Serenity HEALTH CENTERS
For Complete Well Being
Ph: 352 241 9282 Fax: 352 241 4282
Locations:
835 Oakley Seaver Dr, Clermont, FL 34711 803 East Dixie Avenue, Leesburg, FL 34748

Hello and welcome to our office!

The following paperwork is everything you need to fillout and either **fax, email, or upload ·within 2 days of receiving it.** To guarantee your appointment, ONLY those with fully COMPLETED paperwork received **PRIOR to** the appointment will be guaranteed. PLEASE arrive **45 minutes PRIOR** to your scheduled appointment time. Every document is essential and has a purpose, please fully complete each page, prior to our first meeting with you or your child.

Documents needing to bring with you: ***Appointment Time:_____Appointment Date:_____***

- ID Card/ Driver's License
- Copy of Insurance Card
- Name and Address of Pharmacy
- Fill out complete list of ALL medications you are taking; from doctors & over the counter; include dosages

Information about our office:

- WE **DO NOT** PRESCRIBE **ADDERALL/ Benzodiazepines/Hypnotics/ OR AMBIEN MEDICATIONS**
- We do not place 0r fill out any forms related to Disability, FYILA, Service Animals, Workman's Compensation or Medical Marijuana
- Patients will be evaluated, but there is no guarantee that they will be given thetype of medication they seek or any medication. Dr. Dhungana and her Nurse Practitioners believe m a holistic approach to medicine.
- *ALL patients must arrive 15 minutes prior* to their scheduled appointments.
- Please arrive 45 minutes prior to your appointment time. if you have completed all your New Patient paperwork and have sent it to: ***email:Support@Serenityhc.net,*** *or* ***faxed to 352-241-4282*** within 48 hours of receiving it.
- Please bring in your medication list and bottles of your medications.
- Please ensure you CONFIRM your appointment at least 24 hours in advance of every visit to avoid a $50 Fee

ALL MINORS- 17 and under

- If parents are married: BOTH PARENTS ARE REQUIRED TO ATTEND INITIAL APPOINTMENT
- If parents are divorced: Both parents are Strongly Encouraged to attend the first visit - will also need the legal divorce paperwork.
- If adopted: Legal court paperwork is required.

Patient Name: _____

Patient/ Guardian Signature: _____

Date: _____

Thank you!

Psychiatry Clinic Intake Questionnaire

Child's Name:. _____ Today's Date:._____
Last First Middle

Legal Guardian's Name:._____

Home Address:_____

Telephone:_____ CELL#: _____Work#:._____

SSN:_____Sex: M / F Other._____ Date of Birth:._____

Child's social status: **Still at home** **In School** **Away in School** **Working**

Email:_____**Allergies:**_____

Highest Level of Education:

Elementary____(grade) *Middle _____(grade)*

HS____(grade) (Graduated Yes / No) *Graduate School_____(Graduated Yes/ No.)*

GED College _____ (Graduated Yes I No)

Child's Place of Education: _____
Name Address City

Child's Place of Employment:_____
Name Address City

Who referred you to our office? _____ _____
Name Telephone

Who is the Child's Pediatrician?_____ _____
Name & Practice **Telephone**

For what problem {s) do you seek help?_____

What problem(s) with your child do you seek help?_____

_____

What makes the problem worse? _____

What makes the problem better? _____

What goal(s) do you hope psychiatric treatment will help you to achieve? _____

_____

What form of treatment do you expect (medication, psychotherapy, other)? _____

How long do you feel this will take?_____

The SNAP-IV Teacher and Parent Rating Scale

James **M.** Swanson, Ph.D., University of California, Irvine, CA 92715

Name:_____ Gender:_____ Age:_____ Grade_____

Ethnicity (circle one which best applies): African-American Asian Caucasian Hispanic Other: _____

Completed by: _____Type of Class: _____Class size: _____

For each item, check the column which best describes this child:	**Not At All**	**Just A Little**	**Quite A Bit**	**Very Much**
1. Often fails to give close attention to details or makes careless mistakes in schoolwork or tasks	_____	_____	_____	_____
2. Often has difficulty sustaining attention in tasks or play activities	_____	_____	_____	_____
3. Often does not seem to listen when spoken to directly	_____	_____	_____	_____
4. Often does not follow through on instructions and fails to finish schoolwork, chores, or duties	_____	_____	_____	_____
5. Often has difficulty organizing tasks and activities	_____	_____	_____	_____
6. Often avoids, dislikes, or reluctantly engages in tasks requiring sustained mental effort	_____	_____	_____	_____
7. Often loses things necessary for activities (e.g., toys, school assignments, pencils, or books)	_____	_____	_____	_____
8. Often is distracted by extraneous stimuli	_____	_____	_____	_____
9. Often is forgetful in daily activities	_____	_____	_____	_____
10. Often has difficulty maintaining alertness, orienting to requests, or executing directions	_____	_____	_____	_____
11. Often fidgets with hands or feet or squirms in seat	_____	_____	_____	_____
12. Often leaves seat in classroom or in other situations in which remaining seated is expected	_____	_____	_____	_____
13. Often runs about or climbs excessively in situations in which it is inappropriate	_____	_____	_____	_____
14. Often has difficulty playing or engaging in leisure activities quietly	_____	_____	_____	_____
15. Often is "on the go" or often acts as if "driven by a motor"	_____	_____	_____	_____
16. Often talks excessively	_____	_____	_____	_____
17. Often blurts out answers before questions have been completed	_____	_____	_____	_____
18. Often has difficulty awaiting turn	_____	_____	_____	_____
19. Often interrupts or intrudes on others (e.g., butts into conversations/games)	_____	_____	_____	_____
20. Often has difficulty sitting still, being quiet, or inhibiting impulses in the classroom or at home	_____	_____	_____	_____
21. Often loses temper	_____	_____	_____	_____
22. Often argues with adults	_____	_____	_____	_____
23. Often actively defies or refuses adult requests or rules	_____	_____	_____	_____
24. Often deliberately does things that annoy other people	_____	_____	_____	_____
25. Often blames others for his or her mistakes or misbehavior	_____	_____	_____	_____
26. Often touchy or easily annoyed by others	_____	_____	_____	_____
27. Often is angry and resentful	_____	_____	_____	_____
29. Often is quarrelsome	_____	_____	_____	_____
30. Often is negative, defiant, disobedient, or hostile toward authority figures	_____	_____	_____	_____
31. Often makes noises (e.g., humming or odd sounds)	_____	_____	_____	_____
32. Often is excitable, impulsive	_____	_____	_____	_____
33. Often cries easily	_____	_____	_____	_____
34. Often is uncooperative	_____	_____	_____	_____
35. Often acts "smart"	_____	_____	_____	_____
36. Often is restless or overactive	_____	_____	_____	_____
37. Often disturbs other children	_____	_____	_____	_____
38. Often changes mood quickly and drastically	_____	_____	_____	_____
39. Often easily frustrated if demand are not met immediately	_____	_____	_____	_____
40. Often teases other children and interferes with their activities	_____	_____	_____	_____

Check the column which best describes this child:	**Not At All**	**Just A Little**	**Quite A Bit**	**Very Much**
41. Often is aggressive to other children (e.g., picks fights or bullies)	_____	_____	_____	_____
42. Often is destructive with property of others (e.g., vandalism)	_____	_____	_____	_____
43. Often is deceitful (e.g., steals, lies, forges, copies the work of others, or "cons" others)	_____	_____	_____	_____
44. Often and seriously violates rules (e.g., is truant, runs away, or completely ignores class rules)	_____	_____	_____	_____
45. Has persistent pattern of violating the basic rights of others or major societal norms	_____	_____	_____	_____
46. Has episodes of failure to resist aggressive impulses (to assault others or to destroy property)	_____	_____	_____	_____
47. Has motor or verbal tics (sudden, rapid, recurrent, no rhythmic motor or verbal activity)	_____	_____	_____	_____
48. Has repetitive motor behavior (e.g., hand waving, body rocking, or picking at skin)	_____	_____	_____	_____
49. Has obsessions (persistent and intrusive inappropriate ideas, thoughts, or impulses)	_____	_____	_____	_____
50. Has compulsions (repetitive behaviors or mental acts to reduce anxiety or distress)	_____	_____	_____	_____
51. Often is restless or seems keyed up or on edge	_____	_____	_____	_____
52. Often is easily fatigued	_____	_____	_____	_____
53. Often has difficulty concentrating (mind goes blank)	_____	_____	_____	_____
54. Often is irritable	_____	_____	_____	_____
55. Often has muscle tension	_____	_____	_____	_____
56. Often has excessive anxiety and worry (e.g., apprehensive expectation)	_____	_____	_____	_____
57. Often has daytime sleepiness (unintended sleeping in inappropriate situations)	_____	_____	_____	_____
58. Often has excessive emotionality and attention-seeking behavior	_____	_____	_____	_____
59. Often has need for undue admiration, grandiose behavior, or lack of empathy	_____	_____	_____	_____
60. Often has instability in relationships with others, reactive mood, and impulsivity	_____	_____	_____	_____
61 Sometimes for at least a week has inflated self-esteem or grandiosity	_____	_____	_____	_____
62. Sometimes for at least a week is more talkative than usual or seems pressured to keep talking	_____	_____	_____	_____
63. Sometimes for at least a week has flight of ideas or says that thoughts are racing	_____	_____	_____	_____
64. Sometimes for at least a week has elevated, expansive or euphoric mood	_____	_____	_____	_____
65. Sometimes for at least a week is excessively involved in pleasurable but risky activities	_____	_____	_____	_____
66. Sometimes for at least 2 weeks has depressed mood (sad, hopeless, discouraged)	_____	_____	_____	_____
67. Sometimes for at least 2 weeks has irritable or cranky mood (not just when frustrated)	_____	_____	_____	_____
68. Sometimes for at least 2 weeks has markedly diminished interest or pleasure in most activities	_____	_____	_____	_____
69. Sometimes for at least 2 weeks has psychomotor agitation (even more active than usual)	_____	_____	_____	_____
70. Sometimes for at least 2 weeks has psychomotor retardation (slowed down in most activities)	_____	_____	_____	_____
71. Sometimes for at least 2 weeks is fatigued or has loss of energy	_____	_____	_____	_____
72. Sometimes for at least 2 weeks has feelings of worthlessness or excessive, inappropriate guilt	_____	_____	_____	_____
73. Sometimes for at least 2 weeks has diminished ability to think or concentrate	_____	_____	_____	_____
74. Chronic low self-esteem most of the time for at least a year	_____	_____	_____	_____
75. Chronic poor concentration or difficulty making decisions most of the time for at least a year	_____	_____	_____	_____
76. Chronic feelings of hopelessness most of the time for at least a year	_____	_____	_____	_____
77. Currently is hypervigilant (overly watchful or alert) or has exaggerated startle response	_____	_____	_____	_____
78. Currently is irritable, has anger outbursts, or has difficulty concentrating	_____	_____	_____	_____
79. Currently has an emotional (e.g., nervous, worried, hopeless, tearful) response to stress	_____	_____	_____	_____
80. Currently has a behavioral (e.g., fighting, vandalism, truancy) response to stress	_____	_____	_____	_____
81. Has difficulty getting started on classroom assignments	_____	_____	_____	_____
82. Has difficulty staying on task for an entire classroom period	_____	_____	_____	_____
83. Has problems in completion of work on classroom assignments	_____	_____	_____	_____
84. Has problems in accuracy or neatness of written work in the classroom	_____	_____	_____	_____
85. Has difficulty attending to a group classroom activity or discussion	_____	_____	_____	_____
86. Has difficulty making transitions to the next topic or classroom period	_____	_____	_____	_____
87. Has problems in interactions with peers in the classroom	_____	_____	_____	_____
88. Has problems in interactions with staff (teacher or aide)	_____	_____	_____	_____
89. Has difficulty remaining quiet according to classroom rules	_____	_____	_____	_____
90. Has difficulty staying seated according to classroom rules	_____	_____	_____	_____

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version—Pg. 1 of 2 (To be filled out by the PARENT)

Name:_____

Date: _____

Directions:
Below is a list of statements that describe how people feel. Read each statement carefully and decide if it is "Not True or Hardly Ever True" or "Somewhat True or Sometimes True" or "Very True or Often True" for your child. Then for each statement, fill in one circle that corresponds to the response that seems to describe your child for the last 3 months. Please respond to all statements as well as you can, even if some do not seem to concern your child.

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
1. When my child feels frightened, it is hard for him/her to breathe.	○	○	○
2. My child gets headaches when he/she is at school.	○	○	○
3. My child doesn't like to be with people he/she doesn't know well.	○	○	○
4. My child gets scared if he/she sleeps away from home.	○	○	○
5. My child worries about other people liking him/her.	○	○	○
6. When my child gets frightened, he/she feels like passing out.	○	○	○
7. My child is nervous.	○	○	○
8. My child follows me wherever I go.	○	○	○
9. People tell me that my child looks nervous.	○	○	○
10. My child feels nervous with people he/she doesn't know well.	○	○	○
11. My child gets stomachaches at school.	○	○	○
12. When my child gets frightened, he/she feels like he/she is going crazy.	○	○	○
13. My child worries about sleeping alone.	○	○	○
14. My child worries about being as good as other kids.	○	○	○
15. When he/she gets frightened, he/she feels like things are not real.	○	○	○
16. My child has nightmares about something bad happening to his/her parents.	○	○	○
17. My child worries about going to school.	○	○	○
18. When my child gets frightened, his/her heart beats fast.	○	○	○
19. He/she gets shaky.	○	○	○
20. My child has nightmares about something bad happening to him/her.	○	○	○

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version-Pg. 2 of2 (fo be filled out by the PARENT)

	0 Not True or Hardly Ever True	1 Somewhat True or Sometimes True	2 Very True or Often True
21. My child worries about things working out for him/her.	○	○	○
22. When my child gets frightened, he/she sweats a lot.	○	○	○
23. My child is a worried.	○	○	○
24. My child gets really frightened for no reason at all.	○	○	○
25. My child is afraid to be alone in the house.	○	○	○
26. It is hard to my child to talk with people he/she doesn't know well.	○	○	○
27. \11/hen my child gets frightened, he/she feels like he/she is choking.	○	○	○
28. People tell me that my child worries too much.	○	○	○
29. My child doesn't like to be away from his/her family.	○	○	○
30. My child is afraid of having anxiety (or panic) attacks.	○	○	○
31. My child worries that something bad might happen to his/her parents.	○	○	○
32. My child feels shy with people he/she doesn't know well.	○	○	○
33. My child worries about what is going to happen in the future.	○	○	○
34. When my child gets frightened, he/she feels like throwing up.	○	○	○
35. My child worries about how well he/she does things.	○	○	○
36. My child is scared to go to school.	○	○	○
37. My child worries about things that have already happened.	○	○	○
38. When my child gets frightened, he/she feels dizzy.	○	○	○
39. My child feels nervous when he/she is with otl1er children or adults and he/she has to do something while they watch him/her (for example: read aloud, speak, play a game, play a sp01t.)	○	○	○
40. My child feels nervous when he/she is going to parties, dances, or any place where there will be people that he/she doesn't know well.	○	○	○
41. My child is shy.	○	○	○

Developed by Boris Birmaher, M.D., Suneeta Khetarpal, M.D., Marlane Cully, M.Ed., David Brent M.D., and Sandra McKenzie, Ph.D., We tem Psychiatric Institute and Clinic, University of Pgh. (10/95). E-mail: birmaherb@msx.upmc.edu

Screen for Child Anxiety Related Disorders (SCARED)

Child Version - Page 1 of 2 (To be filled out by the CHILD)

Name: _____ **Date:** _____

Directions:
Below is a list of sentences that describe how people feel. Read each phrase and decide if it is "Not True or Hardly Ever True" or "SomeWhat True or Sometimes True" or "Very True or Often True" for you. Then for each sentence, fill in one circle that corresponds to the response that seems to describe you for the last 3 months.

		0 **Not True or Hardly Ever True**	**1 Somewhat True or Sometimes True**	**2 Very True or Often True**
1.	When I feel frightened, it is hard for me to breathe	**0**	**0**	**0**
2.	l get headaches when I am at school	**0**	**0**	**0**
3.	I don't like to be with people I don't know: wen	**0**	**0**	**0**
4.	I get scared if I sleep away from home	**0**	**0**	**0**
5.	l worry about other people flaking me	**0**	**0**	**0**
6.	When l get frightened, I feel like passing out	**0**	**0**	**0**
7.	I am nervous	**0**	**0**	**0**
8.	I follow my mother or father wherever they go	**0**	**0**	**0**
9.	People tell me that I look nervous	**0**	**0**	**0**
10.	I feel nervous with people l don't know well	**0**	**0**	**0**
11.	My I get stomachaches at school	**0**	**0**	**0**
12.	When I get frightened, I feel like lam going crazy	**0**	**0**	**0**
13.	I worry about sleeping alone	**0**	**0**	**0**
14.	I. worry about being as good as other kids	**0**	**0**	**0**
15.	When I get frightened, I feel like things are not real	**0**	**0**	**0**
16.	I have nightmares about sometl11ng bad happening to my parents	**0**	**0**	**0**
17.	1 worry about going to school	**0**	**0**	**0**
18.	When 1 get frightened, my heart beats fast	**0**	**0**	**0**
19.	I get shaky	**0**	**0**	**0**
20.	l have nightmares about something bad happening to me	**0**	**0**	**0**

Screen for Child Anxiety Related Disorders (SCARED)

Child Version- Page 2 of 2 (To be filled out by the CHILD)

		0 Not True or Hardly Ever True	1 Some What True or Sometimes True	2 Very True or Often True
21.	I worry about things working out for me	0	0	0
22.	When I get frightened, I sweat a lot	0	0	0
23.	I am a worrier	0	0	0
24.	I get really frightened for no reason at all	0	0	0
25.	I am afraid to be alone in the house	0	0	0
26.	It is hard for me to talk with people I don't know well	0	0	0
27.	When I get frightened, I feel like I am choking	0	0	0
28.	People tell me that I worry too much	0	0	0
29.	I don't like to be away from my family	0	0	0
30.	I am afraid of having anxiety (organic) attacks	0	0	0
31.	I worry that something bad might happen to my parents	0	0	0
32.	l feel shy with people I don't know well	0	0	0
3.3.	I worry about what is going to happen in the future	0	0	0
34.	When I get frightened, I feel like throwing up	0	0	0
35.	l worry about how well I do things	0	0	0
36.	I am scared to go to school	0	0	0
37.	I worry about things that have already happened	0	0	0
38.	When I get frightened, I feel dizzy	0	0	0
39.	I feel nervous when I am with other children or adults and I have to do something while they watch me (for example: read aloud, speak, play a game, play a sport)	0	0	0
40.	l feel nervous when I am going to parties, dances, or any place where there will be people that I don't know well	0	0	0
41.	I am shy	0	0	0

For children ages *8 to 11, it* is *recommended that the clinician explain all questions, or have the child answer the questionnaire sitting with an adult in* case *they have* any *questions.*

Developed by Boris Birmher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. {10195). Email:birmaherb.@msx.upmc.edu

CHILDREN'S DEPRESSION INVENTORY CDI

Name:_____

Date_____

Kids sometimes have different feelings and ideas.

This form lists different feelings & Ideas in groups. From each group, pick one sentence that describes you best over the past two weeks. After you pick a sentence from the first group, go on to the next group.

There is no right or wrong answer. Just pick the sentence that best describes the way you have been feeling recently.

Fill in the circle (O) next to the sentence that you pick for your answer.

Here is an example of how this form works. Try it. Fill in the circle next to the sentence that describes you best.

Example:
O I read books all the time
O I read books once in a while
O I never read books

REMEMBER; PICK OUT THE SENTENCES THAT BEST DESCRIBE YOUR FEELINGS & IDEAS OVER THE PAST TWO WEEKS.

1. **O** I am sad once in a while.
O I am sad many times.
O I am sad all the time.

2. **O** Nothing will ever work out for me.
O I am not sure if things will work out for me.
O Things will work out for me.

3. **O** I do most things OK.
O I do many things wrong.
O I do everything wrong.

4. **O** I have fun doing many things.
O I have fun doing some things.
O Nothing is fun at all.

5. **O** I am bad all the time.
O I am bad sometimes.
O I am bad once in a while.

6. **O** I think about bad things happening to me once in a while.
O I worry that bad things will happen to me.
O I am sure that terrible things will happen to me.

7. **O** I hate myself.
O I do not like myself.
O I like myself.

8. **O** All bad things are my fault.
O Many bad things are my fault.
O Bad things are usually not my fault.

9. **O** I do not think about killing myself.
O I think about killing myself but I would not do it.
O I want to kill myself.

10. **O** I feel like crying every day.
O I feel like crying once in a while.
O I do not feel like crying.

11. **O** Things bother me all the time.
O Things bother me once in a while.
O Things do not bother me.

12. **O** I like being with people.
O I do not like being with people.
O I do not want to be around people at all.

13. **O** I cannot make up my mind about things.
O It is hard to make up my mind about things.
O I make up my mind about things easily.

14. **O** I look okay.
O There are some bad things about my looks.
O I look ugly.

15. **O** I have to push myself all the time to do my school/home work.
O I have to push myself some of the time to do my school/home work.
O Doing school/home work is not a big problem.

16. **O** I have trouble sleeping every night.
O I have trouble sleeping on some nights.
O I sleep pretty well.

17. **O** I am tired once in a while.
O I am tired some days.
O I am tired all the time.

18. **O** Most days I do not feel like eating.
O I sometimes do not feel like eating.
O I eat pretty well.

19. **O** I do not worry about aches and pains.
O I sometimes worry about aches and pains.
O I worry about aches and pains all the time.

20. **O** I do not feel alone.
O I feel alone often.
O I feel alone all the time.

21. **O** I never have fun at school.
O I have fun at school once in a while.
O I have fun at school all the time.

22. **O** I have plenty of friends.
O I have some friends but I wish I had more.
O I do not have any friends.

23. **O** My school/ home work is alright.
O My school/ home work is not as good as before.
O I do badly in subjects I used to be good

24. **O** I can never be as good as other kids.
O I can be just good as other kids if I want to.
O I am just as good as other kids.

25. **O** No one really loves me.
O I am not sure if someone loves me.
O I am sure that someone loves me.

26. **O** I usually do what I am told.
O I do not do what I am told a lot of the time.
O I never do what I am told.

27. **O** I get along with people.
O I do not always get along with people.
O I do not get along with people.

TOTAL:_____

CMRS, PARENT VERSION

Child's name _____ Date of Birth (mm/dd/yy) ____ ____ ____ Case # / ID # _____

INSTRUCTIONS

The following questions concern your child's mood and behavior in the **past month**. Please place a check mark or an 'x' in a box for each item. Please consider it a problem if it is **causing trouble** and is beyond what is normal for your child's age. Otherwise, check 'rare or never' if the behavior is not causing trouble.

Does your child . . .	NEVER/ RARELY	SOMETIMES	OFTEN	VERY OFTEN	
1. Have periods of feeling super happy for hours or days at a time, extremely wound up and excited, such as feeling "on top of the world"	0	1	2	3	____
2. Feel irritable, cranky, or mad for hours or days at a time	0	1	2	3	____
3. Think that he or she can be anything or do anything (e.g., leader, best basket ball player, rap singer, millionaire, princess) beyond what is usual for that age	0	1	2	3	____
4. Believe that he or she has unrealistic abilities or powers that are unusual, and may try to act upon them, which causes trouble	0	1	2	3	____
5. Need less sleep than usual; yet does not feel tired the next day	0	1	2	3	____
6. Have periods of too much energy	0	1	2	3	____
7. Have periods when she or he talks too much or too loud or talks a mile-a-minute	0	1	2	3	____
8. Have periods of racing thoughts that his or her mind cannot slow down , and it seems that your child's mouth cannot keep up with his or her mind	0	1	2	3	____
9. Talk so fast that he or she jumps from topic to topic	0	1	2	3	____
10. Rush around doing things nonstop	0	1	2	3	____
11. Have trouble staying on track and is easily drawn to what is happening around him or her	0	1	2	3	____
12. Do many more things than usual, or is unusually productive or highly creative	0	1	2	3	____
13. Behave in a sexually inappropriate way (e.g., talks dirty, exposing, playing with private parts, masturbating, making sex phone calls, humping on dogs, playing sex games, touches others sexually)	0	1	2	3	____
14. Go and talk to strangers inappropriately, is more socially outgoing than usual	0	1	2	3	____

Does your child . . .	NEVER	SOMETIMES	OFTEN	VERY OFTEN	
15. Do things that are unusual for him or her that are foolish or risky (e.g., jumping off heights, ordering CDs with your credit cards, giving things away)	0	1	2	3	____
16. Have rage attacks, intense and prolonged temper tantrums	0	1	2	3	____
17. Crack jokes or pun more than usual, laugh loud, or act silly in a way that is out of the ordinary	0	1	2	3	____
18. Experience rapid mood swings	0	1	2	3	____
19. Have any suspicious or strange thoughts	0	1	2	3	____
20. Hear voices that nobody else can hear	0	1	2	3	____
21. See things that nobody else can see	0	1	2	3	____

TOTAL SCORE _____

EXPRESS AND INFORMED CONSENT FOR TREATMENT

Patient Name: _____ Date: _____

I, the undersigned, a ___ patient, ____ guardian advocate, ____ Healthcare surrogate/ proxy, hereby authorize the professional staff of this facility to administer mental health assessment and treatment.

I understand that I am responsible for the fees for services rendered.

I understand that more information will be provided to me before my informed consent is requested for the administration of psychotropic medications.

I understand that my consent can be revoked orally or in writing before or during the treatment period.

I understand that my records are confidential, but there are some exceptions. Serenity Health Center agrees not to release any information about you, other than to Serenity Health Center staff on a need-to-know basis without getting your permission in writing. Florida and Federal law protects such information. Violations of these regulations may be reported as a crime. However, there are times when the law also says that information must be shared. These include cases where there is physical and sexual abuse or neglect of children, elders, or disabled persons; there is an expression of intent to harm self or others; there is a threat or commission of a crime on Serenity Health Center's premises or to staff; a court order is issued requiring Serenity Health Center to release information; we learn of a contagious disease which may harm others; and or the State requires that we report client data for follow-up study.

Patient Signature: _____ Date: _____

Parent/ Guardian/Surrogate Signature: _____ Date: _____

I hereby _____ GIVE _____ DO NOT GIVE Serenity Health Center permission to contact me by:

___Phone ___ Text You can call me at: _____ _____ _____

We may want to contact you by phone and/or text to remind you of your appointment, or how you are doing upon the completion of your treatment.

Patient Signature: _____ Date: _____

Parent/ Guardian/ Surrogate Signature: _____ Date: _____

Serenity HEALTH CENTERS
For Complete Well Being
Ph: 352 241 9282 Fax: 352 241 4282
Locations:
835 Oakley Seaver Dr, Clermont, FL 34711
803 East Dixie Avenue, Leesburg, FL 34748

Consent to Perform Urine Lab Testing on Minor Children

As the undersigned parent or legal guardian of _____, Born

_____ , I do hereby consent to any laboratory testing deemed necessary by Serenity

Health Center for the welfare of my child..

This authorization is effective _____.

_____ _____/ _____ /_____
Print Name of Parent or Legal Guardian Date

_____
Signature of Parent or Legal Guardian

Patient Rights and Responsibilities

While receiving services from Serenity Health Center you have the right to…

- An environment that preserves dignity and contributes to a positive self-image.
- Be served in the least restrictive treatment alternative available to your treatment needs.
- Have all identifying and treatment information held in a confidential manner.
- Know that information disclosed concerning abuse, neglect, or exploitation of a child, disabled adult, or the elderly MUST be reported to the Department of Health and Rehabilitation for possible investigation (under Florida State Law).
- Be involved in the development and review of the clinical records compiled as a result of treatment.
- Refuse care, treatment, or services at any time.
- Treatment free from mental, physical, sexual, and verbal abuse, neglect and exploitation, or any form of corporal punishment.
- To be informed (and when appropriate, family members) about the outcomes of care, including unanticipated outcomes.
- Exercise citizenship privileges.

As a patient of Serenity Health Centers, you have the Responsibility to…

- ➢ Provide accurate and complete information.
- ➢ Schedule appointments and make any calls during normal office hours 9 am - 4 pm Mon-Fri. If you call after normal business hours, please leave a message and we will return your call within 24 to 48 business hours. If you are in a crisis or have an Emergency immediately call 911.
- ➢ Meet financial commitments by: a.) Paying the fees for services rendered
  b.) Being financially responsible for missed appointments.
- ➢ Ask questions when you do not understand your care or do not know what are expected of you.
- ➢ Show respect and consideration. You may be held legally responsible for any verbal or physical abuse towards Serenity Health Center's staff.
- ➢ Follow rules and regulations set forth by staff.
- ➢ Attend medication appointments to obtain prescription refills.
- ➢ Accept the consequences for outcomes if you do not follow treatment recommendations.

By signing this form, I am verifying that I have read and received a copy of my Rights and Responsibilities form:

Patient Signature: _____ Date: _____

Parent/ Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice describes our practice's privacy practices and that of:

- Any physician or health care professional authorized to enter information into your medical chart.
- All departments and units of the practice.
- All employees, staff, and other personnel.
- All these individuals, sites, and locations follow the terms of this notice. In addition, these individuals, sites, and locations may share medical information with each other or with third-party specialists for treatment, payment, or office operations purposes described in this notice.

OUR PLEDGE REGARDING MEDICAL INFORMATION

We understand that medical information about you and your health is personal. We are committed to protecting medical information about you, We create a record of the care and services you receive at our office. We need this record to provide you with quality care and to comply with certain legal requirements. This notice applies to all of the records of the care generated by our office.

This notice will tell you about the ways in which we may use and disclose medical information about you. We also describe your rights and certain obligations we have regarding the use and disclosure of medical information.

We are required by law to:

- Make sure that medical information that identifies you is kept private;
- Give you this notice of our legal duties and privacy practices with respect to medical information about you; and
- Follow the terms of this notice that is currently in effect.

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be used. However, all of the ways permitted to use and disclose information will fall within one of the categories.

- **For Treatment:** We may use medical information about you to provide you with medical treatment or services. We may disclose medical information about you to the practice's office personnel who are involved in taking care of you in the office and elsewhere. We may also disclose medical information about you to people outside our office who may be involved in your care after you leave the office, such as family members or others we use to provide services that are a part of your care provided you have consented to such disclosure. These entities include third-party physicians hospitals, nursing homes, pharmacies, or clinical labs with whom the offices consult or make referrals.
- **For Payment:** We may use and disclose medical information about you so that the treatment and services you receive at our office may be billed to and payment may be collected from you, an insurance company, or a third party. For example, we may need to give your health plan information about procedures you received at the office so your health plan will pay us or reimburse you for the services. We may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.
- **For Healthcare Operations:** We may also use and disclose medical information about you for medical office operations. These uses and disclosures are necessary to run our office and make sure that all patients receive quality care. For example, we may use medical information to review our treatment and services and to evaluate the performance of our staff in caring for you. We may also combine medical information about many patients to decide what additional services the office should offer, what services are not needed, and whether certain new treatments are effective. We may also disclose information to our physicians, staff, and other office personnel for review and learning purposes.
- **Appointment Reminders:** We may also use your information to contact you as a reminder that you have an appointment for treatment or medical care in our office. You may be contacted by any of our personnel via phone, mail, text, or email.
- **Treatment Alternatives:** We may use your information to tell you about possible recommended treatment options or alternatives that may be of interest to you.
- **Individuals Involved In Your Care or Payment For Your Care:** We may release medical information about you to a friend or family member who is involved in your medical care provided you have consented to such disclosure. We may also give information to someone who helps pay for your care. In addition, we may disclose information about you to an entity assisting in a disaster relief effort so that your family can be notified of your condition, status, and location.
- **As Required By Law:** We will disclose medical information about you when required to do so by federal, state, or local law.
- **To Avert a Serious Threat to Health or Safety:** We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety of the public or another person. Any disclosure, however, would only be to someone able to help prevent the threat.

- **Health Oversight Activities:** We may disclose medical information to a health oversight agency for activities authorized by law. The oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the healthcare system, government programs, and compliance with civil rights laws.
- **Lawsuits and Disputes:** If you are involved in a lawsuit or dispute, we may disclose medical information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement:** We may release medical information if asked to do so by a law enforcement official in response to a court order, a subpoena, a warrant, a summons, or a similar process. To identify or locate a suspect, fugitive, material witness, or missing person about the victim of a crime if, under certain limited circumstances, we are unable to obtain the person's agreement about a death we believe may be the result of criminal conduct, about criminal conduct at the office, and the person's emergency circumstances to report a crime, the location of the crime or victims, or the identity, description or location of the person who committed the crime.
- **Coroners, Medical Examiners, and Funeral Directors:** We may release medical information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person to determine the cause of death. We may also release medical information about patients of the office to funeral directors as necessary to carry out their duties.

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

You have the following rights regarding medical information we obtain about you:

- **Right to inspect and copy:** You have the right to a copy of your medical information that may be used to make decisions about your care. To inspect and/or receive a copy of medical information that may be used to make decisions about you, you must submit it in writing to Serenity Health Center. If you request a copy of the information, we may charge you a minimum fee of $50.00 to cover the costs of copying and mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances.
- **Right to Amend:** If you feel that the information we have about you is incomplete or incorrect, you may ask us to amend the information. You have the right to ask for an amendment as long as the information is kept by our office. To request an amendment, you must request it in writing to your physician. In addition, you must provide a reason that supports your request. We may refuse to amend your record under limited circumstances.
- **Right to Accounting Disclosures:** You have the right to request a list of disclosures we made of medical information about you, To request this list you must submit a request in writing to Serenity Health Center and denote a time period not to exceed seven years. The first request will be free of charge, but additional lists may apply fees to be determined before any charges will be applied, at which time you may retract your request before any costs are incurred.
- **Right to Request Restrictions:** You have the right to request restrictions or limitations on the medical information we use to disclose about you for treatment, payment, or healthcare operations. You also have a right to request a "limit" on the medical information we disclose about you to someone who is involved in your care or payment for your care, like a family member or friend.
    - **We Are Not Required to Agree to Your Request:**. If we do not agree to comply with your request, and only do so if the information is needed to provide you with emergency treatment. You must submit, in writing to Serenity Health Center citing: (1) which information you wish to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply.
- **Right to Request Confidential Communications:** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you may request that we only contact you at work or by mail. Please submit your request in writing. We will not ask for a reason for your request and we will accommodate all reasonable requests.

- **Right to a Paper Copy of this Notice:** You have the right to receive a paper copy of this notice. You may ask us to give you a copy of this notice at any time. You may request in writing to Serenity Health Center that a copy be mailed to you.
- **Mental Health Exemption:** As per the HIPAA Privacy Rule Mental Health Care providers who specialize in Psychiatry and Mental Health are specifically exempt from disclosing patient records to patients directly. The Privacy Rule definition of Psychiatric notes are "notes recorded in any medium" by a healthcare provider who is a Licensed Mental Health Care Provider, Therapist, or Psychiatrist. We can, however, send your medical records, upon written request and with a properly signed Medical release form stating the Facility, physician's name, and Fax number, to the medical provider of your choice.

CHANGES TO THIS NOTICE

We reserve the right to change this notice. We reserve the right to make the revised or changed notice effective for medical information we already have or may obtain in the future. We will post a current copy of this notice in the office. The notice will contain on the first page, in the top left corner, the effective date. In addition, each time we will offer you a copy of the current notice in effect.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a written complaint with Serenity Health Center, 835 Oakley Seaver Drive, Clermont, FL. 34711. Or with the Office of Civil Rights within the Department of Health and Human Services by visiting their website at www.hhs.gov/ccr/hipaa. All complaints must be submitted in writing. You will not be penalized or retaliated against for filing a complaint.

OTHER USES OF MEDICAL INFORMATION

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission, you may also revoke that permission at any time, in writing. If you revoke your permission, we will no longer use or disclose
information about you for reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission and that we are required to retain our records of the care that we provided to you.

Acknowledgement and Consent
Notice of Privacy Practices

The Notice of Privacy Practices tells you how we may use and share your health records.

1. We will use and share your health records to treat you and to bill for the services we provide.
2. We will use and share your health records to run our practice.
3. We will use and share your health records as required by law.

You have the following rights with respect to your health records:

1. You have the right to have your psychiatric medical records sent to another medical professional.
2. You have the right to receive a list of whom we have given your records to.
3. You have the right to ask us to correct a mistake in your health records.
4. You have the right to ask that we not use or share your health records.
5. You have the right to ask us to change the way we contact you.

All of these rights are explained in more detail in the Notice of Privacy Practices.

I have received a copy of Serenity Health Center's Notice of Privacy Practices.

I consent to the use and sharing of my health records for treatment, payment, and operation purposes as described in the Notice of Privacy Practices. I know that if I do not consent, Serenity Health Care cannot provide services to me.

_____ _____

Signature of patient or legal representative **Date**

Billing and Insurance Procedure Consent

You Must Read And Initial Where Indicated

1. I request that payment of authorized Medicare/ other Insurance Company benefits be made on behalf of Serenity Health Centers for services rendered by physicians or associates of Serenity Health Centers. **(_____) Initial**

2. I authorize Serenity Health Centers to release any medical information concerning me to my insurance company or its agents necessary to determine benefits or the benefits related to the payable services. I am aware that I am responsible for any deductibles, co-insurance, and non-covered services. I understand this applies to all Medicare and Commercial Insurance Companies. **(_____) Initial**

3. I understand that payment is due at the time services are rendered. All co-pays and deductibles will be collected. **(_____) Initial**

4. Serenity Health Centers will file a claim with your Insurance Company. If your insurance company does not respond to the claim within 60 days from the date of filing, then the balance will become the Patient's responsibility. The patient will receive a statement and payment will be due upon receipt. If payment is not received within 30 days, further action will be taken. If your deductible has not been met, or if you do not have insurance, arrangements must be made before your first appointment with the Physician or any medical personnel. **(_____) Initial**

5. Medicare patients: We will file your secondary insurance as a courtesy. We will only bill one insurance company after Medicare. If we receive no response, the balance after Medicare pays will be your responsibility. **(_____) Initial**

6. If you have an HMO, obtaining authorization is your responsibility for all visits, procedures, etc. If you choose to be seen without prior authorization and your insurance company denies payment, you will be responsible for your entire bill. **(_____) Initial**

Important Note: Please remember that your coverage is a contract between you and your insurance company. WE ARE NOT PART OF THAT CONTRACT. We file as a COURTESY to you.

I, _____, have read and understand the above billing and insurance procedures.

Print Name

_____ _____

Patient Signature **Date**

NO SHOW / NO CONTACT / OFFICE ARRIVAL POLICY

Appointments are scheduled to accommodate both your and the practitioner's schedules

- Patients are required to arrive at ***least 15 minutes prior*** to their scheduled appointment time. **(____) Initial**

- New patient appointments are required to arrive with **completed paperwork** at least **30 minutes prior** to their scheduled appointment time. If your paperwork is not completed PRIOR to your appointment, you will need to arrive ***45 minutes prior to your scheduled appointment,*** or your appointment WILL BE RESCHEDULED. **(____) Initial**

- If you are running late- Please call **352-241-9282** as a Courtesy to the office & staff, so we are aware you are running late. We may be able to accommodate the next appointment. **(____) Initial**

- We allow a grace period of a total of **7 minutes** after your appointment time before you are considered a **NO SHOW**. You may be seen after the next appointment if you are running late in order to keep the office on schedule. **(____) Initial**

- If any patient arrives more than 7 minutes after their scheduled appointment time, and without a 24-hour prior notice to cancel or reschedule the following charges will be charged to your account, and must be paid prior to rescheduling your next appointment;
    - ***New Patients who Confirmed appointment $100 No Show Fee***
    - Established patients who Confirmed $50.00 1st Occurrence
      $100.00 2nd Occurrence
      $125.00 3rd Occurrence

  After 3 No Show/ No Contact in a calendar year will Automatically be Discharged from our practice. **(____) Initial**

- An appointment that is NOT confirmed will be canceled and will be your responsibility to reschedule. The NO Show/ No Contact fee will be charged to those appointments that have been confirmed, and who have NOT called to cancel or reschedule no less than **24 hours prior** to the scheduled appointment time. **(____) Initial**

Please be aware that Serenity Health Centers will NOT be responsible for any adverse reactions due to the discontinuation of any medications due to the inability to come to your scheduled appointments as determined by your provider. (____) Initial

_____ _____
Patient Name **Date**

_____
Signature of patient/ Legal Guardian

CURRENT MEDICATION PROFILE

Please list any medications that you are currently taking. Prescribed OR over the counter:

Medication	Dosage	Start Date	Stop Date	Diagnosis	Date last filled	Prescribing Physician