wellward
Regenerative Medicine

New Patient: Psychiatry

Name of Patient: _____ Date: _____

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

Telephone: Home (_____) _____ Cell (_____) _____ SS#: _____-_____-_____

E-Mail Address: _____

Marital Status: Single Married Divorced Widowed Separated Age: _____ Date of Birth _____

Race: American Indian Asian Black/African American Native Hawaiian White/Caucasian Other: _____

Occupation: _____ Full-Time Part-Time Unemployed Retired Disabled

Education: Less Than 8th Grade 8th 9th 10th 11th 12th Some College Associate's Bachelor's Master's Doctorate

Do you smoke? Never Smoker Former Smoker: Quit _____ Years Ago Current Smoker: _____ pack(s) daily

List any medication allergies and their reactions: _____

List Medications & Doses you are currently taking: _____

_____

Briefly describe your reason for seeking help.:_____

Who suggested that you contact this office?: _____

Name of Family Physician: _____ Phone: (_____) _____

Review of Systems:

Hypertension	Y	N	Medicine for Treatment: _____
Diabetes	Y	N	Medicine for Treatment: _____
Kidney Disease	Y	N	Medicine for Treatment: _____
Thyroid Disease	Y	N	Medicine for Treatment: _____
Heart Disease	Y	N	Medicine for Treatment: _____
Cancer	Y	N	Medicine for Treatment: _____
Stroke	Y	N	Medicine for Treatment: _____
Seizures	Y	N	Medicine for Treatment: _____
Lung Disease	Y	N	Medicine for Treatment: _____
Do you smoke?	Y	N	

Past History:

Depression:	Y	N	Alcohol Abuse	Y	N
Bipolar Disorder	Y	N	Drug Abuse	Y	N
Psychosis	Y	N	Suicide Attempt	Y	N

If you answered yes to the above, please explain any treatment:_____

_____

Family History:

Diabetes	Y	N	Relative(s): _____
Hypertension	Y	N	Relative(s): _____
Thyroid Disease	Y	N	Relative(s): _____
Memory Problems	Y	N	Relative(s): _____
Cancer	Y	N	Relative(s): _____
Depression	Y	N	Relative(s): _____
Mood Swings	Y	N	Relative(s): _____
Anxiety	Y	N	Relative(s): _____
Psychosis	Y	N	Relative(s): _____
Suicide Attempt	Y	N	Relative(s): _____
Alcohol Abuse	Y	N	Relative(s): _____
Drug Abuse	Y	N	Relative(s): _____

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The Mood Disorder Questionnaire

	YES	NO
1. Has there even been a period of time when you were not your usual self and…	O	O
…You felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	O	O
…You were so irritable that you shouted at people or started fights or arguments?	O	O
…You felt much more self-confident than usual?	O	O
…You got much less sleep than usual and found you didn't really miss it?	O	O
…You were much more talkative or spoke much faster than usual?	O	O
…Thoughts raced through your head or you couldn't slow your mind down?	O	O
…You were so easily distracted by things around you that you had trouble concentrating or staying on track?	O	O
…You had much more energy than usual?	O	O
…You were much more active or did many more things than usual?	O	O
…You were much more social or outgoing than usual. For example, you Telephoned friends in the middle of the night?	O	O
…You were much more interested in sex than usual?	O	O
…You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	O	O
…Spending money got you or your family in trouble?	O	O
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	O	O
3. How much of a problem did any of these cause you – like being unable to work; having family, money, or legal troubles; getting into arguments or fights? Please circle ONLY 1. No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e.: children, siblings, parents, grandparents, aunts, uncles) had a manic-depressive illness or bipolar disorder?	O	O
5. Has a health professional ever told you that you have a manic depressive illness or bipolar disorder?	O	O

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Treatment Authorization

I hereby grant permission to Dr. Manoochehr Mazloomdoost, Dr. Danesh Mazloomdoost, and/or Dr Camellia Shirazi Mazloomdoost to administer medication and/or treatment as needed. I also allow medical students to attend any evaluation and be present in all of my visits and procedures.

Medical Records

I hereby grant permission to send my medical records and financial information for purpose(s) of proper medical treatment, insurance, insurance filing, worker's compensation, or attorney requests. I also grant permission to communicate in writing and/or verbally to my family doctor and all other physicians involved with my care.

Payment for Services Rendered

I hereby assign all benefits to Dr. Manoochehr Mazloomdoost, Dr. Danesh Mazloomdoost, and Dr. Camellia Shirazi Mazloomdoost and understand that the balance not paid by my insurance and/or any amount predetermined not to be covered by my insurance carrier will be my responsibility. After reasonable notice, delinquent accounts may be turned over to a collection agency and/or attorney for collection. Should it be necessary to place this account in the hands of an attorney for collection, the undersigned patient or responsible party, as appropriate, agrees to pay the costs of collection, including any court costs and all reasonable fees to the attorney employed by the office to collect said amount.

A 24-hour notice must be given on ALL appointment cancellations. Failure to do so will result in a $50 fee that must be paid in full prior to any future appointments. There will also be an $80 fee for missed injection appointments without a 24-hour notice of cancellation. These fees are <u>NOT</u> covered by your insurance. <u>IT IS YOUR RESPONSIBILITY.</u>

If the doctor or nurse is accidentally is stuck from a needle, I will allow them to withdraw blood from me to be tested for contagious diseases, including HIV, for their protection.

PATIENT'S SIGNATURE: _____ DATE: _____

Medication Agreement

We are now sending electronic prescriptions. Please inform us of which pharmacy you would like any medication prescriptions sent to. We must send all of your medications to only 1 (one) pharmacy, and may only send it to the pharmacy we have your signed consent to send to. In the event you change pharmacies, please inform us BEFORE your visit and you may update this form. If you do not inform us until after your visit, the medications will already be sent to your previous pharmacy.

I understand the above terms and agreements. I also acknowledge in the event that I cancel or no show any appointment, Dr. Camellia Shirazi Mazloomdoost reserves the right to charge my account $10 per medication (not payable by insurance) that she accepts to refill without the appointment and a $50 no show fee (not payable by insurance) for any visit not cancelled with 24 hour advance notice.

PATIENT'S SIGNATURE: _____ DATE: _____

Pharmacy Name: _____

Pharmacy Street Address: _____

Pharmacy City, State Zip: _____

Pharmacy Telephone Number: _____Pharmacy Fax Number:_____

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HIPAA Authorizations

Effective April 14, 2003

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

OUR PLEDGE REGARDING YOUR PROTECTED HEALTH INFORMATION (PHI)

We are committed to protecting the privacy of all health information we create and maintain as a result of the health care we provide you. Your "protected health information" (PHI) includes information about you past, present, or future health, healthcare we provide you and payment for your healthcare contained in the record of care and services provided by Wellward Regenerative Medicine. The purpose of this Notice is to explain who, what, when, where and why your PHI may be used or disclosed, and assist you in making informed decisions when authorizing anyone to use or disclosure your PHI.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

- To request in writing to the Privacy Officer a restriction on the uses and disclosures of PHI as described in this notice. We are not required to agree to the restriction you request. We may not be able to comply with you request in certain situation, which include emergency treatment, disclosures to the Secretary of the Department of Health and Human Services and uses and disclosures that do not require you authorization.
- To obtain a paper copy of this Notice and upon written request submitted Wellward Regenerative Medicine inspect and/or obtain a copy of your health record.
- To amend your health record by submitting a written request with the reasons supporting the request to the Privacy Officer. We may deny your request if a) the record was not created by us, unless the person that created the record is no longer available to make the amendment; b) the record is not part of the health information used to make decisions about you; c) we believe the record is correct and complete; or d) you would not have the right to inspect and copy the record as described herein.
- To request in writing to the Privacy Officer a written list of disclosures we made of your health information, except that we are not required to account for disclosures for purposes of treatment, payment, operations, directory notification, disaster relief, as allowed under certain circumstances by law or pursuant to your authorization. To request in writing to the Privacy Officer that we communicate with you by a specific method and at a specific location. We will typically communicate with you in person; or by letter, e-mail, fax, and/or telephone.
- To revoke your authorization to use or disclose PHI at any time except, unless you authorization was obtained as a condition of obtaining insurance coverage, and except to the extent your PHI has already been disclosed pursuant to your authorization. You revocation request must be made in writing to the Privacy Officer.

OUR RESPONSIBILITIES We are required by law to:

- Maintain the privacy of your PHI and provide you with notice of our legal duties and privacy practices with respect to PHI.
- Abide by the terms of the notice currently in effect. We have the right to change our Notice of Privacy Practices and we will apply the change to all of your PHI, including information obtained prior to the change.
- Post notice of any changes to our Privacy Policy in the lobby and make a copy available to you upon request.

CONTACT FOR QUESTIONS/ COMPLAINTS/ REQUESTS

Direct your questions, complaints and requests made pursuant to this Notice to: Privacy Officer, **101 N. Eagle Creek Drive, Lexington, KY 40509 (859) 275-4878.** You may also file a complaint with the Secretary of Health and Human Services. Filing a complaint will not result in retaliation.

HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose you PHI for the following purposes:

Treatment: We may use and disclose your PHI to anyone involved in the provision of health care to you, including for example, physician assistant, office employees and other medical professionals.

We may also disclose your PHI to outside treating medical professionals and staff as deemed necessary for your health care.

Payment: We may use and disclose your PHI to billing and collection agencies, insurance companies and health plans to collect payment for our services.

Health Care Options: We may use and disclose your PHI for our own health care operations. For example, we may use your PHI to assess your care in an effort to improve the quality of our service to you; to evaluate the skills, qualifications and performance of our health care providers; to provide training programs to students, trainees and other health care providers. In addition, our accountants, auditors and attorneys may use your PHI to assist our compliance with applicable law.

Business Associates: There are some services provided to our organization through contracts with business associates, such as laboratory and radiology services. We may disclose your health information to our business associates so that they can perform these services. We require the business associates to safeguard your information to our standards.

Individuals Involved With Your Care: We may disclose your PHI to family or others identified by you or who is involved in your care or payment for your care. We may also notify a family member, or another person responsible for your care, about your location and general condition, unless you object by contacting registration for the facility providing your care.

Legally Required Disclosures & Public Health: We may disclose PHI as required by law, including to government officials to prevent or control disease, to report child, adult or spouse abuse, to report reactions or problems with products, and to report births and deaths.

Health Oversight Activities: We may disclose your PHI to federal or state health oversight agency that is authorized to oversee our operations.

Workers Compensation: We may disclose PHI for workers compensation or similar programs.

Law Enforcement & Subpoenas: We may disclose PHI to law enforcement such as limited information for identification and location purposes, or information regarding suspected victims of crime, including crimes committed on our premises. We may also disclose PHI to others as required by court or administrative order, or in response to a valid summons or subpoena.

Inmates: We may disclose your PHI to a correctional facility which has custody of you if necessary a) to provide health care to you; b) for the health and safety of others; or, c) for the safety and security of the correctional facility.

Information Regarding Decedents: We may disclose health information regarding a deceased person to: 1) coroners and medical

examiners to identify cause of death or other duties, 2) funeral directors for their required duties and 3) to procurement organizations for purposes of organ and tissue donations.
Research: We may also disclose PHI where the disclosure is solely for the purpose of designing a study, or where the disclosure concerns decedents, or an institutional review board or privacy board has determined that obtaining authorization is not feasible and protocols are in place to ensure the privacy of your health information. In all other situations, we may only disclose PHI for research purposes with your authorization.
Marketing & Fund Raising: We may contact you with information about treatment alternatives or other health related benefits and services that may be of interest to you. We may also contact you as part of a fund raising effort.
Directory Information: We may disclose your name, location and general condition to those persons who ask for you by name or to members of the clergy. You may object to such disclosure by contacting registration at the facility from which you receive this notice.

Appointment Reminders: We may use and disclose your PHI provide a reminder to you about an appointment.
Treatment Alternatives: We may use and disclose your PHI to contact you about treatment alternatives that may be of interest to you.

DISCLOSURES REQUIRING AUTHORIZATION
All other disclosures of you PHI will only be made pursuant to your written authorization, which you have the right to revoke at any time, except to the extent we have already made disclosures pursuant to your authorization.

Changes To This Notice
We reserve the right to change the terms of this Notice and to make new notice provisions effective for all PHI that we maintain by posting the revised notice at our facilities, making copies of the revised notice upon request to the facility or the Privacy Officer.

Please let us know if you have any questions about our Notice of Privacy Practices. You may contact our Privacy Officer at (859) 275-4878, or discuss any questions you may have with your physician.

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES NOTICE:

I, _____ acknowledge that I have received a Notice of Privacy Practices from Wellward Regenerative Medicine.

Signature: _____ Date: _____

Printed Name: _____

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Authorization for Medical Records Disclosure

****Please only fill out the box and sign below. This form will remain on file for use only when/if we need to obtain further records from your other past or current treating physicians.****

_____
(Name of Patient)

_____
(Social Security Number)

_____
(Date of Birth)

Authorizes:

_____
(Name or specific identification of the person(s) authorized to make requested disclosure)

To release protected health information to **Wellward Regenerative Medicine**

INFORMATION TO BE RELEASED:

_____ History & Physical	_____ Surgical Reports	_____ ER Records
_____ Progress Reports	_____ Laboratory Reports	_____ Radiology Reports
_____ Mental Health	_____ Entire Record	_____ Other (specify:

REASON FOR DISCLOSURE:

_____ Additional Medical Care	_____ Physician Change	_____ Personal
_____ Insurance Eligibility/Benefits	_____ Legal Proceedings	_____ Other

If the person(s) and/or organizations(s) listed above are not health care providers, health plans, or healthcare clearinghouses, who must follow the Federal privacy standards, the health information disclosed as a result of this authorization may no longer be protected by the Federal privacy standards and your health information may be re-disclosed without obtaining your authorization.

YOUR RIGHTS AND OBLIGATIONS WITH RESPECT TO THIS FORM:

You are under no obligation to sign this form. You may withdraw this authorization by written notification. If you agree by signing this authorization, you must be provided a signed copy of this form if so requested.
I have had an opportunity to review the contents of this authorization and my rights in relation to this form. By signing below, I am certifying my agreement with the statements made in this form and agreeing to the release of my protected health information as indicated by this form.

_____	_____	_____
Patient Printed Name	Patient Signature	Date
_____	_____	_____
Witness Printed Name	Witness Signature	Date

859-275-4878
www.wellwardmed.com

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HIPAA Information Release

Name: _____ Date of Birth: _____/____/_____

Release of Information

[ ] I authorize Wellward Regenerative Medicine to release information including the diagnosis, records of examination rendered to me, appointments, and claims information. This information may be released to:

[ ] Spouse_____
If yes, please list Full Name

[ ] Child(ren)_____
If yes, please list Full Name(s)

[ ] Other_____
If yes, please list Full Name(s) & Relationship(s)

[ ] Information is not to be released to anyone but myself.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call:

[ ] my home _____ [ ] my work _____ [ ] my cell _____

Please List Number Please List Number Please List Number

If unable to reach me:

[ ] you may leave a detailed message.
[ ] please leave a message asking me to return your call.
[ ] _____

Signed: _____ Date: ____/____/_____

Witness:_____ Date: ___/____/_____

Witness Print:_____

859-275-4878
www.wellwardmed.com