHER CHILDHOOD SYMPTOMS
□ Bedwetting
□ Accidental bowel movements
□ Tics (habits of movements or sounds)
□ Stops mid-sentence and stares

PROBLEMS BEING GROUNDED IN REALITY
□ Talks to people who are not there
□ Literally believes he/she is someone else
□ Hears voices talking when no one is there
□ Sees things when nothing is there
□ Believes mind is being read or controlled by others
□ Claims to get special messages from the TV or radio
□ Paranoid – believes people are out to get him/her (But no gang or drug activity justifying this belief)
□ Grandiose delusions (fixed, false beliefs)
□ Involved in Satan worship or strange religious activities
□ Has developed strange or bizarre ideas about the world
□ Speech at times makes no sense

FAMILY HISTORY

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

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

SLEEP ISSUES

IN THE LAST TWO WEEKS, if your child has trouble sleeping too much or too little, or their sleep is interrupted by awakening several times each night, please answer the following:	
What time does your child typically go to bed? ________ What time do they typically fall asleep? ________	
What time do they typically wake up? ________ Do they seem to feel rested when they wake up in the morning? □ Yes □ No	
Including naps during the day, how many hours, on average, do they sleep per 24 hour day? ________	
If they awaken frequently through the night, how many times does your child awaken, and how long does it take them to go back to sleep? Awaken approximately ________ times. Time it takes to get back to sleep: ____________	
□Yes □No	Does your child have a tendency to snore?
□Yes □No	Have you observed your child stop breathing briefly at times while they are sleeping at night?

RELATIONSHIPS AND SOCIAL SUPPORTS

FAMILY RELATIONSHIPS

How would you rate your child's happiness in your family? □ 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 Does child experience a lot of loneliness?

□ Yes □ No Does child have a close friend whom they can tell things and trust that the friend won't tell others? How often do they talk?_________

OTHER CONFLICTUAL RELATIONSHIPS

□ Yes □ No Is child having significant conflict or stress with anyone outside of your family, being bullied, etc? If so, who, and about what?

____

SCHOOL

How is child doing in school? Explain any problems, such as not passing classes, worries about grades, or conflict with people at school.

____

____

PARENTING DIFFICULTIES/OTHER ISSUES OR QUESTIONS

Describe what problems you have as you try to parent your child. For example, are there ways in which you or the child's other parent may be contributing to, or at least not helping, the problem; or things that as a parent you might need help with and would like to discuss?

If divorce has occurred, how well would you say the two of you are able to cooperate with regard to the child?

PROBLEMS WITH EMOTIONAL INSTABILITY (For teenagers only)

Having problems with emotional instability means having unstable relationships, low self-esteem, and problems with impulsive behavior, beginning by late adolescence or 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 – does your child 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 (if driving age, or driving a car without permission).

□ 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.

SOCIAL INTERACTIONS AND ASPERGER'S SYMPTOMS

I. *Social Interactions and Relationships*

1) Significant problems with nonverbal communication skills, such as understanding the meaning of eye-to-eye contact, facial expressions, or body posture. □ Yes □ No

The problems with nonverbal communication skills involve difficulty 'reading' people. For example, the child may recognize, that another person does not like something they just said or did, but they may not understand why the other person was bothered. Or, for example, when another person bumps into them accidentally, they assume it was on purpose.

2) Marked difficulty in establishing or maintaining friendships with children of the same age. □ Yes □ No

Though may play well with younger children, or be able to converse with adults. Seems 'clueless' in many social situations, often saying and doing things which a child even much younger in age would intuitively know not to do. Lacks 'common sense' in relating to other people.

3) Lack of interest in sharing enjoyment, interests, or achievements with other people. □ Yes □ No

On the other hand, may go on and on talking about something in which they are interested despite the fact that the person to whom they are talking is not interested and does not want to hear (example of a problem with reading body language).

4) Lack of empathy. Has difficulty understanding other people's feelings and connecting to them in a personal way. □ Yes □ No

May be able sometimes to recognize what others' feelings are, but has difficulty connecting with others and apparent difficulty identifying the distress of other people and responding appropriately.

Total *YES* answers _____

II. *Limited interests in activities or play*

1) Preoccupation with certain topics □ Yes □ No

For example, may be fascinated by Star Wars, Japanese cartoon cards or characters, video games, military history, dinosaurs, maps, weapons, or other interests which are 'different' from other children the same age.

2) A need for sameness and routines; or being rigid and inflexible □ Yes □ No

For example, insisting that things be done a certain way, though there is no reason why they should be done so.

3) Can't 'let go' of a topic or request. □ Yes □ No

For example, repeatedly asks over and over for something they want to do or have. They won't take 'no' for an answer.

4) Unusual behaviors or movements of the body □ Yes □ No

These may include body rocking and hand flapping.

Total *YES* answers _____

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)			