Clarity Clinic

New Client Intake Paperwork

In order to serve you properly, please complete ALL of the following information and bring it with you to your first visit. You may need to ask family members about the family history. If assistance was required in filling this form out, please indicate on form with name and relationship.

CONTACT INFORMATION	
Patient Name:	Date:
Date of Birth (D.O.B)	
Email:	
Medical Emergency Contact (with phone number) and relationship to patient:	
Primary Care Physician (PCP):	
Current Psychiatrist:	
Current Therapist/Counselors:	
How Did You Hear About Us?: (PCP, ZocDoc, Friend, Google, Etc.):	
Assigned Sex At Birth:	Current Gender Identity:
Race And Ethnicity You Identify With:	

REASON FOR VISIT
What Is/Are The Problem(s) You Are Seeking Help For?

YOUR MEDICAL HISTORY
Current Medical Problems:
Allergies:

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Any Past Head Injuries or Seizures (please circle)? **Yes** **No**

REVIEW OF SYMPTOMS

(Please circle if you are experiencing any of the following symptoms)

Constitutional:	**Ear/Nose/Mouth/ Throat**:	**Respiratory:**	**Cardiovascular:**
Fever Chills Fatigue Weight loss Weight gain Changes in vision Blurry vision Double vision Glaucoma	Decreased hearing Ringing in ears Nosebleeds Dry mouth	Shortness of breath Cough	Chest pain palpitations

Gastrointestinal:	**Genitourinary:**	**Hematology/ lympathics:**	**Musculoskeletal::**
Nausea Vomiting Diarrhea Abdominal pain	Frequency burning/pain Urinary retention Urinary incontinence Decreased libido Menstruating Postmenopausal	Shortness of breath Cough	Muscle pain Muscle stiffness

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Integumentary/ skin: Rash Sores Scars Abrasions/lacerations	**Endocrine**: Sweating Heat or cold intolerance Increased thirst Increased urination Change in appetite	**Neurologic**: Dizziness Seizures Tremor Tics Confusion Headache Abnormal movements of muscles	**Psychiatric**: Depression Anxiety Mood swings Anger Memory loss Other (_____)

Please List all Psychiatric Medications

Medication Name	Dosage	Frequency	Estimated Start Date

Please List Any Other Medications (including supplements or over the counter medications)

Medication Name	Dosage	Frequency	Estimated Start Date

FOR WOMEN ONLY		
Date Of Last Menstrual Period:		
Are You Currently Pregnant Or Think You Might Be Pregnant (please circle one)?	**Yes**	**No**
Are You Planning To Get Pregnant In The Near Future (please circle one)?	**Yes**	**No**
Any History of Postpartum Depression Or Psychosis (please circle one)?	**Yes**	**No**

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PAST PSYCHIATRIC HISTORY		
History of Psychiatric Treatment:		
Previous and Current Psychiatric Diagnosis:		
Psychiatric Hospitalizations (please circle one):	**Yes**	**No**
Past Psychiatric Medication Trials (please list) :		
Any History of Self-Injury Or Suicide Attempts: (please circle one)	**Yes**	**No**

FAMILY PSYCHIATRIC HISTORY			
Has anyone In your family been diagnosed with (mark "X" in corresponding field):			
	Yes	**No**	**Which Family Member?**
Bipolar Disorder			
Schizophrenia			
Depression			
Anxiety			
Alcohol Abuse			
Other Substance Abuse			
Suicide			

Has Any Family Member Been Treated With Psychiatric Medications that were effective (Please circle):	**Yes**	**No**
If Yes, Who Was Treated And What Medications And How Effective Was The Treatment?		

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SUBSTANCE ABUSE HISTORY
Have You Ever Had Problems With Drugs or Alcohol (please circle): **Yes** **No**
If Yes, For Which Substances:
If Yes, Have You Participated in Treatment:
Any History Of Complicated Withdrawal From Substances, Including Seizures Or Delirium Tremens: If Yes, explain:
Are You Currently Using Any Recreational Drugs, or Misusing Prescription Medications (please circle): **Yes** **No**

TOBACCO HISTORY
Do You Currently Use Any Tobacco Products Such As Cigarettes, E-Cigarettes, Cigars, Pipes, Or Chewing Tobacco: **Yes** **No**

SOCIAL HISTORY
Are You Currently Working (please circle): **Yes** **No**
What Is Your Occupation (if applicable):
Have You Ever Served In The Military: **Yes** **No**
Are You Currently (please circle): Married Divorced Single Widowed Partnered
Do You Have Any Children (please circle): **Yes** **No**
What Is Your Highest Level Of Education:
Have You Ever Been Arrested (please circle): **Yes** **No**
Any Pending Legal Problems (please circle): **Yes** **No**

Clarity Clinic

THANK YOU FOR COMPLETING THE FOLLOWING INFORMATION.
If There Is Anything Else That You Would Like The Provider To Know, Please Indicate Below:

SIGNATURE (please sign and print your name, with the date below)	
_____	
Print Name	
_____	_____
Signature	**Date**
_____	_____
Witness or Provider Signature	**Date**
If signed by a patient representative, please state relationship to patient:	

Clarity Clinic

Clarity Clinic Billing Information

Please fill out the below information for our billing purposes.

BILLING INFORMATION		
Patient Name:	Date:	
Date of Birth (D.O.B.)	Sex:	
Social Security #:		
Address:		
City:	State:	Zip:
Preferred Telephone Number (Home/Cell /Work):		
Email:		
RESPONSIBLE PARTY		
Name Of Person Responsible For This Account:		
Address:		
City :	State:	Zip:
Telephone Number (Home/Cell /Work):		
Driver's License #:		
Date of Birth (D.O.B.)		
Employer:	Employer Work Phone:	

Clarity Clinic

INSURANCE INFORMATION	
Name of Insured: DOB:	Relationship to Patient:
Subscriber ID:	Group #:
Insurance Company:	
(continued from page 7) Insurance Company Address:	

AUTHORIZATION AND RELEASE:

I authorize release of any information concerning my (or my dependents) health care, advice and treatment provided for the purpose of evaluating and administering claims for insurance benefits. Clarity clinic may use and disclose PHI in order to collect payment for the health care services provided to you. Clarity may also disclose PHI to their business associates, such as billing companies, claims processing companies, and others that assist in processing health claims.

I also hereby authorize payment of insurance benefits otherwise payable to me directly to the doctor. I understand that unless a 24-hour notice of cancellation is given, I may be charged for the time that the doctor has set aside for the appointment. In addition, that if my (or my dependents) account requires the services of a collection agency, I may incur charges to cover court and legal fees.

SIGNATURE	
Signature (patient, parent, or legal guardian)	**Date**
Witness or Provider Signature	**Date**

Clarity Clinic

Patient Easy Pay Consent Form

I authorize Clarity Clinic to charge my credit/debit card for no shows and late cancellations (within 24 hours of the scheduled appointment) as outlined in the "Policies and Procedures" Form.

I authorize Clarity Clinic to charge my credit/debit card for all charges for services not paid by my insurance company within 90 days of services rendered including co-pays and no-shows unless discussed otherwise with the office staff.

BILLING INFORMATION		
Name on Card:		
Card Number:		
Expiration Date: Type of Card: VISA MasterCard AMEX Discover		
CW Code:		
Billing Address:		
City:	State:	Zip:

I understand that this form is valid without expiration unless I cancel this authorization by notice in writing submitted to Clarity Clinic.

SIGNATURE	
Signature (patient, parent, or legal guardian)	Date
Witness or Provider Signature	Date

Clarity Clinic

Patient Telephone Session Rate

I acknowledge that any phone calls made to my therapist or psychiatrist exceeding 15 minutes will be billed as an out-of-pocket expense. The following rates apply:

Phone Call Duration	Therapist Rate	Psychiatrist Rate
15-30 Minutes	$50	$75
30-45 Minutes	$100	$150
45-60 Minutes	$120	$200

Authorization and Release:
By signing below I understand and acknowledge these charges are out-of-pocket and will not be billed to my insurance company.

SIGNATURE	
Signature (patient, parent, or legal guardian)	Date
Witness or Provider Signature	Date

Clarity Clinic

Consent for Treatment, Release and Use of Confidential Information and Receipt of Notice of Privacy Practices Form

I voluntarily request a physician, and/or mid level provider (Nurse Practitioner, Physician Assistant), and other health care providers (therapists) or the designees as deemed necessary, to perform reasonable and necessary medical examination/evaluation, testing and treatment for the condition which has brought me to seek care at this practice. By signing below, you are indicating that you (1) intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

I give my consent to Clarity Clinic and all its health care providers, to use or disclose my protected health information (PHI) to carry out my treatment, to obtain payment from insurance companies, and for health care operations as below.

I acknowledge receipt of the practice Notice of Privacy Practices, which provides detailed information about how the practice may use and disclose my confidential information.
I understand that this practice has the right to change their privacy practices that are described in the notice and that I may obtain any revised notices at the practice. I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice to the office. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information.

I understand I have the right to receive my information confidentially. I understand I have authorization rights before my information may be used or shared. I understand I have a right to see and receive copies of my health records. I understand I have the rights to amend my health information. I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice/clinic is not required to agree to the request. If the practice/clinic agrees to my requested restrictions, they must follow the restrictions.

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

SIGNATURE		
_____	_____	_____
Patient Print Name	**Patient Signature**	**Date**
_____	_____	
Witness or Provider Signature	**Date**	

Clarity Clinic

Policies and Procedure Overview

Thank you for choosing Clarity Clinic for your healthcare needs. We are committed to providing high quality, personalized and compassionate, comprehensive patient care. We ask that these policies be reviewed and acknowledged so that we may provide quality service and ensure proper reimbursement. Please sign the policy indicating that you have read the terms and conditions, in agreement to abide by them.

Clarity Clinic will use or disclose your protected health information (PHI):

FOR TREATMENT: Clarity may use and disclose PHI in the course of providing, coordinating, or managing your medical treatment, including the disclosure of PHI for treatment activities at another healthcare facility. These types of uses and disclosures may take place between physicians, nurses, technicians, students, and other healthcare professionals who provide you health care services or are otherwise involved in your care.

CONFIDENTIALITY AND PRIVACY PRACTICES: Clarity Clinic is required by law to maintain the privacy of your protected health information (PHI). All information disclosed within sessions and the written records pertaining to those sessions are confidential and may not be revealed to anyone without your written authorization. Clarity Clinic may use and disclose PHI without your written authorization under the following circumstances:

When required by law, such as where there is a reasonable suspicion of child, dependent, or elder abuse or neglect; where a client presents a danger to self, to others, to property, or is gravely disabled; or when a client's family members communicate to Clarity Clinic staff that the client presents a danger to others. Disclosure may also be required pursuant to a legal proceeding by or against you. If you place your mental status at issue in litigation initiated by you, the defendant may have the right to obtain the psychotherapy records and/or testimony by Clarity Clinic staff. In addition, Clarity Clinic may disclose PHI under the following circumstances: specialized government functions, for public health purposes, for health care operations, for health oversight activities, to avoid a serious threat to health or safety, workers compensation, and disclosure to HIPPA compliance investigations. In couple and family therapy, or when different family members are seen individually, even over a period of time, confidentiality and privilege do not apply between the couple or among family members, unless otherwise agreed upon. Clarity Clinic staff will use his/her clinical judgment when revealing such information. Clarity Clinic will not release records to any outside party unless s/he is authorized to do so by all adult parties who were part of the family therapy, couple therapy or other treatment that involved more than one adult client.

EMERGENCY: If there is an emergency during therapy, or in the future after termination, where Clarity Clinic becomes concerned about your personal safety, the possibility of you injuring someone else, or about you receiving proper psychiatric care, s/he will do whatever s/he can within the limits of the law, to prevent you from injuring yourself or others and to ensure that you receive the proper medical care. For this purpose, s/he may also contact the person whose name you have provided on the biographical sheet or emergency contact.

E–MAILS, CELL PHONES, COMPUTERS, AND FAXES: It is very important to be aware that computers and unencrypted email, texts, e-faxes and faxes communication (which are part of the clinical records) can be relatively easily accessed by unauthorized people and hence can compromise the privacy and confidentiality of such communication. Emails, texts, e-faxes and faxes in particular, are vulnerable to such unauthorized access due to the fact that servers or communication companies may have unlimited and direct access to all emails, texts, faxes and e-faxes that go through them. While data on Clarity Clinic's laptops are encrypted, emails, texts, faxes and e-fax are not. It is always a possibility that e-faxes, faxes, texts, and email can be sent erroneously to the wrong address and computers.Please notify Clarity Clinic staff if you decide to avoid or limit, in any way, the use of email, texts, cell phones calls, phone messages, faxes, or e-faxes. If you communicate confidential or private information via unencrypted email, texts,faxes or e-fax or via phone messages, will assume that you have made an informed decision, will view it as your agreement to take the risk that such communication may be intercepted. Please do not use texts, email, voice mail, or for emergencies.

MINORS IN TREATMENT: If you are under eighteen years of age, please be aware that the law may give your parents or guardians the right to obtain information about your treatment and/or examine your treatment records. It is Clarity Clinic policy to request a written agreement from your parents or guardians indicating that they consent to give up access to such information and/or, to your records. If they agree, Clarity Clinic will provide them only with general information subject to your approval, or, if Clarity Clinic staff feel it is important for them to know in order to make sure that you and people around you are safe. Clarity Clinic will involve them if there is a high risk that you will seriously harm yourself or another/others. Before giving them any verbal or written information, Clarity Clinic staff will discuss the matter with you, if possible.

GROUP THERAPY: In group therapy, it is of utmost important that all members maintain confidentiality and neither disclose the content of sessions nor the identity of fellow group members. It is highly recommended that any meaningful exchange outside the group also be discussed in the group. In group therapy, the other members of the group are not therapists. They are not regulated by the same ethics and laws that bind your therapist. The limits of confidentiality and the reporting laws have been outlined earlier in this document. While the expectation is that all group members will maintain confidentiality regarding anything said in the group, you cannot be certain that they will. You are ultimately responsible for what you say and what you think, feel, or do with the feedback you receive in the group.

Additional client responsibilities:

- **PRIOR-AUTHORIZATION FOR BENEFITS**
  - I acknowledge that I am also required to call my insurance company to verify my benefits and insurance coverage for services rendered. I understand that a quote of benefits is not a guarantee of payment.
  - It is the responsibility of the patient to know and understand the benefits of his/her insurance plan - some insurance companies pay a different percentage of charges based on whether or not the physician is a part of the network. If our physician is not contracted with your insurance plan network, the patient will be required to remit full payment at the time of the office visit. If an account is sent to the collection agency, a 10% service fee will be added to the account balance.

- **PAYMENT GUARANTEE**
  - Co-payments are due in FULL at the time of each visit.
  - Full payment is due at the time of each appointment, unless managed care insurance covers authorized services in full or payment arrangement made with Clarity Clinic Billing Department.
  - Sessions shortened by the patient will still be charged at the full reserved fee. Checks written and returned NSF/Account Closed will be charged an additional $35.00.
  - In the event that a check has been returned NSF/Account Closed, all future payments must be made via Cash, Credit, or Debit Card.
  - If you do not have insurance, payment is due in full at the time of each visit.
  - Services may be turned away at the discretion of the physician.
  - Responsibility of an account balance is always the Patient's, NOT the insurance company.
  - If a patient decides to have an appointment with two providers within the same day, one appointment will be billed through insurance and the other must be paid out of pocket at time of service.
  - The out of pocket fee schedule for medication management is $300.00 for new evaluations; $170.00 for follow-up appointments. New therapy appointments are $150.00 and therapy follow-up are $130.00.

- **RELEASE OF INSURANCE-RELATED INFORMATION**
  - I authorize Clarity Clinic to release any information about me to insurance carriers needed to process claims.

- **DELINQUENT ACCOUNTS**
  - Patients must settle past due balances prior to scheduling future appointments. All outstanding balances are due in full at the time of service unless payment arrangements have been made with Clarity Clinic Billing Department.
  - Non-payment of delinquent balances will be grounds for termination of services rendered by Clarity Clinic until the delinquent balance is resolved in its entirety. Delinquent balances will be sent to our collection agency. In the event that services are not paid in full and we must pursue legal action, all attorney fees court costs, and filing fees will be the responsibility of the patient/guarantor.

- **LATE CANCELLATION/MISSED APPOINTMENT CHARGE**
  - Since the scheduling of an appointment involves the reservation of time specifically for you, a minimum of 24 hours notice is required for re-scheduling or canceling an appointment. Unless Clarity Clinic staff and you reach a different agreement, a $50 out of pocket fee will be charged for sessions missed without such notification.

- **PRESCRIPTIONS**
  - Please notify your pharmacy 5 days before you run out of a medication, and have them fax the refill request to our office during regular business hours (8:00am-4:00pm Monday through Friday). Prescriptions are not refilled when our office is closed. Missing appointments may result in your doctor's inability to refill your prescription
  - Refill and prescribing of controlled substances can only be done at the appointment and will not be called into the pharmacy.
  - In the event a physician changes, discontinues, or adjusts a patient's medications, the patient will be required to make any follow up appointments in the timeframe the physician deems necessary.

- **FOLLOW-UP APPOINTMENTS BY PHONE**
  - Clarity Clinic clinicians charge for clinical phone consultations with patients. Charges are according to the Patient Telephone Session Rate form. You will see such charges on your patient statements. Please be aware that phone consultations cannot be billed to insurance. All phone consultations charges are solely the patient's responsibility.

- **MEDICAL RECORDS**
  - We take the time and consideration to ensure your records are kept confidential. There is a standard processing rate of $30 for released medical records to cover the cost of time and materials required for copying and mailing the record.
  - Medical records releases take a minimum of 10 business days from the date Clarity Clinic received a signed release form. You will be informed of our decision to approve or deny the request within 30 days. If clarity is unable to comply, it may extend the deadline for up to 30 more days by notifying me in writing.

- **COMPLETION OF FORMS/LETTERS**
  - The charge for the completion of forms/letters can typically range from $15 per page.
  - Due to the increased frequency and complexity of the medication prior authorization process required by some insurance companies, government, and employers, there will be an administration fee of $25.00 cover time spent by your doctor on the paperwork and on the phone to complete prior-authorizations.

- **DISCHARGE FROM CARE**
  - You have control over your care, and you have the right to eliminate your care with us at any time. We reserve the right to discharge any patient from this practice at any time for failure to comply with office policies or treatment recommendations. We will provide referral suggestions for continuation of treatment.

Please sign below to consent and authorize treatment, indicating that you acknowledge these stated policies and your full financial responsibility for services rendered.

SIGNATURE		
_____ **Patient Print Name**		
_____ **Patient/Guarantor Signature**		_____ **Date**
Provider Name	**Provider Signature**	**Date**

Clarity Clinic

Authorization to Release Outpatient Records

Patient Information: Please print the name of the patient whose records are being requested for release

Patient Name (Last, First) :
Date of Birth:
Phone Number:

The persons or entities, including self, authorized to receive the information and records covered by this consent are:

Name/Organization:
Relationship:
Phone:
Fax:
Address:

The type of information to be disclosed (please check)

___Psychiatric Notes ___Psychological Testing ___Psychotherapy Notes ___Entire Medical Record	___Information during specific dates of service, indicate dates of service ___Genetic testing ___Other:_____

Clarity Clinic

Authorization to Release Outpatient Records

The purpose of such disclosure is (please check)

(continued from page 17)

__Coordination of Care (transfer, second opinion)

__Personal

__Ligation

__Disability determination

__Other:_____

Requested format: _____mail _____picked up in person ____efax _____fax

SIGNATURE

_____

Patient Print Name

_____ _____

Patient Signature **Date**

_____ _____

Provider Signature **Date**

If Patient is a Minor or has a Designated Representative

_____

Print Name

_____

Relationship to Patient

_____ _____

Signature **Date**

Address of patient or legal representative signing this form:

Clarity Clinic

ADULT ADHD SELF-REPORT SCALE (ASRS-VI.I) Symptom Checklist

Patient Name: Date of Birth:

Please answer the questions below rating yourself on each of the criteria shown using the scale on the right side of the page. **As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months.** Please give this completed checklist to your healthcare professional to discuss during today's appointment.	**Never**	**Rarely**	**Some-times**	**Often**	**Very Often**
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even					

when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Clarity Clinic

GENERALIZED ANXIETY DISORDER 7-ITEM (GAD-7) SCALE

Patient Name: **Date of Birth:**

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
(Continued from page 20) 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)				

Clarity Clinic

Bipolar Symptoms Checklist

Patient Name: **Date of Birth:**

Symptoms of Manic-Depression (mark "X")	Yes	No
I've felt more irritable than I would expect to usually feel in a situation; or I was surprised by how irritable I reacted to a situation because I could not control my anger.		
Have you ever gone at least 1-2 nights in a row without any sleep?		
Have you ever felt restless at night? Did you feel like you had to keep moving around or you could not stay still at night?		
Inflated self-esteem, feeling "on top of the world", "I feel invincible", "nothing can stop me."		
Decreased need for sleep (e.g. feeling rested after only 3 hours of sleep)		
More talkative than usual or pressure to keep talking (uninterruptible speech, speech is much faster than usual		
Subjective experience that thoughts are racing and are overwhelming		
Racing thoughts are jumping from topic to topic		
Do you ever drink to fall asleep?		
Do you ever smoke marijuana to "turn off your mind" or "slow your mind down"?		
Distractibility (i.e. attention too easily drawn to unimportant or irrelevant external stimuli)		
Increase in goal-directed activity (either socially, at work or school, or sexually)		
Engaging in unrestrained buying sprees, excessive spending, and being surprised by it after the fact?		
Feeling much more sexual than usual (hyper sexuality)		
Do you ever feel like your concentration fluctuates and worsens at certain times than others ... possibly to the point where your thoughts feel disorganized or you can't function throughout the day?		
Do you ever feel like you have more energy than usual and then "crash hard" and feel like you can't, or don't want to, get out of bed and have no energy?		
It feels like I get depressed for no reason sometimes		

Clarity Clinic

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

** Health risk assessment (depression and suicide risk assessment)**

Patient Name: **Date of Birth:**

Over the last **2 weeks**, how often have you been bothered by any of the following problems? (Circle your answer)	Not At All Sure	Several Days	Over Half The Days	Nearly Every Day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed. Or the opposite - being so fidgety or restless than 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 the score for each column				
(For healthcare professional): For interpretation of score, please refer to accompanying scorecard)	**TOTAL:**			
10. It 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	Some-what Difficult	Very Difficult	Extremely Difficult

Clarity Clinic

ALCOHOL AND SUBSTANCE ABUSE SCREENING

Patient Name: **Date of Birth:**

THESE QUESTIONS REFER TO THE PAST **12 MONTHS:**	Yes	No
1. Have you used drugs other than those required for medical reasons?		
2. Have you abused prescription drugs or alcohol?		
3. Do you abuse more than one substance (drugs or alcohol) at a time?		
4. Can you get through the week without using drugs or alcohol?		
5. Are you able to stop using drugs/alcohol when you want to?		
6. Have you had “blackouts" or "flashbacks" as a result of drug/alcohol use?		
7. Do you ever feel bad or guilty about your drug/alcohol use?		
8. Does your spouse (or parents) ever complain about your involvement with drugs/alcohol?		
9. Has drug/alcohol abuse created problems between you and your spouse or your parents?		
10. Have you lost friends because of your use of drugs/alcohol?		
11. Have you neglected your family because of your use of drugs/alcohol?		
12. Have you been in trouble at work or school because of drug/alcohol abuse?		
13. Have you lost your job because of drug/alcohol abuse?		
14. Have you gotten into fights when under the influence of drugs/alcohol?		
15. Have you engaged in illegal activities in order to obtain drugs/alcohol?		
16. Have you been arrested for possession of illegal drugs?		
17. Have you ever experienced withdrawal symptoms when you stopped taking		
18. Have you had medical problems as a result of your drug/alcohol use (e.g. memory loss, hepatitis, convulsions, bleeding, etc.)?		
19. Have you gone to anyone for help for drug/alcohol problem?		
20. Have you been involved in a treatment program specifically related to drug/alcohol use?		

Clarity Clinic

Controlled Substance Agreement

Patient Name:_____**Date of Birth**:_____

I UNDERSTAND:

- Part of my treatment may include prescriptions for benzodiazepines, stimulants, and narcotics to improve my ability to function. These medications are only part of my treatment.
- Treatment with these medicines may have side effects including nausea, sleepiness, difficulty breathing (if taken in excess), itching, cardiac death, seizures, difficulty concentrating, constipation, and difficulty urinating.
- Additional side effects for men include low testosterone levels
- Additional side effects for women include changes in menstrual cycles
- If I take these medicines for more than a few weeks, I may become used to them and could develop physical dependence and/or addiction. I could experience withdrawal if I stop taking them suddenly, which could lead to death. The risks of dependence, tolerance, and side effects specific to the medication have been explained to me.
- If I do not reach my treatment goals from use of these medications, my provider may gradually discontinue them or may adjust my dose.
- Medication will not be refilled on weekends or holidays. Medications above the FDA max dose will require monthly monitoring. All other monitoring for controlled substances requires office visits at least once every two (2) months. Medication scripts must be obtained in person at an office visit.
- Psychiatric symptoms can be improved by good health habits such as exercise, healthy diet, and abstinence from tobacco, alcohol, and illicit drugs.

I WILL:

- Tell my provider if I have been diagnosed with, treated, or arrested for drug dependence or abuse prior to starting treatment with the prescribed medications.
- Tell my provider if I have been involved in the sale, illegal possession, or transport of controlled substances prior to starting treatment.
- Take my controlled medication as prescribed, taper the medication if recommended by my provider at any time, and reduce the medication only under the supervision of my provider.
- Tell my other provider(s) and any emergency department I may visit that I am taking controlled medication and have an agreement with Clarity Clinic.
- Tell my provider about ALL of the medications (over-the-counter, herbs, vitamins, those ordered by other providers, legal, illegal) that I am taking because this medication can interact with other substances, which could potentially lead to death.
- Only ask for refills from 8:00am-4:00pm, Monday-Friday.
- Provide at least three (3) days notice for refills of medications.
- Tell my provider if I get the prescribed medications or other controlled substances from

any other provider.
- Keep my controlled medications in a safe place, locked away from children and to prevent theft.
- Attend my appointments regularly and call my provider's office at least twenty-four (24) hours in advance if I need to cancel my appointment.
- Submit to random tests of my urine or blood and pill counts within twenty-four (24) hours of request.
- Actively participate in therapy and other non-medication treatment if I am recommended to do so by the provider as part of my treatment plan.

I WILL NOT:
- Share, sell, or trade my medications with anyone.
- Use someone else's medications.
- Use any illegal drugs (crystal meth, marijuana, cocaine, etc.).
- Change how I take my medications without asking my provider.
- Ask my provider for extra refills if I use up my supply or lose or misplace my medications before my next refill is due. Looking after my medications and complying with my prescriptions are my responsibility.

IF I AM NOT COMPLIANT WITH THE ABOVE, MY PROVIDER:
- May no longer prescribe the medications for me.
- May stop giving me medical care.
- May send me to drug abuse treatment.

SIGN THE FORM:
The decision to use controlled substances (benzodiazepines, stimulants, narcotics) has been made between my provider and me because of my specific condition. When I sign this form, I acknowledge that I understand and agree to the above conditions to make my treatment as safe and successful as possible.

A copy of this agreement will be maintained in my medical record. This agreement can be canceled by me at any time, except to the extent my provider has already acted in reliance on it. If not canceled before, this agreement will end on my last dose of the medications prescribed by my provider. If I cancel this agreement, my provider may take any or all of the actions described above.

_____ _____
Patient Signature Date

_____ _____
Provider Signature Date