Evansville Psychiatric Associates
Complete Outpatient Mental Health Care

2015 Maxwell Avenue, Evansville, IN 47711
Phone: 812-422-7974 Fax: 1-812-671-0627
Email: faxes+2038119@waitingroomsolutions.com

REGISTRATION AND CONSENT TO TREAT AND OFFICE POLICY REVIEW

Patient Name: First: _____ Middle: _____ Last: _____

Preferred Name: _____ DOB: _____ Social Security # _____

Gender: ○Male ○Female ○Transgender Male ○Transgender Female ○Non-Binary/Genderfluid

Address: _____ City/State: _____ ZIP: _____

Home # _____ Cell # _____ Work # _____

Employer: _____ Emp Phone # _____

Patient's email address: _____

Preferred Local Pharmacy/Street address: (Choose one) _____

Doctor/NP/PA: _____ Phone: _____

Primary Insurance: (You need to verify you are in network with us **BEFORE** your appointment. We **DO NOT** verify your in-network status for you.)

Subscriber Name: _____ Employer:_____
DOB: _____ SSN: _____ Email: _____
Address: _____ City/State: _____ Zip: _____
Insurance Company: _____ Ins Phone # _____
Subscriber ID # _____ Group # _____

Secondary Insurance:
Subscriber Name: _____ Employer:_____
DOB: _____ SSN: _____ Email: _____
Address: _____ City/State: _____ Zip: _____
Insurance Company: _____ Ins Phone # _____
Subscriber ID # _____ Group # _____

Emergency Contact(s): (If the patient is under 18, please complete this section with parent names)

Name: _____ Relationship: _____ Phone: _____
DOB: _____ SSN: _____ Email: _____
Address: _____ City/State: _____ Zip: _____

Name: _____ Relationship: _____ Phone: _____
DOB: _____ SSN: _____ Email: _____
Address: _____ City/State: _____ Zip: _____

PLEASE INITIAL:

____ ARRIVE & CHECK IN EARLY/PAYMENT EXPECTED AT TIME OF SERVICE: Check in 5 minutes before your appointment. The Patient Portal can be used to update all demographics. For in-office visits, please have your Driver's License/state ID and insurance card(s). Copays are due at time of service *unless previously arranged with our billing department*. Payments may be made via the Patient Portal or by phone. We accept cash, check, VISA, MASTERCARD, DISCOVER, and AMERICAN EXPRESS.

____ CREDIT CARD ON FILE: We ask you to keep a credit card on file with our office. You may always pay by other means at check in, but if payment is missed, then we will charge it for you and it prevents missed copay fees and statement fees. Any unpaid balances and fees will be processed for you. If you are delinquent or sent to collections, a new credit card on file is required. All statements are sent by email. If we do not have a current card on file, missed copay/coinsurance fees and statement fees apply to all balances.

____ SMS Consent Policy: You consent to receive text messages from our practice regarding appointments, care instructions, billing updates, and other health-care related information, including links for telehealth appointments. Message frequency may vary and standard message and data rates may apply.

____ BILLS: Statements are emailed and may be paid online, by phone, by mail, or in office. Payment is required upon receipt of statement. Charges left unpaid after 90 days may be sent to collections without additional notice. Collection fees are set by state law and incur an additional 33% fee that is the patient's responsibility. Returned checks incur a non-sufficient fund (NSF) fee per Indiana allowance. If we are required to send a printed statement, an additional mailing fee will be added (see front desk for current fee).

____ NON-COVERED SERVICES: Services not covered by insurance are the patient's responsibility. This includes out of network charges, whether with primary or secondary insurance. Other examples are letters, forms, mailings and certain *types* of appointments. We do not traditionally allow appointments with two different providers on the same day, as such situations may not be covered by insurance and could cause the full cost of the appointment(s) to fall on the patient. It is your responsibility to know how, or if, your insurance covers your services. We will not verify for you if our providers or services are in-network with your plan. Insurance policies vary widely in coverage and change periodically. Your insurance policy is a contract between you and your insurance company. Likewise, our relationship is with you as a patient and *not* the insurance company.

____ Rx INSURANCE: If your insurance assigns prescription benefits to another policy, we need that information as well. If you have separate coverage for your prescription benefits, we will need this information to complete prior authorizations for your prescriptions.

PATIENT PORTAL: The Patient Portal uses your email address as your username and is accessed through our website. For minor children, the username for the account is your email with a "+childsname" modification inserted between the user name and the domain,e.g. youremail+childsname@domain.com. Emails will come directly to your email address.

Your Patient Portal is HIPAA compliant and secure, and can be used to pay your bill, request refills, make/change/cancel appointments, and send messages to your provider. You can send a message 24/7 and we will respond on the next business day and/or when we hear back from your provider.

If you are having trouble with your password, follow the reset password prompts or contact the office.
If you do not have online access and need to call, leave the nurses only *one* message.

NOTIFY US IMMEDIATELY OF INSURANCE CHANGES to include Medicaid enrollment**.** New policies require a verification of benefits, and may need pre-authorization or a change of provider. We do not bill traditional Medicaid, and those fees could become your responsibility. If you add Medicaid as a secondary insurance, the nurses may be unable to complete medication prior authorizations for you if your prescriptions are billed through Medicaid.

COURTEOUS WAITING ROOM BEHAVIOR is expected. Guest Wi-Fi is available. Do not talk on your phone, play audio aloud, or use a camera in our waiting room. If you cannot agree to these requests or are otherwise disruptive, you will be asked to leave and refunds will not be issued.

FOLLOW-UP APPOINTMENTS: Your provider will discuss when you need to return for a follow-up appointment. Schedule your follow-up at check-out.For telehealth, please send a portal message after your appointment to request your follow-up and tell us the dates and times that would work best for you. If you are a therapy client and need a specific weekday and/or time for your appointments, you may schedule up to four future appointments with your therapist, and after each appointment, you may schedule an additional appointment on your provider's schedule. If you no-show/late cancel, future appointments are subject to cancellation.

If you are seeing a provider who prescribes medications for you, you must schedule/attend all requested appointments. You must have a follow-up appointment scheduled in order for the nurses to be authorized to handle refills, prior authorizations, and any paperwork you need for FMLA, ESAs, life insurance forms, etc.

REFILLS: Check with your pharmacy *first* to make sure if you have refills or a prescription *on hold/ on file*. If you submit refill requests by entering prescription numbers, make sure you are using *your most current bottle*. If you still need a refill, send a message through the Patient Portal. Patient Portal requests are the preferred method for refill requests. Request all Schedule II and III prescriptions 3-5 business days in advance to prevent delays.

Patients who are prescribed controlled medications are subject to random pill counts or Urine Drug Screens as part of the requirements of the Controlled Substances Act. If you are selected, then you must comply with the pill count on the same business day or submit a urine sample to a lab within 24 hours. You must keep your contact information current and make your voicemail is able to accept messages.

CANCELLATIONS: Use the Patient Portal to notify us of cancellations. Please cancel with at least 48 hours' notice. Appointments that are missed or cancelled in less than 24 hours are subject to a missed appointment fee. If you are late, the provider may be unable to see you. If you have 2 or more missed and/or late canceled appointments, you are subject to having your case closed without additional warning. Arriving late for an appointment may be considered a missed appointment. Telehealth appointments follow the same guidelines. If you are forced to miss an appointment or arrive late due to a verified emergency, please speak to the office staff. Missed appointment fees require payment and review by management before rescheduling.

If there is an illness, quarantine or a transportation problem, please notify us and we will do our best to arrange a telehealth appointment for you. If your provider has a similar issue, they may also request to complete your appointment by telehealth. Some insurances differ on coverage for telehealth services. You are responsible for knowing the parameters of your insurance policy. Patients will be held responsible for telehealth services if they are not covered under the insurance benefits.

Office closings due to inclement weather, electrical outage, or natural disaster will be posted to our website and Facebook page https://m.facebook.com/evansvillepsychiatric/, or X (formerly Twitter) @EvvPsychiatric. If we are able to arrange telehealth visits on those days, you will be contacted through the Patient Portal. Keep your contact information current with the office so we can reach you for emergencies.

PRIVACY: We follow HIPAA privacy regulations. The policy is on our website. Your providers may communicate with each other for coordination of care. Your providers may use transcribing software that utilizes AI for the purpose of dictation. This software does not release any identifying info outside of the clinic. Your health information remains confidential to our office with only a few exceptions: (1) Your insurance company may request records for payment, to approve a medication, or as part of an audit (2) Court subpoenas (3) Child or elder abuse as mandated by state law.

Outside of these very specific situations, information and records are released only with your authorization. Authorizations may be signed for a single release, a specific time period, or for the duration of your active patient status in our clinic. If you wish to allow someone to be able to speak on your behalf, request appointments, or handle billing, make sure we have a completed release that includes their name, their contact information, and the timeframe for the release.

TELEHEALTH APPOINTMENTS: We use a HIPAA compliant platform for telehealth. We need your accurate email address and cell number. Telehealth invitations are sent early on the day of your appointment. Please call us immediately if you do not see your telehealth email. Make sure to check all email folders and spam. Your telehealth room name changes with each appointment.

Open your email and scroll to the bottom of your message. The room link is in a grey box at the end of your email. The grey box is a hyperlink that will open your telehealth room. If you are using a smartphone or tablet, make sure you have the GOOGLE MEET APP downloaded on your device. If you join early, or if your provider is running behind, your request to join may time out. If this happens, simply request to join again.

You must have a good internet connection and private space for your telehealth appointment. When you open your link, your device may ask for permission to access your camera and microphone for the appointment. Do not take calls or open other programs on your device during this time, as you may miss when your provider connects. If you are having trouble connecting, our office may call you. If you live out of state, you may be required to come across state lines or to the office even for a telehealth appointment. *This is dependent on your state's laws*. If you are required to come to the office, we will provide a private space and tablet for your appointment.

RECORD REQUESTS: Records can be faxed to a new provider at no charge. Requests for printed records must be approved by your provider and will incur fees per state standards (labor fee plus print page fees by number of pages and additional fees for urgent requests for printing within 48 hours or less, and certification). Attorney, disability and life insurance requests may incur fees.

AFTER HOURS EMERGENCIES: If you have an emergency after hours, you may reach a provider through the answering service. Please follow the prompts on our phone tree, 812-422-7974. If it is a non-urgent request, please use the portal or leave a phone message at the office.

PARENTS AND PARENTAL SEPARATION: The person who brings the child in for treatment is responsible for payment of any copay or balance due at time of service. If there is a divorce situation, the parent or adult who brings the child to the appointment is responsible for charges unless a credit card is on file already.
We an provide a receipt so that the responsible party can be reimbursed. We will not bill third parties for payments of balance due.
We require a copy of any court orders in instances where there is a custody issue, restraining order, or Power of Attorney that we need documented.
The appointment that your child has with their health care provider is the child's appointment and should be a safe space for them. We do not engage in releasing records to a parent seeking litigation involving their child's custody, etc. If records are subpoenaed by the court, we will follow procedure and fax them directly to the judge or officer of the court as ordered.

Per HHS.Gov: *"HIPAA also allows a healthcare provider to determine, based on professional judgment, that treating someone as a patient's personal representative for HIPAA purposes would endanger the patient, and to refuse to treat the person as a personal representative under those circumstances. This applies whether the patient is an adult or a minor child."*

COURT APPEARANCES: We do not traditionally perform court-ordered services. If you subpoena your clinician to be a witness for a court case, be advised: these requests will require prepayment in full for the clinician's time to include preparation, travel, and testimony and cancellation of a day or more of appointments. These fees range from $250-600/hour. If your clinician is treating your child: be aware that court involvement with your child's therapist is not therapeutic for your child, and may influence the therapeutic relationship the child has with the provider.

TRUST: Good mental health care requires mutual trust. We expect patients to be honest with their providers. We also ask that administrative staff be treated with respect. Aggressive, abusive, discriminatory, or destructive behavior will not be tolerated. If you have a complaint or suggestion for improvement, please allow us the opportunity to hear it first. We take pride in providing excellent service, and we would love to have your feedback. We appreciate the opportunity to address any issues when possible.

By signing this form you acknowledge that you have read and understand the above information, rights, and responsibilities. By signing this form, I authorize my insurance company to make payment directly to Evansville Psychiatric Associates unless I choose to pay for all services in full at time of service. I understand that medical records may need to be released to my insurance company in order to substantiate claims.

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian: _____ Date: _____
(Required if patient is under 18)
Relationship of Parent/Guardian to patient: _____
Provide a copy of any custody agreement, court judgments, or POA papers necessary.

Witness: _____ Date: _____

Credit Card Authorization Information

As a convenience to you Evansville Psychiatric Associates will keep a credit card authorization on file to fulfill your financial requirements. This ensures timely posting for your financial responsibility due at the time of service. If you have insurance we will bill the amount to insurance first and charge the card when the patient responsibility is posted to your account. Receipts are in the portal and can be provided upon request.

○ MasterCard	○ Visa	○ American Express	○ Discover

Is this an HSA or FSA Card? O Yes O No ***If your card is an HSA, it will be charged for insurance based costs only. If the charge can not be billed to insurance it can not be paid with an HSA and you should consider adding a back-up card.***

Card Number:	CVV:
Card Holder Name: _____ Address: _____Zip:_____ Signature:	Expiration Date:

By signing this agreement I understand the terms and conditions listed above. I also understand that any charges incurred for treatment and are not included with this date's payments will be due at the next billing cycle. A receipt will be sent through the portal upon my request.

Declined charges are subject to fees; Failed payment plans are subject to fees or collections processing. (See Registration paperwork) If you update your card with us or in the portal, we will use the updated encrypted version for this agreement unless you contact us differently.

This Credit Card Authorization can be used for the following patient account(s):

_____ _____ _____

OR----------

O **Check here & sign below for Credit Card OPT-OUT Only:** I understand that all balances are due on date of service or upon receipt of statement. If I opt out of placing a card on file, I understand that I will accumulate missed copay fees and statement fees. I understand that my balance must be paid in full to reschedule. Balances are billed by email only and forward to collections after 3 billing cycles.

Name: _____ DOB: _____

Signature: _____ Date: _____

Initial Assessment - Child (4-16 years old)

Date: _____ Parent/Guardian: _____

Child Name: _____ Cell Phone: _____

Child Age: _____ Email: _____

Please list everyone who lives in the home and his/her relationship to the child: _____

_____

What are your child's strengths, interests, and/or hobbies? _____

_____

_____

What are the concerns/issues that bring you to therapy today? _____

_____

_____

_____

When did these behaviors begin? _____

How frequently do these behaviors occur? _____

How much do these behaviors impact the child's daily routine/functioning? (1-no impact; 10-severe impact)

1 2 3 4 5 6 7 8 9 10

What strategies have you tried to address these behaviors? _____

_____

_____

What changes are you hoping to see in therapy? _____

_____

How hopeful are you about seeing improvement in your child?

1 - Not at all hopeful 2 - A little hopeful 3 - Somewhat hopeful 4 - Very hopeful

If you are not hopeful, why not? _____

_____

Medical History

Is your child currently under the care of a physician? Yes No

Name of Physician _____

Date of last visit _____

Are your child's immunizations up to date? Yes No

Has your child ever undergone surgery? Yes No

If yes please explain: _____

Does your child have any allergies? Yes No

If yes please explain: _____

Please list current medical conditions your child is being treated for and date of diagnosis:

Current medications being prescribed:	Dosage	Frequency	Improvement Noticed

Does your child have any trouble falling asleep? Yes No

Does your child have any trouble staying asleep? Yes No

Is your child easy to wake up in the morning? Yes No

Usual Bedtime: _____

Usual Wake Time: _____

Does your child experience nightmares/terrors? Yes No

Comments/Explanation of Positive Responses: _____

Have you noticed any changes in your child's appetite/eating habits? Yes No

If yes, please explain: _____

_____

What form of discipline is used in the home: _____

_____

Does your child respond to discipline? Yes No

Birth History & Development

Mother's Age at time of Pregnancy	_____	
Father's Age at time of Pregnancy	_____	
Planned Pregnancy	Yes	No
Known use of drugs/alcohol during pregnancy	Yes	No
Medical Problems/Complications during pregnancy	Yes	No
Prenatal Care	Yes	No
Full Term Pregnancy	Yes	No
Birth Weight:	_____	
Complications at delivery for child	Yes	No
Complications at Delivery for Mother	Yes	No
Did baby stay more than 5 days in Hospital	Yes	No
Follow up Child Care	Yes	No
Post-Partum Depression for Mother	Yes	No
Follow up care for Mother	Yes	No
COMMENTS/Explanation of Positive Responses:		

Early Development of Child

Was growth and weight gain normal	Yes	No
Was there any Failure to Thrive	Yes	No
Was child colicky	Yes	No
Age when child did the following:		
sat up independently	_____	
crawled	_____	
walked	_____	
spoke words	_____	
spoke sentences	_____	
was fully toilet trained	_____	
Any concerns about Global Development Delay	Yes	No
Any current enuresis or encopresis	Yes	No
COMMENTS/Explanation of Positive Responses:		

Family History of Mental Illness

Please identify any family members with a mental health diagnosis and/or substance abuse issues:

_____

_____

_____

_____

Psychiatric Social History

Was child adopted?	Yes	No		
Relationship status of biological parents	Married	Divorced	Separated	Never married
Loss of parent by death prior to age 18	Yes	No		
Would you describe childhood as	Happy	Average	Unhappy	
How would you describe socio-economic status/class	Lower	Middle	Upper	
Has this child experienced any of the following:				
Emotional Abuse	Yes	No		
Physical abuse	Yes	No		
Sexual abuse	Yes	No		
Has child ever witnessed violence or been involved in a violent episode?	Yes	No		
COMMENTS/Explanation of Positive Responses:				

Education

Current School: _____

Grade: _____ Teacher: _____

Does your child enjoy school?	Yes	No		
Academic Performance:	Failing	Poor	Average	Above average
Has child ever repeated a grade?	Yes	No		
Has your child been suspended/expelled?	Yes	No		

If yes, please explain: _____

Does your child have an IEP/receive Special Education Services? (including Speech)	Yes	No

If yes, what accommodations are being provided? _____

Does your child have problems with teachers/authorities?	Yes	No

If yes, please explain: _____

Social

Does your child make friends easily?	Yes	No	
How would you describe the nature of his/her friendships?	Good	Average	Poor
Is the child involved in community activities/after school activities?	Yes	No	
Does your family participate in community activities?	Yes	No	
Does the child usually attend religious services with the family?	Yes	No	
COMMENTS/Explanation of Positive Responses:			

Legal History

Is custody of child with biological family	Yes	No
Past DCS involvement or services	Yes	No
Any past Foster Care placement	Yes	No
Has the child ever been arrested	Yes	No
Any past placement in Detention	Yes	No
Any past placement in a YDC	Yes	No

COMMENTS/Explanation of Positive Responses:

Past Psychiatric History

Prior outpatient psychiatric treatment in the past?	Yes	No
Prior outpatient alcohol/substance abuse treatment?	Yes	No
Prior outpatient treatment was helpful?	Yes	No
Number of prior psychiatric hospitalizations:		
Date of last psychiatric hospitalization:		
Involuntary hospitalizations in the past?	Yes	No
Other levels of Care	Yes	No
History of non-suicidal injury (scratching, cutting, burning)?	Yes	No
Method of self harm:		
Prior History of suicide attempts?	Yes	No
Number of attempts		
Last attempt was:		
Attempt resulting in medical hospitalization:	Yes	No
Prior History of Aggression or Violence?	Yes	No
Aggression towards:		
Legal charges stemming from aggression:	Yes	No
Incarceration stemming from aggression:	Yes	No

Please identify any current stressors in the home that may be impacting your child: _____

_____

_____

Please provide any current or past use of substances			If yes, how much how often?
Alcohol: (beer, wine, liquor)	Yes	No	
Cannabinoids: (marijuana, hashish)	Yes	No	
Opioids and Morphine Derivatives: (codeine, morphine, heroin, opium)	Yes	No	
Stimulants: (cocaine, amphetamines, methamphetamines)	Yes	No	
Club Drugs: (MDMA, GHB, Flunitrazepam)	Yes	No	
Dissociative Drugs: (Ketamine, PCP, Dextromethorphan, salvia)	Yes	No	
Depressants: (barbiturates, benzodiazepines)	Yes	No	
Hallucinogens: (LSD, Psilocybin, Mescaline)	Yes	No	
Anabolic steroids: (depo-testosterone, anadrol)	Yes	No	
Inhalants: (huffing, glue, solvents etc)	Yes	No	
Intravenous drug use	Yes	No	
Have you had any difficulties with any of the following issues related to substance abuse?	Yes	No	
TOLERANCE (increased amount of substance required to obtain initial effect of the drug)	Yes	No	
WITHDRAWAL (symptoms of physiologic or psychological distress upon stopping or reducing the amount of drug used)	Yes	No	
consumption exceeds intended amount	Yes	No	
efforts to reduce/control consumption	Yes	No	
excessive time spent related to substance use and leading to disruption of daily functioning	Yes	No	

Domestic Violence Screening (parent)

Have you been emotionally or physically abused by your partner or someone close/important to you?	Yes	No
Have you ever been hit, kicked, punched or otherwise hurt by someone close/important to you within the past year?	Yes	No
Do you feel safe in your current relationship?	Yes	No
Is there a partner from a previous relationship who is making you feel unsafe now?	Yes	No
Was Victim Services information provided to client/family	Yes	No

COMMENTS/Explanation of Positive Responses:

Legal Issues (parents/guardians)

Prior difficulties with the legal system ever?	Yes	No
Prior incarcerated?	Yes	No
Current legal issues?	Yes	No
Currently on Disability?	Yes	No
Currently seeking Disability?	Yes	No

COMMENTS/Explanation of Positive Responses:

Education & Employment

Mother's Highest Grade Completed: _____

Father's Highest Grade Completed: _____

Please explain any difficulty parents had in school:

Do parents work outside the home?	Yes	No

Please provide name of employer and hours worked/schedule:

Please check all that apply

- ☐ Excessive/unrealistic worry
- ☐ Motor tension (restlessness, shakiness)
- ☐ Hypervigilance
- ☐ Social anxiety
- ☐ Separation anxiety
- ☐ Panic attacks
- ☐ Sleep disturbances

- ☐ Verbal aggression
- ☐ Physical aggression
- ☐ Mood swings
- ☐ Impulsive
- ☐ Low frustration tolerance
- ☐ Lying/Cheating/Stealing
- ☐ Defiance
- ☐ Argues with authority
- ☐ Sibling conflict
- ☐ Peer conflict
- ☐ Cursing/Inappropriate Language

- ☐ Difficulty paying attention to details
- ☐ Has difficulty sustaining attention
- ☐ Often does not seem to listen when spoken to directly
- ☐ Often unable to follow through on tasks
- ☐ Trouble with organization
- ☐ Avoids tasks requiring sustained mental effort
- ☐ Often loses things necessary for completing tasks
- ☐ Easily distracted
- ☐ Forgetful in daily activities

- ☐ Depressed mood
- ☐ Irritable
- ☐ Withdraws/isolates
- ☐ Suicidal thoughts or actions
- ☐ Disinterest in previously enjoyed activities
- ☐ Low energy, easily tired
- ☐ Significant weight loss or gain
- ☐ Low self-esteem
- ☐ Feelings of hopelessness
- ☐ Inappropriate guilt
- ☐ Unresolved grief issues
- ☐ Hallucination or delusions

- ☐ Fidgets/squirms
- ☐ Has trouble staying seated
- ☐ Excessive running/climbing or restlessness
- ☐ Trouble with quiet activities
- ☐ Needs to be “on the go”
- ☐ Often talks too much
- ☐ Blurts out answers
- ☐ Difficulty awaiting turn
- ☐ Interrupts conversations or intrudes on others

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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**
☐	☐	☐	☐

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.

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over 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's 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
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

The information contained in this publication should not be used as a substitute for the medical care and advice of your pediatrician. There may be variations in treatment that your pediatrician may recommend based on individual facts and circumstances.

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Adapted from the Vanderbilt Rating Scales developed by Mark L. Wolraich, MD.

Revised - 1102

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ National Institute for Children's Health Quality

McNeil Consumer & Specialty Pharmaceuticals

NICHQ Vanderbilt Assessment Scale—PARENT Informant

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

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McNeil Consumer & Specialty Pharmaceuticals

Evansville Psychiatric Associates
Complete Outpatient Mental Health Care

2015 Maxwell Avenue, Evansville, IN 47711
Phone: 812-422-7974 Fax: 1-812-671-0627
Email: faxes+2038119@waitingroomsolutions.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Address:_____

Any Previous Name(s): _____ SSN: _____

The undersigned, Patient or Personal Representative of Patient, does hereby request and authorize Evansville Psychiatric Associates to:
(Please **CHECK** all that apply)

- ☐ Receive records from
- ☐ Schedule and cancel appointments with
- ☐ Release records to
- ☐ Manage billing matters with

The following office or individual:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ FAX:_____
(**NOTE**: This release is **VOID** unless this section is filled out with the relevant party's information)

For the following purpose: **O** Patient request, **O** Coordination of Care, **O** Legal Purpose, **O** Billing
(Please **CHECK** all that apply)

- Offices or individuals that do not share a physical address will each need a separate signed release.
- Medical records may include but are not limited to the following information: described and disclosed demographics, symptoms, history and physical, diagnosis, functional status, treatment plan, medication, psychological test results, psychiatric records, recent lab results, prognosis, attendance, progress, which may include mental health and drug/alcohol information.
- Information shared through this release may be subject to redisclosure.
- This release may be revoked early at any time, by providing a written request to Evansville Psychiatric Associates.
- Refusal to sign this release does not affect ability to obtain treatment, payment for services, or eligibility for benefits, with the exception of treatment dependent upon information from the above party.
- This release will expire 1 year after the signed date, unless specified otherwise below.

This authorization will expire in: **O** 1 year from last appointment, **O** 1 year, **O** other: _____
(Please **CHECK** an option)

Signature of Patient / Parent / Guardian: _____

Date: _____