Pritha R. Dhungana, MD, FAACAP
Board Certified in Child, Adolescent & Adult Psychiatry

13-17

Serenity

835 Oakley Seaver Dr. Clermont, FL. 34711
Tel: 352-241-9282

803 E. Dixie Ave. Leesburg, FL. 34748
Fax: 352-633-4288

Hello and welcome to our office.

The following paperwork is everything you need to fill out and either fax, email, upload, or bring with you to your first appointment. Every document is important and has a purpose, please fill each one out, prior to our first meeting with you or your child.

Documents needing to bring with you:

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

Information about our office:

- WE DO NOT PRESCRIBE **ADDERALL/ Benzodiazepines/Hypnotics/ OR AMBIEN MEDICATIONS**
- We do not place or fill out any forms related to to Disability, FMLA, Service Animals, Workman's Compensation or Medical Marijuana
- Patients will be evaluated but there is no guarantee that they will be given the type of medication they are seeking or any medication at all. Dr. Dhungana and her Nurse Practitioners believe in a holistic approach to medicine.
- *ALL patients must arrive 15 minutes prior* to their scheduled appointments.
- Please arrive 30 minutes, if you have completed all your paperwork and *60-90 min to an hour prior to your first appointment* if you have **not** completed your New Patient Paperwork.
- Please bring in your medication list and bottles of your medications

-ALL MINORS- 17 and under

- ★ If parents are married: BOTH PARENTS ARE REQUIRED TO ATTEND INITIAL APPOINTMENT
- ★ If parents are divorced: Both parents are Strongly Encouraged to attend the first visit - will also need the legal divorce paperwork.
- ★ If legal guardian: legal custodial documentation must be present at appointment
- ★ If a patient is accompanied by someone other than the parent/ legal guardian: a notarized letter MUST be presented. Letter Must specify treatment agreement by Dr. Dhungana and Serenity Health Center or any recommendations.

Thank You,
Serenity Health Centers

Patient Name:_____

Patient/ Guardian Signature:_____ Date_____

15-1t (1)

Serenity HEALTH CENTERS

Psychiatry Clinic Intake Questionnaire

(Please Print Clearly and Complete ALL Page)

Child's NAME:_____ Today's Date:_____
Last First Middle

Legal Guardian's Name:_____

Home Address:_____

Telephone:_____ CELL #: _____ Work #:_____

SSN:_____ Sex: M / F Other:_____ Date of Birth:_____

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

Email:_____ **Allergies:**_____

Highest Level of Education:
Elementary _____ (grade) Middle _____ (grade) HS _____(grade) (Graduated Yes / No) GED
College _____(Graduated Yes / No) Graduate School_____(Graduated Yes / No)

Child's Place of Education: _____
Name Address City

Child's Place of Employment:_____
Name Address City

Who Referred you to our Office? _____ _____
Name Telephone

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

For what problem(s) do you seek help?:_____

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

_____

What makes the problem worse? _____

What makes the problem better? _____

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

_____

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

How long do you feel this will take? _____

Serenity
HEALTH CENTERS

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Parent(s) / Legal Guardian / Responsible Party

Relationship to Patient: __ Self __Spouse __ Parent __ Other: _____

Name: _____ Relationship to Patient:_____

Address: _____

City:_____ State:_____ Zip:_____

Phone#:_____ Employer:_____

Work: # _____ SSN#: _____

Billing / Insurance Information

Policy Holder:_____ DOB: _____ Relationship to Patient:_____

SSN# _____ Name of Employer:_____

Address of Employer:_____

City: _____ State _____ Zip _____ Work: # _____

Insurance Company: _____ Grp#_____ ID#_____

Ins. Co. Address: _____ Ins. Phone#:_____

>> Do you have Secondary Insurance ? NO _____ YES _____ If yes, please complete the following <<

Policy Holder:_____ DOB: _____ Relationship to Patient:_____

SSN# _____ Name of Employer:_____

Address of Employer:_____

City: _____ State _____ Zip _____ Work: # _____

Insurance Company: _____ Grp#_____ ID#_____

Ins. Co. Address: _____ Ins. Phone#:_____

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Parent-Report Questionnaire

Demographics:

Child's Name: _____
Last First M

Address: _____

_____
City State Zip code

Phone: _____ Home / Cell Work Phone: _____

Person completing this form: _____ Relationship to the child: _____

Sex: M F Date of Birth: _____ Age at Today: _____ years _____ months

Race _____
1- White
2- African- American
3- Hispanic
4- Asian
5- Native- American
6- Pacific Islander
7- Other_____

Religion ____
1- Catholic
2- Protestant
3- Jewish
4- Agnostic
5- Other_____

Living Situation _____
1- Both Biological parents
2- Single Parent - Mother
3- Single Parent- Father
4- Parent & Step- Parent
5- Other_____

Who lives in the same household as the child?

Name Sex Age Relationship

_____

_____

_____

_____

_____

_____

_____

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Demographics (continued) Child's Name:_____ Date;_____

Father's highest level of education: _____
1-less than 7 years of schooling
2- junior high school
3- partial high school
4- high school graduate

Mother's highest level of education: _____
5- technical school
6- partial college
7- college graduate
8- professional degree

Father's current occupation: _____
1-Executive/ Professional
2- Manager/ Lesser Professional
3- Administrator/ Minor Professional
4-Clerical/ Sales

Mother's current occupation: _____
5- Skilled
6- Semi- Skilled
7- Unskilled
8- Student
9- Never worked Why:_____

Father's preferred Hand:_____ Mother's preferred Hand:_____

Child's last grade completed: _____ Grades:_____ IEP ___ 504____ Special Ed:__

Name of School last attended:_____

Has your child ever repeated a grade? _____ If yes, which grade & why?_____

Developmental History: Not all parents remember the answers to these questions. You can write down what you do remember now or you can look in your baby book, if you kept one.

1. What was the length of your pregnancy? _____ weeks
2. Were any medications used during your pregnancy? _____. If so, what & why?_____

3. Were forceps used during the delivery? Yes No Not Sure Don't Know
4. Were there any complications with delivery?
   ____ Premature rupture of membranes ____ Extraction ____ Hemorrhage
   ____ Twins ____ Triplets ___Version ____ High Blood Pressure
5. How much did your child weigh at birth? _____ lbs _____ oz
6. Did your child start breathing right away? Yes No Not Sure Don't Know
7. Did your child cry? Yes No Not Sure Don't Know
8. Were there any problems after your child was born?
   ____ Incubator ____ Jaundice ____ Blueness or trouble breathing
   ____ Convulsions ____ Hyaline membrane disease ___Trouble feeding
   ____ Other:_____ ____ **Breast fed** ____**Bottle fed**

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Demographics (continued) Child's Name:_____ Date;_____

9. When did your child leave the hospital? _____
10. After your child came home, were there any problems?
    _____ Slept too little _____ Colic, excessive irritability or crying _____ Too stiff
    _____ Sleepiness, too quiet, lethargic _____ too floppy _____ Poor feeding
11. When did your child really smile (not from gas):_____ months/ years
12. When was your child able to sit by himself WITHOUT propping or help? ___months/ years
13. When did your child start to walk by him/herself WITHOUT holding on? ____months/ years
14. When did your child say their first word? _____months/ years
15. When did your child say short sentences (eg. "I want milk"; "go bye-bye")? ____months/yrs
16. Did your child have trouble learning to speak? Yes No
    a. Was he/she different from brother or sisters, or other children?_____
17. Is your child toilet trained? Yes No If so, how old when trained? _____
18. How old was your child when he/she was able to :
    a. Ride a tricycle: _____
    b. Ride a bicycle without training wheels: _____
    c. Get dressed by him/herself: _____
    d. Tie his/ her own shoelaces:_____
19. What hand does your child prefer to use? _____
    a. At what age did you notice this? ___ Before age 1 __ after age 2 __after age 4
20. Anything else significant occur during your child's development years?

    _____
    _____
    _____

Current MEDICATION PROFILE

Please list any medications that you are ***currently*** taking prescribed OR over the counter.

MEDICATION	DOSE	Start Date	Stop Date	Diagnosis	Date Last Filled	Prescribing Physician

MEDICAL HISTORY

Child's Name:_____Date:_____

Does your child have any of the following :

Illness	**NO**	**YES**	If still present	**Comments**
Allergies (please describe)			☐	
Asthma			☐	
Chicken Pox			☐	
Complications at birth			☐	
Convulsions			☐	
Seizures			☐	
Epilepsy			☐	
Dizziness / Fainting			☐	
Head Injury			☐	
High Blood pressure			☐	
Loss of Consciousness			☐	
Low Blood Pressure			☐	
Measles			☐	
Respiratory Illness			☐	
Rhuematic Fever			☐	
PANDAS			☐	
Sleep Problems			☐	
Urogenital problems			☐	
Visual Problems (e.g. Lazy eye)			☐	
Other Serious Illness:			☐	
Other Serious Illness:			☐	

MEDICAL PROCEDURES	**NO**	**YES**	**Date**	**Comments**
Has your child ever had surgery or an operation? Tpye?				

Child Name:_____ Date: _____

Medical History (continued)

Has your child ever had any serious injuries? Describe	NO	YES	Date	Comments:

Is your child taking any medications? Please List	NO	YES	Dose	Date Started & Reason for taking

Girls Only: Has your daughter had her 1st period? **NO** **YES** If yes, at what age:_____

Are the periods regular? **NO** **YES**

Date of last menstrual period:_____

Is there any change in symptom serverity with her periods? **NO** **YES** If yes, describe:_____

Is there any possibilty that your daughter is pregnant? **NO** **YES** On birth control? Type:_____

NEUROPSYCHIATRIC HISTORY

Has your child ever ...	NO	YES	age of first	Describe:
Made involuntary body movements ?				
Made involuntary sounds (tics)?				
Had recurrent disturbing thoughts or worries (obsessions)?				
Had repetitive or excessive habits (compulsions)?				
Had problems with attention, concentration or hyperactivity?				
Been diagnosed with a learning disability?				
Had other emotional or behavioral problems?				

Have you ever sought professional treatment for your child for any of the above problems? **NO** **YES** **- If yes, please list on the next page**

PAST MENTAL HEALTH HISTORY

List professional treatment sought for your child here

PROBLEM / Diagnosis	Start Date	Stop Date	Type of care	Benefit:

*Therapy Type Scale: **1**= Drug / Medication **2**= Talk Therapy **3**= Behavior Therapy **4**= Other (Specify)* *Benefit Scale: **Good, Fair, Poor***

FAMILY HISTORY

Is your child adopted ? **NO** **YES**

Have any of your child's blood relatives had a serious emotional, behavioral, or neurological problem? For example, hyperactivity, learning disability, abnormal movements? **NO** **YES** If yes, please fill in the table below

Name or Initial of family members	Age	Reltionship	Father's side	Mother's side	Suspected diagnosis	Recieved Therapy?

How would you describe your family life? Stable Unstable

Has your child experienced any difficulties listed below? NO YES Check all that apply

	☑	Child's age	Duration
Death of a parent	☐		N/A
Death of a loved one or close friend	☐		N/A
Separation from parent or family	☐		
Parent's separation or divorce	☐		N/A
Loss of home	☐		
Family financial problems	☐		
Physical abuse	☐		
Sexual abuse	☐		
Parent with substance abuse problem	☐		
Conflicts with parents	☐		
Removal of child from home	☐		
Victim of crime or violence	☐		N/A
Unwanted pregnancy	☐		N/A
School problems	☐		
Illness in self (specify)	☐		
Illness in family (specify)	☐		
Other:	☐		

Serenity HEALTH CENTERS

Previous Medication Trials

Antipsychotic/ Neuroleptics/ Major Tranquilizers/ Anti-Parkinsonians

Thorazine/ chlorpromazine
Trilafon/ perphenazine
Compazine/ prochlorperazine
Orap/ Pimozide
Moban/ molindone
Clozaril/ Clozapine
Artane/ Trihexyphenidyl
Exelon/ Rivastigmine
Mellaril/ thioridazine
Stelazine/ trifluoperazine
Torecan/ Norzine/ thiethylperazine
Navane/ thiothixene
Loxitane/ Loxapine
Seroquel/ Quetiapine
Cogentin/ Benztropine
Reminyl/ Galantamine
Serentil/ mesoridazine
Prolixin/ fluphenazine
Haldol/ Haloperidol
Taractan/ chlorprothixene
Risperdal/ risperidone
Geodon/ Ziprasidone
Aricept/ Donepezil
Namenda/ Memantine

Antidepressants / Mood Elevators

Elavil/ Endep/ Amitriptyline
Tofranil/ Imipramine
Triavil/ Etrafon
Surmontil/ Trimipramine
Ludiomil/ Maprotilline
Prozac/ Sarafem/ Fluoxetine
Luvox/ Fluvoxamine
Effexor/ Venlafaxine
Nardil/ Phenelzine
Eldepryl/ deprenyl/ Selegiline
Pamelor/ Aventyl/ Nortriptyline
Norpramin/ Desipramine
Limbitrol
Anafranil/ clomipramine
Desyrel/ Trazodone
Zoloft/ Sertraline
Celexa/ Citalopram
Wellbutrin/ Zyban/ Bupropion
Parnate/ Tranylcypromine
Moclobemide
Sinequan/ Adapin/ Doxepin
Vivactil/ protriptyline
Symbyax
Asendin/ Amoxapine
Serzone/ Nefazodone
Paxil/ Pexeva/ Paroxetine
Lexapro/ Escitalopram
Remeron/ Mirtazapine
Marplan/ isocarboxazid
Cymbalta/ Duloxetine

Anxiolytics/ Minor Tranquilizers/ Sleeping Pills

Valium/ Diazepam
Paxipam/ Halazepam
Ativan/ Lorazepam
Dalmane/ Flurazepam
Halcion/ Triazolam
Lunesta/ Eszopiclone
BuSpar/ Buspirone
Librium/ Chlordiazepoxide
Centrax/ Prazepam
Xanax/ Alprazolam
Restoril/ Temazepam
ProSom/ Estazolam
Sonata/ Zaleplon
Tranxene/ Clorazepate
Serax/ Oxazepam
Klonopin/ Clonazepam
Doral/ Quazepam
Ambien/ Zolpidem
Rozerem/ Ramelteon

Other Psychoactive Substances

Alcohol
LSD/ Mescaline/ Peyote
Amphetamines/ Speed/ Diet pills
Ritalin / Concerta / Metadate / Methylin/ Methylphenidate
Cocaine/ Crack
Quaaludes/ Barbiturates
Tobacco
Marijuana/ grass/ Pot/ Weed/ Hash/ Reefer
Psilocybin/ Mushrooms
Adderall/ Adderall XR
Cylert/ Pemoline
Glue/ Other Volatile Inhalants
Other Downers: _____
Ecstasy/ MDMA
DMT/ STP/ PCP
Strattera/ Atomoxetine
Focalin/ Dexmethylphenidate
Provigil/ Modafinil
Heroin/ Other Opiates

PAST MEDICATION PROFILE

Please list ALL psychotropic medications that have been prescribed in the past and their effects

PAST MEDICATION	DOSE	Start Date	Stop Date	Diagnosis	Benefit?	Side Effects

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version - Page 1 of 2 (To be filled out by the PARENT)

Name: _____ **Date:** _____

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

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

Screen for Child Anxiety Related Disorders (SCARED)

Parent Version - Page 2 of 2 (To be filled out by the PARENT)

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

Developed by Boris Birmaher, MD, Suneeta Khetarpal, MD, Marlane Cully, MEd, David Brent, MD, and Sandra McKenzie, PhD. Western Psychiatric Institute and Clinic, University of Pgh. (10/95). Email: birmaherb@msx.upmc.edu

Screen for Child Anxiety Related Disorders (SCARED)

Child Version—Pg. 1 of 2 (To be filled out by the CHILD)

Name: _____

Date: _____

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

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

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Screen for Child Anxiety Related Disorders (SCARED)

Child Version—Pg. 2 of 2 (To be filled out by the CHILD)

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

SCORING:

A total score of ≥ **25** may indicate the presence of an **Anxiety Disorder**. Scores higher that 30 are more specific.

A score of **7** for items 1, 6, 9, 12, 15, 18, 19, 22, 24, 27, 30, 34, 38 may indicate **Panic Disorder** or **Significant Somatic Symptoms**.

A score of **9** for items 5, 7, 14, 21, 23, 28, 33, 35, 37 may indicate **Generalized Anxiety Disorder**.

A score of **5** for items 4, 8, 13, 16, 20, 25, 29, 31 may indicate **Separation Anxiety Disorder**.

A score of **8** for items 3, 10, 26, 32, 39, 40, 41 may indicate **Social Anxiety Disorder**.

A score of **3** for items 2, 11, 17, 36 may indicate **Significant School Avoidance**.

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

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

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CHILDREN'S DEPRESSION INVENTORY

CDI

Name: _____ Date: _____

Kids sometimes have different feelings and ideas.

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

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

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

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

Example:
- ❍ I read books all the time.
- ❍ I read books once in a while.
- ❍ I never read books.

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

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

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

3. ❍ I do most things OK.
   ❍ I do many things wrong.
   ❍ I do everything wrong.

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

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

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

7. ❍ I hate myself.
   ❍ I do not like myself.
   ❍ I like myself.

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

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

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

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

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

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

14. ❍ I look OK.
❍ There are some bad things about my looks.
❍ I look ugly.

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

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

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

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

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

20. ❍ I do not feel alone.
❍ I feel alone often.
❍ I feel alone all the time.

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

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

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

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

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

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

27. ❍ I get along with people.
❍ I do not always get along with people.
❍ I do not get along with people.

TOTAL: _____

Childs Name: _____ DATE: _____

YMRS - PARENT VERSION

Directions: *Please read each question below and circle the answer number which most closely describes your child.*

1. **Mood - Is your child's mood higher (better) than usual?**
   0. No
   1. Mildly or possibly increased
   2. Definite elevation- more optimistic, self-confident; cheerful; appropriate to their conversation
   3. Elevated but inappropriate to content; joking, mildly silly
   4. Euphoric; inappropriate laughter; singing/making noises; very silly

2. **Motor Activity/Energy - Does your child's energy level or motor activity appear to be greater than usual?**
   0. No
   1. Mildly or possibly increased
   2. More animated; increased gesturing
   3. Energy is excessive; hyperactive at times; restless but can be calmed
   4. Very excited; continuous hyperactivity; cannot be calmed

3. **Sexual Interest - Is your child showing more than usual interest in sexual matters?**
   0. No
   1. Mildly or possibly increased
   2. Definite increase when the topic arises
   3. Talks spontaneously about sexual matters; gives more detail than usual; more interested in girls/boys than usual
   4. Has shown open sexual behavior- touching others or self inappropriately

4. **Sleep - Has your child's sleep decreased lately?**
   0. No
   1. Sleeping less than normal amount by up to one hour
   2. Sleeping less than normal amount by more than one hour
   3. Need for sleep appears decreased; less than four hours
   4. Denies need for sleep; has stayed up one night or more

5. **Irritability - Has your child appeared irritable?**
   0. No more than usual
   2. More grouchy or crabby
   4. Irritable openly several times throughout the day; recent episodes of anger with family, at school, or with friends
   6. Frequently irritable to point of being rude or withdrawn
   8. Hostile and uncooperative about all the time

6. **Speech (rate and amount) - Is your child talking more quickly or more than usual?**
   0. No change
   2. Seems more talkative
   4. Talking faster or more to say at times 6. Talking more or faster to point he/she is difficult to interrupt
   8. Continuous speech; unable to interrupt

Childs Name: _____ DATE: _____

YMRS - PARENT VERSION (Continued)

7. **Thoughts - Has your child shown changes in his/her thought patterns?**
   0. No
   1. Thinking faster; some decrease in concentration; talking "around the issue"
   2. Distractible; loses track of the point; changes topics frequently; thoughts racing
   3. Difficult to follow; goes from one idea to the next; topics do not relate; makes rhymes or repeats words
   4. Not understandable; he/she doesn't seem to make any sense

8. **Content - Is your child talking about different things than usual?**
   0. No
   2. He/she has new interests and is making more plans
   4. Making special projects; more religious or interested in God
   6. Thinks more of him/herself; believes he/she has special powers; believes he/she is receiving special messages
   8. Is hearing unreal noises/voices; detects odors no one else smells; feels unusual sensations; has unreal beliefs

9. **Disruptive-Aggressive Behavior - Has your child been more disruptive or aggressive?**
   0. No; he/she is cooperative
   2. Sarcastic; loud; defensive
   4. More demanding; making threats
   6. Has threatened a family member or teacher; shouting; knocking over possessions/ furniture or hitting a wall
   8. Has attacked family member, teacher, or peer; destroyed property; cannot be spoken to without violence

10. **Appearance - Has your child's interest in his/her appearance changed recently?**
    0. No
    1. A little less or more interest in grooming than usual
    2. Doesn't care about washing or changing clothes, or is changing clothes more than three time a day
    3. Very messy; needs to be supervised to finish dressing; applying makeup in overly- done or poor fashion
    4. Refuses to dress appropriately; wearing bizarre styles

11. **Insight - Does your child think he/she needs help at this time?**
    0. Yes; admits difficulties and wants treatment
    1. Believes there might be something wrong
    2. Admits to change in behavior but denies he/she needs help
    3. Admits behavior might have changed but denies need for help
    4. Denies there have been any changes in his/her behavior/thinking

Signature of Parent / Guardian: _____

The SNAP-IV Teacher and Parent Rating Scale

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

Name:_____ Gender:_____ Age:_____ Grade:_____

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

Completed by:_____ Type of Class:_____ Class size:_____

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

Check the column which best describes this child:	Not At All	Just A Little	Quite A Bit	Very Much
41. Often is aggressive to other children (e.g., picks fights or bullies)				
42. Often is destructive with property of others (e.g., vandalism)				
43. Often is deceitful (e.g., steals, lies, forges, copies the work of others, or "cons" others)				
44. Often and seriously violates rules (e.g., is truant, runs away, or completely ignores class rules)				
45. Has persistent pattern of violating the basic rights of others or major societal norms				
46. Has episodes of failure to resist aggressive impulses (to assault others or to destroy property)				
47. Has motor or verbal tics (sudden, rapid, recurrent, nonrhythmic motor or verbal activity)				
48. Has repetitive motor behavior (e.g., hand waving, body rocking, or picking at skin)				
49. Has obsessions (persistent and intrusive inappropriate ideas, thoughts, or impulses)				
50. Has compulsions (repetitive behaviors or mental acts to reduce anxiety or distress)				
51. Often is restless or seems keyed up or on edge				
52. Often is easily fatigued				
53. Often has difficulty concentrating (mind goes blank)				
54. Often is irritable				
55. Often has muscle tension				
56. Often has excessive anxiety and worry (e.g., apprehensive expectation)				
57. Often has daytime sleepiness (unintended sleeping in inappropriate situations)				
58. Often has excessive emotionality and attention-seeking behavior				
59. Often has need for undue admiration, grandiose behavior, or lack of empathy				
60. Often has instability in relationships with others, reactive mood, and impulsivity				
61 Sometimes for at least a week has inflated self esteem or grandiosity				
62. Sometimes for at least a week is more talkative than usual or seems pressured to keep talking				
63. Sometimes for at least a week has flight of ideas or says that thoughts are racing				
64. Sometimes for at least a week has elevated, expansive or euphoric mood				
65. Sometimes for at least a week is excessively involved in pleasurable but risky activities				
66. Sometimes for at least 2 weeks has depressed mood (sad, hopeless, discouraged)				
67. Sometimes for at least 2 weeks has irritable or cranky mood (not just when frustrated)				
68. Sometimes for at least 2 weeks has markedly diminished interest or pleasure in most activities				
69. Sometimes for at least 2 weeks has psychomotor agitation (even more active than usual)				
70. Sometimes for at least 2 weeks has psychomotor retardation (slowed down in most activities)				
71. Sometimes for at least 2 weeks is fatigued or has loss of energy				
72. Sometimes for at least 2 weeks has feelings of worthlessness or excessive, inappropriate guilt				
73. Sometimes for at least 2 weeks has diminished ability to think or concentrate				
74. Chronic low self-esteem most of the time for at least a year				
75. Chronic poor concentration or difficulty making decisions most of the time for at least a year				
76. Chronic feelings of hopelessness most of the time for at least a year				
77. Currently is hypervigilant (overly watchful or alert) or has exaggerated startle response				
78. Currently is irritable, has anger outbursts, or has difficulty concentrating				
79. Currently has an emotional (e.g., nervous, worried, hopeless, tearful) response to stress				
80. Currently has a behavioral (e.g., fighting, vandalism, truancy) response to stress				
81. Has difficulty getting started on classroom assignments				
82. Has difficulty staying on task for an entire classroom period				
83. Has problems in completion of work on classroom assignments				
84. Has problems in accuracy or neatness of written work in the classroom				
85. Has difficulty attending to a group classroom activity or discussion				
86. Has difficulty making transitions to the next topic or classroom period				
87. Has problems in interactions with peers in the classroom				
88. Has problems in interactions with staff (teacher or aide)				
89. Has difficulty remaining quiet according to classroom rules				
90. Has difficulty staying seated according to classroom rules				

Pritha R. Dhungana, MD, FAACAP
Board Certified in Child, Adolescent & Adult Psychiatry

835 Oakley Seaver Dr. Clermont, FL. 34711
Tel: 352-241-9282

803 E. Dixie Ave. Leesburg, FL. 34748
Fax: 352-633-4288

EXPRESS AND INFORMED CONSENT FOR TREATMENT

Patient Name: _____ Date: _____

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

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

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

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

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

Patient Signature: _____ Date: _____

Parent/ Guardian/ Surrogate Signature: _____ Date: _____

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

____Phone ____ Text You can call me at: _____-_____-_____ During these hours:_____

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

Patient Signature: _____ Date: _____

Parent/ Guardian/ Surrogate Signature: _____ Date: _____

Patient Rights and Responsibilities

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

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

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

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

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

Patient Signature: _____ Date: _____

Parent/ Guardian Signature: _____ Date: _____

Witness Signature: _____ Date: _____

Jan 2, 2023

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. If you have any questions regarding this notice please contact:

Serenity Health Center
835 Oakley Seaver Dr.
Clermont, FL. 34711 (Effective date November 14, 2008)

WHO WILL FOLLOW THIS NOTICE:

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

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

OUR PLEDGE REGARDING MEDICAL INFORMATION

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

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

We are required by law to:

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

HOW WE MAY USE AND DISCLOSE MEDICAL INFORMATION ABOUT YOU

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

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

Jan 2, 2023

Serenity HEALTH CENTERS

NOTICE OF PRIVACY PRACTICES

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

YOUR RIGHTS REGARDING MEDICAL INFORMATION ABOUT YOU

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

- **Right to inspect and copy:** You have the right to a copy of your medical information that may be used to make decisions about your care. To inspect and/or receive a copy of medical information that may be used to make decisions about you, you must submit in writing to Serenity Health Center. If you request a copy of the information, we may charge you a minimum fee of $50.00 to cover the costs of copying and mailing or other supplies associated with your request. We may deny your request to inspect and copy in certain limited circumstances.
- **Right to Amend:** If you feel that the information we have about you is incomplete or incorrect, you may ask us to amend the information. You have the right to ask for an amendment for as long as the information is kept by our office. To request an amendment, you must request in writing to your physician. In addition, you must provide a reason that supports your request. We may refuse to amend your record under limited circumstances.
- **Right to Accounting Disclosures:** You have the right to request a list of disclosures we made of medical information about you, To request this list you must submit a request in writing to Serenity Health Center and denote a time period not to exceed seven years. The first request will be free of charge, but additional lists may apply fees to be determined before any charges will be applied, at which time you may retract your request before any costs are incurred.
- **Right to Request Restrictions:** You have the right to request restrictions or limitations on the medical information we use ro disclose about you for treatment, payment, or healthcare operations. You also have a right to request a "limit" on the medical information we disclose about you to someone who is involved in your care or payment for your care, like a family member or friend.
    - **We Are Not Required to Agree to Your Request:**. If we do not agree to comply with your request, and only do so if the information is needed to provide you with emergency treatment. You must submit, in writing to Serenity Health Center citing: (1) which information you wish to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.
- **Right to Request Confidential Communications:** You have the right to request that we will communicate with you about medical matters in a certain way or at a certain location. For example, you may request that we only contact you at work or by mail. Please submit your request in writing. We will not ask for a reason for your request and we will accommodate all reasonable requests.
- **Right to a Paper Copy of this Notice:** You have the right to receive a paper copy of this notice. You may ask us to give you a copy of this notice at any time. You may request in writing to Serenity Health Center that a copy be mailed to you.
- **Mental Health Exemption:** As per HIPAA Privacy Rule Mental Health Care providers who specialize in Psychiatry and Mental Health are specifically exempt from disclosing patient records to patients directly. The Privacy Rule definition of Psychiatric notes are "notes recorded in any medium" by a healthcare provider who is a Licensed Mental Health Care Provider, Therapist, or Psychiatrist. We can, however, send your medical records, upon written request and with proper signed Medical release form stating Facility, Physicians name, and Fax number, to the medical provider of your choice.

CHANGES TO THIS NOTICE

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

COMPLAINTS

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

OTHER USES OF MEDICAL INFORMATION

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

Jan 2, 2023

Serenity
HEALTH CENTERS
NOTICE OF PRIVACY PRACTICES

Acknowledgement and Consent
Notice of Privacy Practices

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

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

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

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

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

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

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

_____ _____

Signature of patient or legal representative **Date**

Billing and Insurance Procedure Consent

You Must Read And Initial Where Indicated

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

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

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

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

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

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

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

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

_____ _____

Patient Signature **Date**

Pritha R. Dhungana, MD, FAACAP
Board Certified in Child, Adolescent & Adult Psychiatry

835 Oakley Seaver Dr. Clermont, FL. 34711
Tel: 352-241-9282

803 E. Dixie Ave. Leesburg, FL. 34748
Fax: 352-633-4288

NO SHOW/NO CONTACT/ OFFICE ARRIVAL POLICY

Appointments are scheduled to accommodate your schedule and the schedule of our providers, please be courteous of their time as we are aware your time is just as valuable.

- Please arrive 15 minutes prior to your scheduled appointment time.
- New patients with completed paperwork, please arrive to the office 30 to 45 minutes prior to your appointment time. If you have **NOT completed your paperwork Please ARRIVE 90 minutes prior to your scheduled appointment.**
- If you are running late please call 352-241-9282, as a courtesy to the office staff, so that we are aware. We may be able to place the next person who is ready in with the provider, and you will not have to rush, without any fees being charged to you.
- We allow Established patients a **7** minute "grace period." If you are late after this time period you will be considered a NO SHOW.
- If any patient arrives 8 minutes after their scheduled appointment time and no calls have been made to reschedule or cancel, you will be charged a NO SHOW fee. ***See fee schedule below***
- If you have an appointment with us and you do not CONFIRM, DO NOT Reschedule or Cancel 24-48 hours prior to your scheduled appointment you will be charged the NO SHOW/ No Contact Fee.
- Be aware that after 3 No Show/ No Contacts within a calendar year you will be automatically discharged from our practice.
- Prior to being rescheduled with a No Show/ No Contact Fee, this MUST be paid PRIOR to being able to Reschedule or and Refills being sent.

No Show/No Contact Fees

New Patient:----------	$100
Established 1st occurrence—---------	$50
Established 2nd occurrence—---------	$100
Established 3rd occurrence—---------	$150

Please be advised that Serenity Health Center WILL NOT be responsible for any adverse reactions due to discontinuation of medication(s), due to the inability of the patient not coming in to their scheduled appointments as determined by their provider. _____ ***(initial)***

Patient Signature:_____ Date: _____

Parent/ Guardian Signature:_____ Date: _____

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In order to reserve your appointment we will need to hold your hour with a credit card. Your credit card will not be charged at this time. The card will be on file in the event that you do not call to cancel 48 hours PRIOR to your scheduled appointment. There will then be a New Patient $100.00 No Show fee assessed.

CREDIT CARD AUTHORIZATION FORM

CREDIT CARD DETAILS

Card Type: ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover ☐ _____

Cardholder Name (as shown on card):_____

Credit Card Number: _____ - _____ - _____ - _____

Expiration Date: _____ / _____

Billing Zip Code: _____

CONSENT

I, the undersigned cardholder, authorize the merchant known as [MERCHANT'S NAME] to charge my credit card for purchases related to goods and services. I agree that my information may be saved by the merchant for future payments and understand that this can be revoked at any time with request.

Cardholder's Signature: _____ Date: _____

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Patient Authorization Disclosure of Confidential Information

I, _____, by signing this authorization form; authorize the use and disclosure of my health information in the manner described below. I have signed this form voluntarily in order to document my wishes regarding the use and disclosure of health information.

I authorize (check all which are appropriate to be used and disclosed)

___ Diagnosis with Medication(s) Prescribed ___ Laboratory Results

___ Outpatient Treatment/Visits ___ Psychiatric Treatment/Services

___ Evaluation Results ___ _____

I authorize Serenity Health Center LLC to obtain my health information from AND/OR to:

Name/Provider Name: _____

Practice/Facility Name (if applicable): _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone Number: (_____) _____-_____ Fax Number: (_____) _____-_____

Purpose: _____

Patient Name: _____ DOB: _____/_____/_____

Signature of Patient: _____ Date: _____/_____/_____

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

Signature of Witness: _____ Date: _____/_____/_____

This Authorization will expire 365 days from the date of signature.