Patient Full Name: ______________________________ Name you go by: ____________________ Age: ______

SSN: ______/______/______ Marital Status: ________ Sex: M / F DOB: ______/______/______

Address: ______________________________ City: ______________ State: ______ Zip code: __________

Home Phone: ( ) ______________ Work: ( ) ________________ Cell: ( ) ________________

Present Employer: ______________________________ Position Held: ______________________

Referred to this office by: __________________________ Reason: ____________________________

Pharmacy used (Name/Address): ____

Pharmacy Phone: ( ) __________________

Allergies: ____

► *Primary Insurance Coverage*: Please fill out the remaining information in FULL ▼

Insurance Policy Holder Information *(Please fill out completely as it applies to you)*

1.Primary Insurance Name: __________________________ Policy Holder Name: __________________________

Member ID # / Group #: ____________________/__________ Member Serv. Phone: ____________________

○ SELF ◄Check here if you are the policy holder, leave the remainder of this form blank ▼

SSN: ______________ DOB: _____/_____/_____

Address: ______________________________ City: ______________ State: ______ Zip: __________

Employer Name and Address: ____ Phone: ______________

Home Phone: ____________________ Alternate number: ____________________

***▼This block below is Your* <u>SECONDARY INSURANCE COVERAGE</u> (Please fill out completely as this applies to you)**

►<u>Please circle if no secondary Insurance</u> ►*N/A* - I do not have a secondary Insurance.

2. Secondary Insurance: __________________________ Policy Holder Name: __________________________

Member ID # / Group #: ____________________/__________ Member Serv. Phone: ____________________

○ SELF **◄Check here if you are the policy holder, leave the remainder of this form blank ▼**

SSN: ______________ DOB: _____/_____/_____

Address: ______________________________ City: ______________ State: ______ Zip: __________

Employer Name and Address: ____ Phone: ______________

Home Phone: ____________________ Alternate number: ____________________

Other Insurance coverage: ____________________ Policy Holder: ______________________ SSN: ____________

RELEASE FOR MEDICAL RECORDS/CLINICAL NOTES/LAB

►*Please sign this form with the name and address of any physician/counselor you may have seen that prescribe or have prescribed medications, taken labs or administered medical or therapeutic attention. This release is for the exchange of written records or verbal communications. One release per Physician/Counselor/Facility. Use this for Family/Individual as well.**

Patient Name: ______________________________, **DOB:** _____/_____/_____, **SSN**__________________

This Patient authorizes this request between the following parties
TO AND FROM THE FOLLOWING LISTED FACILITIES

JASON E. MASTOR, M.D.
KRISTIN C. BROWN, PA-C, M.M.S.
206 Joe V. Knox Ave Ste F Mooresville, N.C. 28117 Ph: 704-662-6500 Fx: 704-662-6503

Provider Name:	Phone:	Fax:
________________________________	________________________	____________________
________________________________	________________________	____________________
________________________________	________________________	____________________

This is for the purpose of continuing care, the data shall include all Psychiatric Notes, Laboratory Reports along with any Medical and medicinal information needed for treatment. I also understand the information released may include drug/alcohol abuse, psychological or psychiatric impairments, and/or HIV/AIDS or any other medical findings. Once information is disclosed to the pursuant party signed on this authorization, I understand that the HIPPA privacy law (45 C.F.R. part 184) protecting health information may not apply to the recipient of the information, and, therefore may not prohibit the recipient from re-disclosing it. Other laws however may prohibit re-disclosure. Upon disclosure of mental health and developmental disabilities information protected by state law (G.S. 122-C) or substance abuse treatment information protected by federal law (42 C.F.R. part 2), this organization informs the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws. This consent is valid for one year.

It has been explained to me and I understand the contents to be released/exchanged for written or verbal communication, I hereby acknowledge that this consent is truly voluntary and is valid until such request is fulfilled. I further understand that I may refuse to sign or revoke this consent at any time except to the extent that action based on this consent has already been taken. Revocation should be presented to my treating clinician by written or verbal consent.

____
Patient / Guardian Name **Date**

____
Witness **Date**

OFFICE USE ONLY:
With this release, our office requests information checked below: ☐ **Need no information, please file**

☐**LABWORK** ☐**INSURANCE INFORMATION**
☐**OFFICE NOTES** ☐**PHONE CALL FROM PHYSICIAN**
☐**MEDICATION LIST**
OTHER____

► ☐ ***Sending requested records to another facility*** ☐ **FOR VERBAL ONLY**

F=Faxed	Date: _______________	F/M/P	☐ Received
M=Mailed	Date: _______________	F/M/P	☐ Received
P=Picked-up	Date: _______________	F/M/P	☐ Received

PATIENT__________________________________SCORE_________DATE_______

THE MOOD DISORDER QUESTIONNAIRE

1. Has there ever been a period of time when you were not your usual self and…

…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 yes O no
…you were so irritable that you shouted at people or started fights or arguments?	O yes O no
…you felt much more self-confident than usual?	O yes O no
…you got much less sleep than usual and found you didn't really miss it?	O yes O no
…you were much more talkative or spoke much faster than usual?	O yes O no
…thoughts raced through your head or you couldn't slow your mind down?	O yes O no
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?	O yes O no
…you had much more energy than usual?	O yes O no
…you were much more active or did many more things than usual?	O yes O no
…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	O yes O no
…you were much more interested in sex than usual?	O yes O no
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	O yes O no
…spending money got you or your family into trouble?	O yes O no

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 yes O no

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 select one response only.

   O No Problem O Minor Problem O Moderate Problem O Serious Problem

-----Adapted with permission from Robert M. A. Hirschfeld, MD.

Name: ________________________________SSN:______________________DOB:________________

Please check any prior psychiatric medications used and/or tried.

☐ BRAND NAME (generic name)

Antidepressants/Anti-Anxiety

☐ Prozac fluoxetine)
☐ Paxil (paroxetine)
☐ Zoloft (sertraline)
☐ Celexa (citalopram)
☐ Lexapro (escitalopram)
☐ Effexor (venlafaxine)
☐ Pristiq (desvenlafaxine)
☐ Luvox (fluvoxamine)
☐ Serzone (nefazadone)
☐ Remeron (mirtazapine)
☐ Wellbutrin (buproprion)
☐ Cymbalta (duloxetine)
☐ Elavil (amitriptyline)
☐ Pamelor (nortriptyline)
☐ Tofranil (imipramine)
☐ Norpramin (desipramine)
☐ Anafranil (clomipramine)
☐ Sinequan (doxepin)
☐ Viibryd (vilazodone)

MAOI's (anti-depressants)

☐ Nardil (phenelzine)
☐ Parnate (tranylcypromine)
☐ Marplan (isocarboxazid)

Mood Stabilizers/Anti-Psychotics

☐ Risperdal (risperidone)
☐ Seroquel (quetiapine)
☐ Geodon (ziprasidone)
☐ Abilify (aripiprazole)
☐ Zyprexa (olanzapine)
☐ Clozaril (clozapine)
☐ Latuda (lurasidone)
☐ Invega (paliperidone)

ADHD/ Psycho-Stimulants

☐ Ritalin (methylphenidate)
☐ Adderall (dextroamphetamine/amphetamine)
☐ Dexedrine (dextroamphetamine)
☐ Strattera (atomoxetine)
☐ Concerta (methylphenidate ER)
☐ Vyvanse (lisdexamfetamine)
☐ Provigil (modafinil)
☐ Nuvigil (armodafinil)

Mood Stabilizers

☐ Lithium (lithium)
☐ Depakote (divalproex)
☐ Tegretol (carbamazepine)
☐ Trileptal (oxcarbamazepine)
☐ Lamictal (lamotrigine)
☐ Keppra (levetiracetam)
☐ Topamax (topiramate)
☐ Neurontin (gabapentin)
☐ Lyrica (pregabalin)
☐ Gabitril (tiagabine)
☐ Zonegran (zonisamide)

Sleep Medications

☐ Ambien (zolpidem)
☐ Sonata (zaleplon)
☐ Lunesta (eszopiclone)
☐ Rozerem (ramelteon)
☐ Vistaril (hydroxyzine)
☐ Desyrel (trazadone)
☐ Restoril (temazepam)
☐ Dalmane (flurazepam)

Tranquilizers/Anti-Anxiety

☐ Xanax (alprazolam)
☐ Klonopin (clonazepam)
☐ Valium (diazepam)
☐ Ativan (lorazepam)
☐ Serax (oxazepam)
☐ Tranxene (chlorazepate)
☐ Librium (chlordiazepoxide)
☐ BuSpar (buspirone)

Alzheimer's Medications

☐ Aricept (donepezil)
☐ Reminyl (galantamine)
☐ Exelon (rivastigmine)
☐ Namenda (memantine)
☐ Razadyne (galantamine)
☐ Cognex (tacrine)

Other Mental Health Meds: ____

Jason E. Mastor, M.D., P.A. **Kristin C. Brown, PA-C, MMS**

Please read carefully and sign

PATIENT AUTHORIZATION RECORD

1. **CONSENT TO TREATMENT: I hereby authorize the physician in charge of my psychiatric care to oversee my treatment plan and monitor my psychiatric medications as required by my behavioral health needs as discussed by myself and my doctor.**
2. **AUTHORIZATION TO RELEASE BEHAVIORAL HEALTH INFORMATION: I hereby authorize the physician to release information requested for continuation of treatment and claims purposes to my insurance carrier liable for their part of the charges incurred in the duration of my active coverage of my behavioral health benefits. Only information such as diagnostic and therapeutic information (including psychiatric, substance abuse or illness status such as HIV or etc.) shall be released according to guidelines of information needed and requested by said Insurance carrier to pay the claim or to authorize further treatment.**
3. **MEDICARE/MEDICAID/PATIENT CERTIFICATION/RELEASE INFORMATION &PAYMENT REQUEST: I certify that the information I give in application for payment XVII and /or XIX of the social security act is correct. I authorize any holder of behavioral health information regarding myself to release to the social security commission or its intermediaries or carriers, any information needed for this or a related Medicare claim. I request that payments be made on my behalf. I assign the benefits payable for physician services to the physician furnishing these services or authorized said physician to submit a claim to Medicare or Medicaid for payment of these services. I UNDERSTAND THAT I AM RESPONSIBLE FOR ALL CO-PAYS, DEDUCTIBLE AMOUNTS AND CO-INSURANCE AMOUNTS THAT ARE DUE PAYABLE BY ME ACCORDING TO MY BENEFIT PLAN.**
4. **ASSIGNMENT OF INSURANCE BENEFITS: I hereby authorize, request and direct any and all assigned Insurance companies to pay directly to the physician in the amount due according to my pending claim for behavioral healthcare. I agree, should the amount be insufficient to cover the entire expense, I will be responsible for the remaining payment according to the benefits coverage and/or treatment plan between myself and my listed physician. I am responsible for knowing my benefits coverage regarding in patient and out patient payable care. I agree to pay my portion of the in patient and out patient fees as directed upon final payment of my said Insurance carrier. *I understand that if I do not qualify for these benefits according to my specific Insurance plan, I will be held responsible for the full amount of the incurred charges.**
5. **GUARANTEE OF PAYMENT: for value received, the undersigned does agree to guarantee and promises to pay the physician all charges and expenses incurred, falling into patient responsibility, that is owed to said physician. If any action by Law or mediation is brought to enforce this agreement, the treating physician shall be entitled to reasonable attorney fees, court costs and reimbursement of any other costs regarding the collection process. I understand that all bills are payable and become due upon representation.**
6. **DENIAL OF PAYMENT AUTHORIZATION: the physicians office will make every effort to obtain payment, authorization /pre-certification for all managed care contractual agreements according to the said Insurance carrier for behavioral healthcare. However, if denial is received, the patient/guarantor of the contracted benefits will be responsible for all incurred charges and penalties based on the reason for denial due to non-coverage, deductible amounts, co-insurance amounts, exceeded visits limitations, failure of providing all Insurance coverage information correctly and any other reason that my insurance sees fit to deny due to coverage issues. I shall be responsible for all needed patient to Insurance negotiations regarding payment of treatment.**
7. **RELEASE OF RESPNOSIBILITY / LIABILTY FOR PERSONAL VALUABLES: I understand and agree that the said physician is NOT responsible for the loss or damage to any personal property/ belongings of the patient or his/her accompaniment to this office.**
8. **CONTINUATION OF CARE ASSISTANCE: I understand that, under the direct supervision of my treating physician, an Advanced Registered Nurse Practitioner, licensed therapist, social worker, case manager or office support staff may be utilized in my treatment. This will only occur with notice and based upon my specific treatment plan with myself and my physician. I reserve the right of refusal to this, however I understand it may compromise my treatment and can be considered as non-compliance of care. If needed, releases will be signed for my protection and filed with my records.**
9. **COMPLIANCE OF CARE GIVEN: I understand that I have given consent for said physician to treat my behavioral health needs and if I compromise that care in anyway it may be grounds for dismissal from this Psychiatric Practice. I understand that I have given this physician the right to handle my medicinal care regarding behavioral healthcare needs. If I take action against authorized care given, such as stop my medication, use street drugs or fail to inform the physician of all my behavioral or medical health problems. I am responsible for contacting my physician at once to inform them and seek immediate advisement.**

Patients Signature: ____Date: ________/______/________

Next of Kin/ Other Signature: ______________________________Relationship: _________________________
Witness: ____

DON'T BE A NO SHOW

We are glad you have chosen us to provide your psychiatric care, but if you miss your appointments you compromise that care. Because we are concerned about you, we now follow the process below if you miss your appointment and do not call to cancel or reschedule within a 72 hr. period prior.

- **1st missed appointment - you will not be charged and we will reschedule.**
- **2nd missed appointment – you will have the chance to reschedule but will be reminded of our policy and will be charged a $35.00 fee for a missed appointment with no notice. This must be paid to be able to reschedule.**
- **3rd missed appointment – this could result in discharge from this practice. You may be informed that you have to find other psychiatric care and will be notified by mail of termination.**

We know that sometimes there are extenuating circumstances, however other people are waiting for appointments as well and ALL of our patients are important to us. Our main concern is to provide you with the highest quality of care. If you have any questions regarding these rules, office staff will be more than happy to help in any way.

So let's work together so we can give you the optimum care you need and be considerate of others who need this kind of care as well. Thank you so much for your cooperation.

Signature: ___________________________________ Date: __________________

Below For Office Use only:

Date	Time	NCNS/RS/C	Reason for NCNS/RS/C	Next Appt. Date & Time	Charge Y/N Fee	# missed

Jason E. Mastor, MD

Kristin C. Brown, PA-C

Consent for Drug Screening

As a patient of Mastor Mental Health, I agree to submit to random drug testing when requested to do so by my provider. All patients taking controlled substances may be subject to random drug screens as well as others at the provider's discretion.

I understand the results will be used as part of my comprehensive treatment plan and agree to provide specimen as requested.

Patient Signature Date

Printed Name Date of Birth

Jason E. Mastor, MD

Kristin C. Brown, PA-C

LIFETIME SIGNATURE AUTHORIZATION

I authorize the release of medical information to the below named family member, Acting Power of Attorney or Health Care Surrogate. I will notify this office in writing if this information should change.

____________________	____________________
Name	Relationship
____________________	____________________
Name	Relationship
____________________	____________________
Patient Signature	Date
____________________	____________________
Physician/Supplier	Date

*** A photocopy of this form will be as valid as the original form.***

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 takes effect on __________________________ and remains in effect until we replace it.

1. OUR PLEDGE REGARDING MEDICAL INFORMATION

The privacy of your medical information is important to us. We understand that your medical information is personal and we are committed to protecting it. 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 will tell you about the ways we may use and share medical information about you. We, also describe your rights and certain duties we have regarding the use and disclosure of medical information.

2. OUR LEGAL DUTY

Law Requires Us to:

1. **Keep your medical information private.**
2. **Give you this notice describing our legal duties, privacy practices, and your rights regarding your medical information.**
3. **Follow the terms of the notice that is now in effect.**

We have the Right to:

1. **Change our privacy practices and the terms of this notice at any time, provided that law permits the changes.**
2. **Make the changes in our privacy practices and the new terms of our notice effective for all medical information that we keep, including information previously created or received before the changes.**

Notice of Change to privacy Practices:

1. **Before we can make an important change in our privacy practices, we will change this notice and make the new notice available upon request.**

3. USE AND DISCLOSURE OF YOUR MEDICAL INFORMATION

The following section describes different ways that we use and disclose medical information. Not every use or disclosure will be listed. However, we have listed all of the different ways we are permitted to use and disclose information. We will not use or disclose your medical information for any purpose other than those that are listed below, without your specific written authorization. Any specific written authorization you provide may be revoked at any time by putting it in writing to us.

FOR TREATMENT: We may use medical information about to provide you with medical treatment or services. We may disclose medical information about you to doctors, nurses, technicians, medical students, or others who are taking care of you. We may also share medical information about you to your other health care providers to assist them in treating you.

FOR PAYMENT: We may use and disclose your medical information for payment purposes.

FOR HEALTH CARE OPERATIONS: We may use and disclose your medical information for our health care operations. This might include measuring and improving quality, evaluating the performance of employees, conducting training programs, and getting the accreditation, certificates, licenses and credentials we need to serve you.

ADDITIONAL USES AND DISCLOSURES: In addition to using and disclosing your medical information for treatment, payment and health care operations, we may use and disclose medical information for the following purposes.

Facility Directory: ***Unless you notify us that you object, the following medical information about you will be placed in our facilities directories: your name; your location in our facility; your condition described in general terms; your religious affiliation, if any. We may disclose this information to members of the clergy, except for your religious affiliation, or to others who contact us and ask for information about you by name.*** **PLEASE READ: SOME OF THE NOTES ABOVE AND BELOW MAY NOT APPLY TO THIS SPECIFIC FACILITY, HOWEVER IS STILL NOTED FOR YOUR INTEREST AND PROTECTION.**

Notification: ***Medical information to notify or help notify: a family member, your personal representative or another person responsible for your care. We will share information about your location, general condition, or death. If you are present, we will get your permission if possible before we share, or give you the opportunity to refuse permission. In case of emergency and if you are not available to give or refuse permission, we will share only the health information that is directly necessary for your health care, according to our professional judgment. We will also use our professional judgement to make decisions in your best interest about allowing someone to pick up medicine, medical supplies, x-ray or medical information for/about you.***

Disaster Relief: Medical information with a public or private organization or person who can legally assist in distaster relief efforts.

Fundraising: We may provide medical information to one of our affiliated fundraising foundations to contact you for fundraising purposes. We will limit our use and sharing to information that describes you in general, not personal, terms and the dates of your health care in any fundraising materials; we will provide you a description of how you may choose to not receive future fundraising communications.

Research in Limited Circumstances: Medical information for research purposes in limited circumstances where the research has been approved by a review board that has reviewed the research proposal and established protocols to ensure the privacy of medical information.

Funeral Director, Coroner, Medical Examiner: ***To help them carry out their duties, we may share the medical information of a person who has died with a coroner, medical examiner, funeral director, or an organ procurement organization.***

Specialized Government Fractions: ***Subject to certain requirements, we may disclose or use health information for military personnel and veterans. For national security and intelligence activities, for protective services for the President and others, for medical suitability determinations for the Department of State, for correctional institutions and the other law enforcement custodial situations, and for government programs providing public benefits.***

Court Orders and Judicial and Administrative Proceedings: ***We may disclose medical information in response to a court or administrative order, subpoena, discovery request or other lawful process, under certain circumstances. Under limited circumstances, such as a court order, warrant, or grand jury subpoena, we may share your medical information with law enforcement officials. We may share limited information with a law enforcement official concerning the medical information of a suspect, fugitive, material witness, crime victim or missing person. We may share the medical information of an intimate or other person in lawful custody with a law enforcement official or correctional institution under certain circumstances.***

Public Health Activities: ***As required by law, we may disclose your medical information to public health or legal authorities charged with preventing or controlling disease, injury or disability, including child abuse or neglect. We may also disclose your medical information to persons subject to jurisdiction of the***

Food and Drug Administration for purposes of reporting adverse events associated with product defects or problems, to enable product recalls, repairs or replacements, to track products or to conduct activities required by the FDA. We may also, when law authorizes us to do so, notify a person who may have been exposed to a communicable disease or otherwise be at risk of contacting or spreading a disease or condition.

Victims of Abuse, Neglect, or Domestic Violence: We may disclose information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect or domestic violence and other crimes. We may share your medical information if it is necessary to prevent a serious threat to your health and safety or the health and safety of others. We may share medical information when necessary to help law enforcement officials capture a person who has admitted to being a part of a crime or has escaped legal custody.

Worker's Compensation: We may disclose health information when authorized and necessary to comply with laws relating to workers compensation or other similar programs.

Health Oversight Activities: We may disclose health information to an agency providing health oversight for oversight activities authorized by law, including audits, civil, administrative, criminal investigations or proceedings, inspections, licensure or disciplinary actions or other authorized activities.

Law Enforcement: Under certain circumstances, we may disclose health information to law enforcement officials. These circumstances include reporting required by certain laws (such as reporting certain types of wounds), pursuant to certain subpoenas or court orders, reporting limited information concerning identification and location at the request of law enforcement officials, reporting death, crimes on our premises and rimes in emergencies.

QUESTIONS AND COMPLAINTS

CONTACT US OF ANY QUESTIONS, COMPLAINTS OR IF YOU FEEL THAT YOUR RIGHTS HAVE BEEN VIOLATED. WRITTEN COMPLAINTS MAY BE SUBMITTED TO DEPT. OF HEALTH AND HUMAN SERVICES. WE WILL NOT RETALIATE IN ANY WAY IF YOU CHOOSE TO COMPLAIN AND MAY BE ABLE TO PROVIDE YOU WITH THE ADDRESS TO FILE YOUR COMPLAINT.

PRIVACY PRACTICES ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices. I have been provided the opportunity to review it in full and I am in understanding of it.

Name:____

DOB:_________________ SS#:___________________

Signature:_____________________________________

Date:____

COMPLAINT

1. To The Person

You have the right to file a complaint with us about our privacy practices or our compliance with our Notice of Privacy Practices, our privacy policies and procedures, or federal or state privacy rules or laws. We will investigate your complaint and give you our written answer. We will not require you to give up any right that you may have under federal or states privacy or any other law to file your complaint, and filing your complaint will not cause us to treat you badly. To use this right, please complete, sign and date the form below then submit it to our facility. If you have any questions, or you need more information to help complete this please contact our office. You may also submit a complaint to the U.S. Dept. of Health and Human Services. For information about how to do that, please contact us.

2. Section A: Person filing a complaint

Your Name: ______________________________________ SS#: ____________________________

Date of Complaint filed: __________________________ DOB: ____________________________

Your (reachable) Phone Number: ____________________________fax: ____________________

Your Current Address: ____

Email (if applicable): ____

Your patient Account Number (if known): ____

2. Section B: Person's Complaint

a. Please give a short, plain statement of your complaint:

____

____

____

____

b. Please give a short, plain statement of how you would like your complaint handled/solved:

____

____

____

4. Person's Signature

I certify that the statements made in this complaint are true and correct to the best of my information and belief. I understand that I have a right to have a copy of this complaint if needed.

Signature__________________________________ Date ____________________________

If a representative for the person who is launching the complaint files this complaint, complete the following:

Name ____________________________ Date ______________ Relation _______________