WELLSTAR.
Medical Group

Dear Valued Patient:

Thank you for selecting the WellStar Medical Group. We are honored that you have chosen us as your health care provider. Our goal is to provide you and all of our patients with the highest-quality, individualized medical care in a timely and respectful manner.

Our commitment to our patients is that we will do our best to provide same-day access for sick visits and will make every attempt to see you at your appointment time for routine scheduled appointments. Last minute cancellations and not arriving on time for appointments are an inconvenience that affects other patients who are scheduled to be seen that day. We have developed a WellStar Medical Group policy regarding no-shows and late cancellations in order to help us meet our goal. Having such a policy enables us to better utilize available appointments for all of our patients in need of medical care.

Cancellation of an Appointment

If you are unable to keep your appointment, please call your WMG healthcare provider's office promptly, so that this time can be reallocated to someone who is equally in need of care. If you must cancel your scheduled appointment, we require that you call at least 24 hours in advance if you are seeing a primary care physician (Internal Medicine, Family Practice, Pediatrics or ObGyn) or at least 48 hours in advance if you are seeing a specialist. Appointments are in high demand, and your early cancellation will give another person access to that appointment time. A **late cancellation** is when a patient fails to cancel his or her scheduled appointment with 24-hours advance notice for primary care or 48-hours notice for specialty care.

How to Cancel Your Appointment

To cancel appointments, please call your WMG healthcare provider's office, or utilize MyChart's "Appointments – Cancel an Appt" function.

Missed Appointment or "No-Show"

A **no-show** is someone who misses an appointment without cancelling it at least 24 hours in advance for a primary care visit or at least 48 hours for a specialty visit. Failure to be present at the time of a scheduled appointment, or arriving 15 minutes or more after your scheduled appointment, will be recorded as a no-show. Patients may be subject to dismissal from the practice on the third occurrence of a missed appointment or no-show, or a combination of either.

Again, we appreciate you placing your trust in the WellStar Medical Group for your healthcare needs.

Sincerely,

WellStar Medical Group

WELLSTAR Medical Group
Psychiatry

New Patient History and Evaluation

Dear Patient,

Thank you for choosing WellStar Psychiatry for your mental health care. Please fill out the forms in this packet to help us assess these important aspects of your life. Your answers will help us determine the best course of treatment in partnership with you and your family.

- **Patient Health Questionnaire (PHQ-9):** This form will help us screen for recent symptoms of depression
- **Mood Disorder Questionnaire (MDQ):** This form will help us assess the likelihood of bipolar disorder
- **Generalized Anxiety Disorder 7-item (GAD-7)** scale: This form will ask you about problems related to stress and anxiety
- **Psychiatric Medication History**: This form lists many of the medications we use to treat mental health conditions. Please indicate any medications you are currently taking or have tried in the past, and whether or you had a positive or negative response to them.

Please bring these completed forms to your appointment. If you are unable to do so ahead of time, please arrive 30 minutes early so that you can complete them before your appointment begins.

If you have any questions or concerns, please contact our office at 770-644-1570.

Thank you

WELLSTAR. Medical Group
Psychiatry

Today's date: _____

Patient name: _____

Date of birth: _____ **Age:** _____

How did you hear about our office? _____

1. What are the problems you are seeking help with today? (Check all that apply)

☐ Depression	☐ Bipolar Disorder	☐ Using Drugs or Alcohol
☐ Anxiety	☐ Trouble sleeping	☐ Obsessions or Compulsions
☐ Panic attacks	☐ ADD or ADHD	☐ Stress in family or relationships
☐ Trauma	☐ Schizophrenia	☐ Personality Disorder

☐ Other _____

2. Past Psychiatric History

Have you ever received mental health treatment in the past? ☐ Yes ☐ No

If yes, who was your last treatment provider? Name: _____

Date of last visit: _____

Can you recall the name of a medication(s) that worked really well for you?

_____

Have you ever attempted suicide or engaged in self-harm behavior (e.g. cutting)? ☐ Yes ☐ No

If yes, when was the last time this happened? _____

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Have you ever been hospitalized or been to the emergency department for a mental health issue? ☐ Yes ☐ No

If yes, how many times? _____ When was the last time? _____

Have you <u>ever</u> experienced any of the following symptoms?

☐ Wished you were dead ☐ Wanted to hurt yourself ☐ Wanted to hurt others

☐ Heard voices ☐ Saw unusual things ☐ Felt paranoid

☐ Flashbacks ☐ Recurrent nightmares ☐ Witnessed trauma

☐ Mood swings ☐ Felt full of energy ☐ Racing thoughts

☐ Binged on food ☐ Restricted or purged ☐ Body image concerns

☐ None of these

3. Family Psychiatric History

Please place an "X" in the table below if any of your family members have a mental health condition.

Family member	Depression	Anxiety	Bipolar	Schizophrenia	Drugs or Alcohol	Suicide
Grandparent						
Mother						
Father						
Sibling						
Child						
Other						

☐ No known history of mental illness in my family

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Psychiatry

4. Medical and Surgical History

Please indicate if you have ever been diagnosed with one of the health conditions below.

☐ Diabetes	☐ High Blood Pressure	☐ Heart Disease
☐ Cancer	☐ Heart Attack	☐ Stroke or TIA
☐ Chronic Pain	☐ Thyroid Disease	☐ Seizures
☐ Head Injury	☐ Liver Disease	☐ Kidney Disease
☐ Sleep Apnea	☐ COPD	☐ HIV/AIDS

☐ Other _____

☐ I don't have any medical problems

Please indicate if you have had any of the following surgeries or procedures below.

☐ Hip replacement	☐ Knee replacement	☐ Neck or Back surgery
☐ Hysterectomy	☐ Gallbladder removal	☐ Cardiac bypass or stents
☐ Cosmetic surgery	☐ Surgery for cancer	

☐ Other _____

☐ I've never had any major surgeries

Please list any medications or supplements that you are currently taking:

1.	**6.**
2.	**7.**
3.	**8.**
4.	**9.**
5.	**10.**

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Are you allergic to any medications? ☐ Yes ☐ No

If so, which one(s): _____

5. Social and Developmental History

Where did you grow up? _____

Who raised you? _____

Education history (select highest level of training):

☐ Didn't finish high school ☐ Graduated high school ☐ Some college

☐ College degree ☐ Master's degree ☐ Doctoral degree

☐ Technical school or trade

Did you experience any abuse, neglect, or bullying growing up?
☐ Yes ☐ No

Current marital status (circle one):

Single Married Separated Divorced Widowed Domestic Partner

Any previous marriages? ☐ Yes ☐ No

Who do you live with? _____

How would you describe your home environment? (Mark with an "X" below the line)

Peaceful——————Somewhere in the middle——————Stressful

Do you have any particular hobbies or interests? _____

Is religion or spirituality important to you? ☐ Yes ☐ No ☐ A little

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Employment status (check one):

☐ Full-time ☐ Part-time ☐ Unemployed ☐ Disabled

What do/did you do for a living? _____

Do you like your job? ☐ Yes ☐ No

Did you ever serve in the military? ☐ Yes ☐ No

Have you ever been in any legal trouble? ☐ Yes ☐ No

6. Lifestyle and Habits

How often do you exercise at least 30 minutes per day?

☐ A few times per month ☐ Once a week ☐ 2-3 days per week

☐ Almost every day ☐ I rarely exercise

Are you sexually active? ☐ Yes ☐ No

Method of birth control: _____

How often do you drink alcohol?

☐ Few times per year ☐ Few times per month ☐ Weekly

☐ Daily ☐ I don't drink alcohol

Regarding your alcohol use, have you ever (check all that apply):

☐ Thought about cutting back ☐ Felt guilty about drinking

☐ Started the day with a drink ☐ Felt annoyed by others asking

☐ None of the above

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Have you ever smoked cigarettes or used tobacco? ☐ Yes ☐ No

Do you currently smoke? ☐Yes ☐ No

If so, are you thinking about quitting? ☐ Yes ☐ No ☐ N/A

Have you ever tried illegal drugs or misused prescription medications?
☐ Yes ☐ No

If so, which ones?

☐ Marijuana	☐ Heroin	☐ Cocaine	☐ Amphetamines
☐ LSD	☐ PCP	☐ Pain pills	☐ Anxiety pills
☐ Muscle relaxants	☐ Sleeping pills	☐ Other_____	

Have you ever been to a detox or rehabilitation facility for treatment of drug or alcohol problems? ☐ Yes ☐ No

****SEE REVERSE SIDE FOR MEDICATION HISTORY****

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Psychiatry

Please circle any medications you have tried in the past, and indicate whether they were helpful for you.

Psychiatric Medication History Form

Depression	Amitriptyline	Librium	Prolixin (Fluphenazine)	Vyvanse	Silenor (Doxepin)
Prozac (Fluoxetine)	Clomipramine	Buspar (Buspirone)	Seroquel (Quetiapine)	Dexedrine	Intermezzo
Paxil (Paroxetine)	Desipramine	Vistaril (Hydroxyzine)	Seroquel XR	Provigil (Modafinil)	**Other Methods**
Zoloft (Sertraline)	Imipramine	**Mood Stabilizers**	Zyprexa (Olanzapine)	Nuvigil	Cytomel
Celexa (Citalopram)	Amoxapine	Depakote	Abilify	Zenzedi	Fish Oil
Lexapro (Escitalopram)	Selegiline	Lithium	Geodon (Ziprasidone)	Daytrana	Deplin or Folic acid
Luvox (Fluvoxamine)	Parnate	Tegretol	Latuda	Quillivant XR	Phototherapy (light box)
Wellbutrin (Bupropion)	Nardil	Lamictal (Lamotrigine)	Saphris	Clonidine	ECT
Effexor (Venlafaxine)	**Anxiety**	Trileptal	Fanapt	Guanfacine	TMS
Cymbalta (Duloxetine)	Xanax (Alprazolam)	Neurontin (Gabapentin)	Invega	Sleep Aids	
Remeron (Mirtazapine)	Ativan (Lorazepam)	Topamax (Topiramate)	Clozaril (Clozapine)	Ambien (Zolpidem)	
Pristiq	Klonopin (Clonazepam)	**Psychosis and Mood**	**ADD/ADHD**	Lunesta	
Viibryd	Valium (Diazepam)	Haldol (Haloperidol)	Adderall	Trazodone	
Brintellix	Restoril (Temazepam)	Risperdal (Risperidone)	Ritalin (Methylphenidate)	Melatonin	
Fetzima	Serax (Oxazepam)	Thorazine	Concerta	Rozerem	
Nortriptyline	Tranxene	Trilafon (Perphenazine)	Focalin	Sonata	

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

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

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

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

10. If you checked off *any problems*, how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all _____ Somewhat difficult _____ Very difficult _____ Extremely difficult _____

A2663B 10-04-2005

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke much faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family into trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.*

No Problem Minor Problem Moderate Problem Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

WELLSTAR Medical Group

Patient Registration Form

1. Patient Information (Please complete all spaces.)

Patient Last Name	First Name		Date of Birth	Age	Patient Gender ☐ M ☐ F
Street Address	City	State	Zip Code	Social Security Number	

Home Telephone ☐ check box if primary	Work Telephone ☐ check box if primary	Cell Telephone ☐ check box if primary	Email Address

Needs Interpreter? ☐ Yes ☐ No	Primary Language	Marital Status	Written Language	Ethnicity Hispanic or Latino? ☐ Yes ☐ No	Religion	Race

Activate My Chart ☐ Yes ☐ No		Employer Name	Employment Status ☐ Full-time ☐ Unemployed ☐ Disabled ☐ Part-time ☐ Retired ☐ Student

Employer Address	City	State	Zip Code	Employer Telephone

Emergency Contact Last Name	First Name				

Emergency Contact Relation to Patient	Legal guardian? ☐ Yes ☐ No	Hearing Impaired? ☐ Yes ☐ No	Visually Impaired? ☐ Yes ☐ No	Home Telephone ☐ check box if primary	Work Telephone ☐ check box if primary	Cell Telephone ☐ check box if primary

Primary Care Physician

Pharmacy Name/Location: _____ Phone #: _____
(i.e. Wellstar Pharmacy at Windy Hill)

2. Responsible Party/Guarantor ☐ (Check if self and skip this section)

Guarantor Last Name	First Name	Guarantor Street Address	City	State	Zip Code

Guarantor Relation to Patient	Guarantor Gender ☐ M ☐ F	Social Security Number	Guarantor Date of Birth	Guarantor Home Telephone

Guarantor Employer	Employment Status ☐ Full-time ☐ Unemployed ☐ Disabled ☐ Part-time ☐ Retired ☐ Student	Employer Telephone

3. Medical Insurance Policy Holder ☐ (Check if self and skip this section)

Primary Insurance Company	Policy Holder Last Name		Policy Holder First Name	
Relationship to Patient	Subscriber ID	Group Number	Social Security Number	Date of Birth

Secondary Insurance Company	Policy Holder Last Name		Policy Holder First Name	
Relationship to Patient	Subscriber ID	Group Number	Social Security Number	Date of Birth

Assignment of Benefits/Consent for Treatment

I do hereby assign all medical and/or surgical benefits to which I am entitled, including all government and private insurance plans to this office. This assignment will remain in effect until revoked by me in writing. I understand that I am responsible for all charges not paid by insurance. I authorize this office to release all information necessary to secure payment. I hereby voluntarily consent to treatment at this office and authorize such treatments, examinations, medications, anesthesia, surgical, operations and diagnostic procedure (including, but not limited to the use of lab and radiographic studies) as ordered by attending physicians. I hereby voluntarily consent to the taking of photographic images for treatment purposes only (wound care progression, documentation of rashes, etc.) as ordered by attending physicians.

Signature of Patient/Legal Guardian:	**Date:**

WELLSTAR
Medical Group

Patient Communication Designation

The information on this form is used to facilitate our communications to you as we strive to provide you with excellent service. The provision of this information is optional.

Patient Information *(please print clearly):*

Last Name	*First Name*	*Middle Initial*	*Date of Birth (Month / Day / Year)*

Street Address	*Apt. # / P.O. Box # (Please include complete mailing address)*	*Medical Record # / Social Security # (optional)*

City	*State*	*Zip Code*	*Primary Contact Number*

If we cannot reach you at the telephone number listed above, WellStar may contact you (including leaving messages) regarding appointments or **normal** lab results at the following number(s):

Business Number	*Cell Phone Number*	*Other Phone Number*

I authorize the WellStar Medical Group to disclose Protected Health Information to the following persons:

☐ Spouse: _____ *Name* _____ *Phone Number*

☐ Child(ren): _____ *Name* _____ *Phone Number*

_____ *Name* _____ *Phone Number*

☐ Other: _____ *Name* _____ *Phone Number*

Information to be disclosed:

☐ All Medical Information ☐ Laboratory Results ☐ All Billing / Account Information

Authorization Statement: *I understand that Protected Health Information (PHI) used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer protected by Federal or State Law. I understand that I have the right to revoke this authorization at any time. I understand that in order to revoke this authorization, I must do so in writing and present my revocation to the WellStar location where I received care. I understand that the revocation will not apply to information that has already been used or disclosed in response to this authorization. I understand that WellStar cannot require me to sign this authorization as a condition of treatment unless the provision of health care by WellStar is solely for the purpose of creating PHI for disclosure to a third party legally authorized to receive such information. I understand that I will be given a copy of this authorization.*

Signature / Date:

(date authorization signed by patient or Legal Guardian / Personal Representative) _____ *Month / Day / Year*

Print Patient Name or Name of Legal Guardian / Personal Representative	***Signature of Patient or Legal Guardian / Personal Representative***

Indicate relationship to patient (required)

Expiration Date: *This authorization is valid until written notice is provided to revoke this authorization.*

WELLSTAR.

Acknowledgment of Receipt
of
"NOTICE OF PRIVACY PRACTICES"
for
Protected Health Information

I acknowledge that I have received a copy of WellStar Health System's ***"Notice of Privacy Practices"*** for Protected Health Information on the date set forth below.

Date of Receipt	**Date of Birth**
Patient Name	**Print Name of Authorized Personal Representative**
Signature of Patient	**Signature of Authorized Personal Representative**
	Please Indicate Relationship to Patient

FOR USE BY WELLSTAR HEALTH SYSTEM PERSONNEL ONLY:
(Complete if patient Acknowledgment is not obtained)

An Acknowledgment of Receipt of Notice of Privacy Practices was not obtained because:

- ☐ Patient refused to sign Acknowledgment.
- ☐ Unable to gain signed Acknowledgment due to communication/language or other barrier.
- ☐ Patient was unable to sign Acknowledgment due to emergency treatment situation.
- ☐ Other: *Please indicate reason* _____

Signature of WellStar Representative _____ Date _____ Time _____ AM / PM

Please ☑ the appropriate facility:

☐ Kennestone Hospital ☐ Cobb Hospital ☐ Douglas Hospital ☐ Windy Hill Hospital ☐ Paulding Hospital
☐ Homecare ☐ Hospice
☐ Medical Group: _____ ☐ Other: _____

WellStar

☐ Cobb ☐ Douglas ☐ Kennestone
☐ Paulding ☐ Windy Hill

Notice of Privacy Practices