Attention Mental Health, PLLC
Cory Alfers, D.O.
Psychiatry
1499 Chain Bridge Rd, Suite 100
McLean, VA 22101
o | 703.232.1743
f | 703.552.3210

Intake Information

GENERAL:

Name: _____ Date: _____
Last First Middle

DOB: _____ Age: _____ SSN: _____ Sex: _____ Marital Status: S / M / D / W

Address: _____
Street City State Zip Code

Home Phone: _____ Work Phone: _____

Cell Phone: _____ Email: _____

Health Insurance: _____ Prescription Coverage: Y / N

Health Insurance Member ID #: _____

How did you hear about Attention Mental Health, PLLC? _____

What is your reason for making an appointment? _____

_____

EMPLOYER:

Name of Employer (name of school if student): _____

Occupation: _____ Hours worked per week? _____

EMERGENCY CONTACT:

Name: _____ Relationship: _____

Address: _____
Street City State Zip Code

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

PRIMARY CARE PROVIDER: □ I do not have a primary care provider.

Name: _____ Date of Last Visit: _____

Address: _____
Street City State Zip Code

Phone: _____ Fax: _____ Frequency of visits: _____

CURRENT/FORMER PSYCHIATRIST: □ I do not have current/former psychiatrist.

Name: _____ Date of Last Visit: _____

Address: _____
Street City State Zip Code

Phone: _____ Fax: _____ Frequency of visits: _____

CURRENT/FORMER PSYCHOTHERAPIST: □ I do not have a current/former therapist.

Name: _____ Date of Last Visit: _____

Address: _____
Street City State Zip Code

Phone: _____ Fax: _____ Frequency of visits: _____

CURRENT MEDICATIONS: □ I currently do not take any medications.

(Please include nutritional supplements, herbal supplements, and over-the-counter medications.)

Name of medication	Dose	Frequency	Reason prescribed	Approximate start date

PHARMACY: □ I do not have a pharmacy.

Name: _____ Phone: _____ Fax: _____

Address: _____
Street City State Zip Code

ALLERGIES: □ I do not have any known allergies.

List any known allergies (to medication, food, etc.): _____

_____

SPECIALISTS SEEN: □ I am not seeing/have seen any specialists.
(Currently or at any point in the past)

___ Allergist
___ Cardiologist
___ Cardiothoracic Surgeon
___ Dermatologist
___ Ear, Nose, Throat Specialist
___ Endocrinologist
___ Gastroenterologist
___ General Surgeon
___ Hematologist
___ Infectious Disease Specialist
___ Internist (other than routine)
___ Nephrologist
___ Neurologist
___ Neurosurgeon
___ OB/Gyn (other than routine)
___ Oncologist
___ Ophthalmologist (other than routine)
___ Orthopedic Surgeon
___ Pain Specialist
___ Plastic Surgeon
___ Pulmonologist
___ Rheumatologist
___ Sleep Specialist
___ Urologist
___ OTHER _____

HAVE YOU EVER HAD: □ No, I have not experienced any of the things below.

___ Blackouts
___ Chest Pain
___ Fainting Spells
___ Fracture or severe injury
___ Head injury/concussion
___ Heart palpitations
___ Seizures
___ Shortness of breath/asthma

MEDICAL CONDITIONS: □ I do not have any known medical conditions.

List any known medical conditions: _____

HOSPITALIZATIONS/SURGERIES/EMERGENCY ROOM VISITS: □ not applicable

Reason for visit:	Date(s)

PAST PSYCHIATRIC MEDICATIONS: □ not applicable

Name of medication	Response to medication

FAMILY PSYCHIATRIC HISTORY: □ not applicable

_____

_____

_____

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Privacy Policies

These policies describe how medical information about you may be used and disclosed, and how you may obtain access to this information. PLEASE REVIEW CAREFULLY.

Confidentiality

Attention Mental Health, PLLC respects the rights and privacy of patients' confidential medical information in accordance with federal law Health Insurance Portability and Accountability Act (HIPAA). A copy of the HIPAA compliance policy is available on request.

Disclosures for Treatment, Payment and Health Care Operations

Your protected health information (PHI) may be disclosed, with your consent, for purposes of treatment, payment, and healthcare operation purposes. To help clarify these terms, the following are examples:

- *PHI* refers to information in your file that could identify you (any information with your name or other description of you).
- *Treatment* is when the physician provides, coordinates, or manages your healthcare. For instance, when the physician consults with another health care provider (psychotherapist, primary care physician, etc.)
- *Payment* is when the physician provides information (i.e. diagnoses) for insurance reimbursement. An example of payment is when the physician shares your PHI with your health insurer in order for you to obtain reimbursement.
- *Health Care Operations* are activities that relate to the performance and operation of the physician's office. Examples of health care operations are quality assessment and improvement activities or business-related matters such as obtaining certificates, licenses, and credentials to serve you.
- *Disclosure* applies to activities outside of the appointment such as releasing or providing access to information about you to individuals outside of the physician's office.
- *Authorization* is your written permission to disclose confidential mental health information. All authorizations must be documented on a signed consent for release of information form.

Initial: _____

Other Uses and Disclosures Requiring Authorization

The physician may disclose PHI for purposes other than treatment, insurance reimbursement for the patient, or health care operations when your appropriate authorization is obtained. In those instances when the physician is asked for information for purposes other than treatment, payment, or health care operations, he will obtain authorization from you before releasing this information. Likewise, he will also need to obtain authorization before releasing your Psychotherapy Notes

- *Psychotherapy Notes* are notes the physician may have made about your conversation during an individual, family, or group therapy session, which he has kept separate from the rest of your record. These notes are given a greater degree of confidentiality than the PHI.

You may cancel all such authorizations (of PHI and/or Psychotherapy Notes) at any time, provided each request to cancel authorization is in writing. You may ***not*** cancel an authorization to the extent that the authorization was obtained as a condition of obtaining insurance coverage; the law provides the insurer the right to contest the claim under the policy.

Uses and Disclosures Without Authorization

The physician may disclose PHI ***without*** your consent or authorization in the following circumstances:

- Serious Threat to Health or Safety – When the physician determines disclosure of PHI is necessary to protect you or another individual from a risk of imminent serious physical injury, he may disclose the PHI to the appropriate individuals.
- Child Abuse – If the physician knows or has reasonable cause to suspect that a child known to him in a professional capacity has been or is in immediate danger of being physically or mentally abused or neglected child, he must immediately report such knowledge or suspicion to the appropriate authorities.
- Dependent Adult Abuse – If the physician believes that an elderly or disabled adult is in need of protective services because of abuse or neglect by another person, he must immediately report this belief to the appropriate authorities.

OTHER USES OR DISCLOSURES THAT CAN BE MADE WITHOUT CONSENT OR AUTHORIZATION:

- As required during an investigation by law enforcement agencies
- As required by military command authorities for their medical records
- To workers' compensation or similar programs for processing of claims
- In response to a legal proceeding
- To a coroner or medical examiner for identification of a body
- If an inmate, to the correctional institution or law enforcement official
- As required by the US Food and Drug Administration (FDA)
- Other covered entities' healthcare operations activities (to the extent permitted under HIPAA)
- Uses and disclosure required by law

Initial: _____

Patient Rights and Physician Duties

Patient Rights:

- *Right to Request Restrictions* – You have the right to request restrictions on certain uses and disclosures of PHI. However, the physician is not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and alternative locations. (For example, you may not want a family member to know that you are seeing the psychiatrist. Upon your request, the physician will send correspondence to another address.)
- *Right to Inspect and Copy* – You have the right to inspect and/or obtain a copy of your PHI. Your physician may deny your access to the PHI under certain circumstances, but in some cases you may have this decision reviewed. You may be denied access to your Psychotherapy Notes if the physician believes that a limitation of access is necessary to protect you from a substantial risk of imminent psychological impairment or to protect you or another individual from a substantial risk of imminent psychological and physical injury. Your physician will notify you or your representative if he does not grant complete access. Upon your request, the physician will discuss with you the detail of the request and denial process.
- *Right to Amend* – You have the right to request an amendment of PHI for as long as your PHI is maintained in the record. The physician may deny your request. Upon your request, he will discuss with you the details of the amendment process.
- *Right to a Listing* – You generally have the right to receive a listing of the disclosures of your PHI. Upon your request, the physician will discuss with you the details of this process.

Physician's Duties:

- The physician is required by law to maintain the privacy of your PHI and provide you with a notice of his legal duties and privacy practices with respect to the PHI.
- The physician reserves the right to change the privacy policies and practices described in this notice. Unless the physician notifies you of such changes, however, he is required to abide by the terms currently in effect.

Complaints

When questions arise regarding these policies or if you think that your privacy rights have been violated, please notify the physician. You may also submit a written complaint to the U.S. Department of Health and Human Services.

Initial: _____

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Patient Acknowledgement of Privacy Policies

I have read Attention Mental Health, PLLC's Privacy Policies, which provides in detail the uses and disclosures of my protected health information (PHI) that may be made by this practice, my individual rights and the practice's legal duties regarding my protected health information. The Privacy Policies identified the following:

- A statement that this practice is required by law to inform the patient of protected health information (PHI).
- A statement that this practice is required to abide by the laws terms identified in the Privacy Policies presently in effect.
- Types of uses and disclosures that the practice makes for each of the following purposes: treatment, payment, and health operations.
- A description of each of the purposes for which this practice is permitted or required to use or disclose protected health information without my written consent or authorization; and a description of use and disclosure that is prohibited or limited by law.
- A description of other uses and disclosures that will be made only with my written authorization and that at any time I have the right to revoke this authorization.
- I am aware of my individual rights with respect to protected health information and a brief description of how I may exercise these rights in relation to:
  - The right to complain to this practice and the U.S. Department of Health and Human Services if I believe my privacy rights has been violated and that no retaliatory actions will be used against me in the event of such a complaint.
  - The right to request restrictions on certain uses and disclosures of my protected health information, and this practice is not required to agree to a requested restriction.
  - The right to receive confidential communications of protected health information.
  - The right to inspect and copy protected health information.
  - The right to amend protected health information.
  - The right to receive an accounting of disclosures of protected health information.
  - The right to obtain a paper copy of the Privacy Policies from this practice upon request.

This practice reserves the right to change the terms of its Privacy Policies and to make new provisions effective for all protected health information it maintains. I understand that I can obtain this practice's current Privacy Policies upon request.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

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Practice Policies

Please call the office directly to make appointments or for urgent matters. Please leave a message if no one is able to take your call, and calls will be returned at the physician's earliest convenience. *In the event of a medical or psychiatric emergency, please call 911 immediately or go directly to the nearest emergency room.*

What To Expect

At Attention Mental Health, PLLC you will be seen in a comfortable office where you will receive discrete and individualized evaluation and treatment. Your confidential health information will be secure and protected.

Payment

Payment is due in full at the time services are rendered. Acceptable forms of payment include all major credit/debit cards, cash and personal checks. Checks returned for insufficient funds are subject to a $35 fee and checks will no longer be accepted. In order to focus on patient care-related issues and individualized care, Attention Mental Health, PLLC does not participate in insurance plans and does not file insurance forms directly for patients. Patients will be provided with a receipt, also referred to as superbill, after each visit that contains the information necessary to submit the claim to insurance companies for out-of-network reimbursement.

Cancellation and Missed Appointments

At least *48 hours advance* notice is required to cancel an appointment without charge. Missed appointments and late cancellations with less than 48-hours notice will be charged the rate of a regular session.

E-mail Policy

I understand that email is not a confidential means of communication. Although email will be checked on a regular basis, I understand that Attention Mental Health, PLLC, cannot ensure email messages will be received and responded to in a timely fashion. I understand email is not the appropriate way to handle confidential information or emergencies. Email will only be used to answer simple questions, reschedule appointments, solve basic problems, and request medication refills.

Initial: _____

Telephone Calls

Clients who require frequent or extended phone consultations will be billed for the additional time and effort. In order to maintain safe and effective clinical care, patients are expected to regularly schedule and keep appointments as medical necessary.

Medication Refills

Medication adjustments, along with prescriptions and refills, are provided during appointment times. This is to appropriately make dosage adjustments, address the side effects and discuss alternatives to treatment. Refills for controlled medications such as stimulants or medications used to treat opiate dependency cannot be called in or faxed to a pharmacy. Lost controlled substances cannot be replaced until the next prescription is due. If a patient is going to run out of a medication prior to the next appointment, and a sooner appointment is not available, a prescription can be called in to allow for enough medication until the next scheduled appointment. *Information regarding your prescription history may be requested from the Virginia Prescription Monitoring Program. By signing this document you acknowledge that you have been notified of the potential for such a request.*

Discontinuation of Treatment

If for any reason, a decision is made by either patient or provider to discontinue treatment, names of alternative providers will be provided. The physician will continue to provide treatment up to 60 days, including a 60-day supply of medication to enable the patient to find alternative treatment without an interruption of care.

I have read and agree to the Practice Policies outlined above.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

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HIPAA Request Form for Alternative Communications

I authorize Attention Mental Health, PLLC to contact me by any of the following alternative means of communication regarding my protected health information such as messages or results for my minor children or myself.

(Please mark all that apply.)

- ☐ Home: _____
- ☐ Work: _____
- ☐ Cell: _____
- ☐ Fax: _____
- ☐ Email: _____
- ☐ Other (please specify): _____

I give permission to leave message/result:

(Please mark all that apply.)

- ☐ On answering machine (messages will not be left on an unidentified answering machine)
- ☐ With a family member

  Name of family member: _____

  Relationship: _____
- ☐ With a family member not living with me

  Name of family member: _____

  Phone Number of family member: _____

  Relationship: _____

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____