Psych-Med Associates
Mark Matta, D.O.
2616 Wilmington Rd., New Castle, PA 16105
Phone: (724) 652-2323 Fax: (724) 654-3461

Biographical Information:

Name: _____ Todays Date: _____

Birthdate: _____ Social Security Number: _____

Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell: _____

Insurance: _____ (If not self) Policy Holder's Name: _____

Policy Holder's Birthdate: _____ Policy Holder's Social Security Number: _____

Pharmacy: _____ Pharmacy Phone: _____

Age: _____ Sex: M F Race: _____ Family Physician: _____

Marital Status: Single Married Separated Divorced Widowed Remarried
Number of marriages _____ Number of divorces _____

Children: Total Number: _____ Daughter(s) _____ Son(s) _____

Emergency Contact : _____ Contact Number: _____

Highest Education COMPLETED: Grade: _____ High School: _____ College: _____ Graduate School: _____

Occupation: Employed: _____ Unemployed: _____ Disabled: _____ Retired: _____ Previous Job: _____
(If retired)

Name of Employer: _____ Since: _____

How did you hear about us: _____ Phone Book _____ Friend _____ Referral from a doctor: _____
_____ Other: _____

Clinical Symptoms:

Reason for Visit: _____

PAST PSYCHIATRIC HISTORY:

Outpatient at: _____ Dates: _____

_____ Dates: _____

Inpatient at: _____ Dates: _____

_____ Dates: _____

Current Psychiatric Medications: _____ Since: _____

_____ Since: _____

_____ Since: _____

_____ Since: _____

Psych-Med Associates, Inc.

PAST PSYCHIATRIC MEDICATIONS ATTEMPTED:

___ Prozac	___ Zoloft	___ Paxil	___ Lexapro	___ Effexor XR	___ Cymbalta	___ Pristiq	___ Wellbutrin
___ Fetzima	___ Viibryd	___ Brintellix	___ Celexa	___Elavil	___ Depakote	___ Tegretol	___ Pamelor
___ Tofranil	___ Lamictal	___ Topamax	___ Lithium	___ Invega	___ Zyprexa	___ Geodon	___ Latuda
___ Saphris	___ Abilify	___ Seroquel	___ Haldol	___ Risperdal	___ Xanax	___ Klonopin	___ Ativan
___ Valium	___ Doxepin	___ Trazodone	___ Lunesta	___ Restoril	___ Remeron	___ Belsomra	___ Ambien
___ Adderall	___ Concerta	___ Metadate CD	___ Focalin	___ Vyvanse	___ Strattera	___ Ritalin	

___ Other medications not listed: _____

Please describe any side effects caused by previous psychiatric medications (please list medication and side effect):

_____

_____

Allergies: _____

PAST MEDICAL HISTORY: _____

_____

_____

Pregnant? _____ Yes _____ No _____ Possible

FAMILY PSYCHIATRIC HISTORY: _____ None

Father's Diagnosis: _____ _____ None

Mother's Diagnosis: _____ _____ None

Number of Brother(s) _____ Sister(s) _____

Brother(s)'s Diagnosis: _____ _____ None

Sister(s)'s Diagnosis: _____ _____ None

SOCIAL HISTORY:

___ Cigarettes/ How many packs/day? _____

___ Alcohol / How much? _____ How often: _____

___ Illicit Drugs / What kind? _____ How often? _____

___ Prescription Drug Abuse / What Kind? _____

How often: _____ Are you currently on methadone? Yes _____ No _____ Dosage: _____

Clinic Name: _____

LEGAL HISTORY:

Have you ever been arrested? Yes _____ No _____

Past & Current Charges: _____

Religion: Christian _____ Jewish _____ Muslim _____ Other _____

PsychMed

Consent to Treatment

Please read carefully before signing:

The following information is being provided to acquaint you with our services and policies. After reading this, please sign at the bottom. Your signature indicates understanding of an agreement to voluntarily participate and cooperate with the treatment team to help you with you problems.

We are specialists in different psychiatric disciplines. Dr. Mark Matta, Psychiatrist has a board clinical experience in treating adolescents, adults and geriatric patients. His associates are competent, experienced professionals – nurse practitioners, psychiatric clinical social workers, physician assistants, therapists, and counselors in fields or individual, group and marriage counseling.

The following are some regulations that specifically apply to your treatment:

1. All patients have the right to have equitable access to treatment regardless of race, religion, sex, ethnicity, age, or handicap.
2. All patients are treated with politeness, respect and care from all the staff, and we expect the same from you.
3. All treatment is completely confidential in accordance with the medical records law; state and federal regulations. No information will be released without prior written consent except in the following conditions.
    a.) To report suspected physical, sexual abuse or criminal activities.
    b.) To report intent of homicidal intentions to the identified victims and authorities notified.
    c.) To report suicidal intentions to your family and hospitalization considered.

The attending clinician reserves the right to terminate treatment due to the patient's failure to comply with treatment recommendations and/or failed appointments. Prior verification and a 30 day notice will be issued.

One of the treatment modalities is prescribing psychotropic medication that can cause some side effects. This will be discussed and explained to you. You have the right to accept or refuse this treatment.

Access to medical records should be discussed on individual cases with Dr. Matta due to the sensitive issues that might be documented in the records. Upon receipt of written consent, medical records might be released to a third party or directly to a requested physician.

I have read or had this read to me. I understand what it means and agree to participate in the treatment.

Signature of Patient/
Parent or Guardian: _____ Date: _____

Signature of Witness: _____ Date: _____

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Insurance Authorization

Patient Name: _____

Insurance Carrier #1: _____

Subscriber's Name: _____ SS#: _____

Subscriber's Employer: _____

Subscriber's ID: _____ Group #: _____

Insurance Carrier #2: _____

Subscriber's Name: _____ SS#: _____

Subscriber's Employer: _____

Subscriber's ID: _____ Group #: _____

I hereby authorize Psych-Med Associates to furnish information to Insurance carriers concerning diagnosis and treatment, and I authorize the Insurance carriers to forward all payments to the doctor for services rendered to myself or my dependents.

I understand that I am responsible for any amount not covered by my Insurance. This authorization will be effective as of the date stated below.

A photocopy of this authorization shall be considered as valid as the original.

Signature: _____ Date: _____

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Medication Management Agreement

To provide the best quality psychiatric care to our consumers, there will be an agreement between the patients and the Psychiatrist/Practitioners regarding controlled substances.

Please initial after reading each statement:

_____ I understand that the main treatment goal in prescribing controlled substances is to improve my ability to function and/or work. In consideration of these goals, I agree to help myself by following better health habits including but not limited to exercise, eating healthy and avoiding the use of alcohol and tobacco.

_____ I am responsible for my controlled substance medication. If the prescription medication is lost, misplaced, stolen or if I need it refilled sooner than prescribed, I understand it will NEVER be replaced.

_____ I will not request or accept the same class of medication from any other physician/ prescriber while I am receiving medication from this office.

_____ Refills of medications:

- Will only occur during regular office hours. Refills will not occur on nights, weekends, holidays, or after 4pm.
- Will not be authorized early because of vacations or personal plans.
- Will not be authorized by our staff in any emergency room or urgent care facility.

_____ I am responsible for taking my medication at the dose and time prescribed.

_____ I will not share, trade, or sell my medications. I understand that doing so will result in my immediate discharge from this office.

_____ I will disclose fully to the best of my knowledge all other medications I am taking, including methadone.

_____ I agree to comply with random drug testing.

_____ I understand that driving a motor vehicle may not be allowed at times while I am taking a controlled substance and it is my responsibility to comply with the laws of this state and in accordance with my prescriber.

_____ I understand that if any criminal charges for receiving, possession or selling of illegal substances and/or a controlled substance prescription will be reviewed by my prescriber and may result in my discharge.

I, the undersigned, agree to follow these guidelines that have been fully explained to me. All questions and concerns regarding this form and my treatment have been adequately answered. If I do not follow these guidelines, Psych-Med Associates has the right to taper and/or discontinue my medication and discharge me from this office with alternative referrals.

Patient Signature: _____ Date: _____

Parent/Guardian (if under 18): _____ Date: _____

Witness Signature: _____ Date: _____

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Authorization to Pick-Up Prescriptions

I, _____(_____/_____/_____), authorize the following person(s) to pick up
(Print Name) (DOB)
paper prescriptions/medications in my absence.

1. Name _____ Relationship _____
2. Name _____ Relationship _____

I understand that the person authorized to pick up these prescriptions may be required to know my date of birth or provide photo I.D.

I understand that some of my prescriptions may be for controlled substances.

I agree that Psych-Med Associates is not liable for any lost or stolen prescriptions that are picked up in this manner and are therefore not required to replace them.

I understand that should I want to change the person(s) on this list it is my responsibility to notify the office staff; otherwise this person will continue to be authorized to pick up my prescriptions/medications.

Signature: _____

Date: _____

Witness: _____

Date: _____

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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 THIS NOTICE CAREFULLY.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your PHI in accordance with applicable law and respective ethical codes of the practitioners in this office. It also describes your rights regarding how you may gain access to and control you PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of our Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. You may request a copy of the Notice of Privacy Practices at any time.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purpose of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that preform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must make disclosures of your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of Privacy Rule.

Without Authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of other situations. The types of uses and disclosures that may be made without your authorization are those that are:

- Required by Law, such as the mandatory reporting of child abuse or neglect or mandatory government agency audits or investigations (such as a licensing board or the health department)

- Required by Court Order
- Necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Verbal Permission

We may use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked upon your request at any time.

YOUR RIGHTS REGARDING YOUR PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Medical Records Coordinator at 2616 Wilmington Rd., New Castle, PA 16105.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that may be used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you. We may charge a reasonable, cost-based gee for copies.
- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment.
- **Right to an Accounting of Disclosure.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.
- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the use or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request.
- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location.
- **Right to a Copy of this Notice.** You have the right to a copy of this notice.

Complaints

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Medical Records Coordinator or Office Manager at 2616 Wilmington Rd., New Castle, PA 16105 or by calling at (724) 652-2323. Additionally, you may issue a complaint with the Secretary of Health and Human Services at 200 Independence Avenue. S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

The effective date of this Notice is July 19,2013.

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CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between behavioral health providers and your primary care physicians is important to help ensure that you receive comprehensive and quality health care. This information will not be released without your consent. This information may include diagnosis, treatment plan, progress, and medication if necessary. You may revoke this consent at any time except to the extent that records have already been released and this consent shall expire twelve months from the date of signature, unless another date is specified.

I, _____, _____ _____, for the purpose of coordinating
(Patient Name-Print) (Patient D.O.B) (Patient Social Security Number)

care, authorize Psych-Med Associates, to release information indicated in the "Consent" portion of this form to:

PCP NAME: _____

PCP Phone: _____ **PCP Fax:** _____

PCP Address: _____
(Street) (City) (State) (Zip)

Information for PCP:
(Provider Completes)

The patient was seen by me on (Date): _____ for (Diagnosis): _____

Treatment Plan: _____

I, the undersigned, understand that I may revoke this consent at any time except to the extent that action has been taken in reliance upon it and that in any event this consent shall expire twelve months from the date of signature, unless another date is specified. I have read and understand the above information and give my consent:

Please check one:

_____ To release any applicable mental health/substance abuse information to my primary care physician.

_____ To release only medication information to my primary care physician.

_____ I do not give my consent to releasing any information to my primary care physician.

_____ _____
Patient Signature (Patients over 18) (Date) Parent/Guardian Signature (Patients under 18) (Date)

_____
Witness (Date)

Notice To Recipient Of This Information: This information has been disclosed to you from records which are protected by federal (42 CFR Part 2) and state laws regarding confidentiality. Such laws prohibit you from making any further disclosure of this information without specific written consent of the person to whom it pertains, or as otherwise permitted by law. A general authorization for the release of medical or other information is not sufficient for this purpose.

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Authorization for Release of Protected Health Information

Patient Name: _____

DOB: _____/_____/_____ SS #: _____

Patient Address: _____

Records are requested for the purpose of: _____

Information to be released/requested FROM:

Agency Name: _____

Agency Address: _____

Agency Phone: ( )_____ Agency Fax: ( )_____

Records to be released TO:
Psych-Med Associates
2616 Wilmington Rd. Suite A
New Castle, PA 16105
Phone: (724) 652-2323
Fax: (724) 654-3461

HIV, Mental Health and Drug and Alcohol records will be released unless otherwise indicated.

Do **NOT** release (circle any that apply):

HIV Mental Health (Psychiatric) Drug & Alcohol

I understand that this authorization is effective for a period of one year from the date of this signature, unless otherwise specified below. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/person I authorized above to release the information.
If applicable specify other expiration date/event here _____

Signature of Patient: _____ Date: _____
(14 years of age and above for inpatient mental health records or 18 years and above for outpatient)

Signature of Parent/Legal Guardian: _____ Date: _____

Signature of Witness/Staff Member: _____ Date: _____

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Acknowledgement of Receipt of Privacy Practices

(You May Refuse to Sign This Acknowledgement)

I, _____, have received a copy of the Notice of Privacy Practices from Psych-Med Associates.

_____
Patient Name (Print)

_____ _____
Signature Relationship to Patient

_____
Date

For Office Use Only
We have made a good faith effort in attempting to obtain written acknowledgment of receipt of the Notice of Privacy Practices. Acknowledgement could not be obtained for the following reason(s):

[ ] Patient/ individual refused to sign (Date of refusal): _____

[ ] Communication barriers prohibited obtaining an acknowledgment.

[ ] An emergency situation prevented us from obtaining an acknowledgment.

[ ] Other: _____

Attempt was made by: _____ Date: _____