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

Adult

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_____

Serenity
HEALTH CENTERS

Psychiatry Clinic Intake Questionnaire

(Please Print Clearly and Complete ALL Page)

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

Home Address:_____

Telephone:_____ CELL #: _____ Work #:_____

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

Marital: **Single** **Married** **Divorced** **Widowed** **Separated** **With a Partner**

Email:_____ **Allergies:**_____

Social Status: Disabled Employed Retired Stay at home Parent Student F/T P/T Unemployed

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

Place of Education: _____
Name Address City

Place of Employment:_____
Name Address City

Who Referred you to our Office? _____ _____
Name Telephone

Who is your Primary Care Physician? _____ _____
Name Telephone

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

What led you to seek help now? _____

_____

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 think 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#:_____

3.

Name: _____ Date: _____

Mark an "X" in the answer that best describes:

SLEEP	None	Mild	Moderate	Extreme
Sleeping too much				
Difficulty falling asleep				
Difficulty staying asleep				
Waking earlier than desired				
INTERESTS	**None**	**Mild**	**Moderate**	**Extreme**
Loss of interest in pleasurable activities				
Changes in sexual interests				
SELF-ESTEEM / GUILT	**None**	**Mild**	**Moderate**	**Extreme**
Excessive guilt				
Feeling worthless				
Regretting some behaviors				
ENERGY	**None**	**Mild**	**Moderate**	**Extreme**
Decreased energy				
Increased energy				
Unable to sit still				
Moving so slowly that others have noticed				
Memory/ Concentration/ Perception	**None**	**Mild**	**Moderate**	**Extreme**
Difficulties with concentration				
Worry about social or performance situations				
Seeing things that others may not see				
Hearing things that others may not hear				
APPETITE	**None**	**Mild**	**Moderate**	**Extreme**
Decreased appetite				
Increased appetite				
Restricting what you eat to lose more weight				
Overeating/ making yourself vomit				
MOOD	**None**	**Mild**	**Moderate**	**Extreme**
Mood swings				
Feeling sad or depressed				
Feeling nothing of feeling numb				
Anger				
Temper outbursts				
Irritability				
Inability to stop worrying				
Anxiety or fear				
OTHER	**None**	**Mild**	**Moderate**	**Extreme**
Avoiding places, people, or situations				

Name: _____ Date: _____

Mark an "X" in the answer that best describes:

RISK ASSESSMENT	Currently	In Last 6 months	More than 6 months ago	Never
Recurrent thoughts about death				
Believing that others would be "better off" if you were dead				
Feeling hopeless about your life and future				
A family member or close friend completing suicide				
Self-harming behaviors without intent to die				
Recurrent thoughts about killing yourself				
Thinking out a plan to kill yourself				
Active preparation to kill yourself				
Attempting to kill yourself				
Recurrent thoughts about killing others				
Thinking out a plan to kill someone else				
Active preparation to kill someone else				
Attempting to kill someone else				
Voices telling you to hurt or kill yourself or others				
Being more physically or verbally aggressive than you intended to be (with spouse / partner / child)				
A physical altercation in which you caused injury				
Throwing or breaking things when angry				

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Name: _____ Date: _____

Mark an "X" in the answer that best describes: Describe in family history as much as possible

Review of Symptoms	YES		YES		YES
Dry mouth		Nasuea		Fainting or dizzy spells	
Constipation		Diarrhea		Unexplained weightloss	
Sweating		Blackouts		Changes in hearing or vision	
Fatigue		Headaches		Numbness in extremities	
Nightmares		Excessive snoring		Sexual concerns	
Constant pain		Taking medication to sleep		Other:	
LIFE EXPERIENCES	**YES**		**YES**		**YES**
Abusive relationship		Miscarriage		Natural disaster	
Experienced physical abuse		Decreased appetite		Death of a parent	
Experienced emotional abuse		Increased appetite		Death of someone close	
Experienced sexual abuse		Abortion		Unhappy childhood	
Witnessed physical abuse		Been a crime victim		Poor academic progress	
Witnessed emotional abuse		Been in War		Few friends	
Witnessed sexual abuse		Poverty		Family problems	
Rape					

FAMILY HISTORY	MOTHER	FATHER	SIBLING	GRANDPARENT	Aunt/ Uncle
Attention Deficit Disorder (ADHD/ADD)					
Bipolar or Manic / Depressive Illness					
Alcohol or Drug Abuse					
Mental retardation					
Depression					
Anxiety (panic disorder, excessive worry)					
Learning Disability / Autism					
Schizophrenia or psychosis					
Other:					

Name: _____ Date:_____

Mark an "X" By all that apply:

Psychological Health History	**YES**
Have seen a physican for a mental health concern	
Have been prescribed medication for a mental health condition	
Have seen a therapist or mental health counselor	
Have received substance abuse counseling or treatment	
Have seen a Psychiatrist for a mental health condition	
Have ever been hospitalized for a mental health condition	
Have ever been diagnosed with an eating disorder	
Occupational History	**YES**
Have you frequently quit jobs or don't stay at a job for long?	
Do you usually get fired from a job?	
Do you have frequent financial difficulties?	
Are you currently unemployed?	
Academic History	**YES**
Have you attented more than one college / University?	
Are you on academic probation or suspension?	
Suspended or expelled from school?	
Needed to take classes over (or repeat a grade)	
Have you ever skipped a grade?	
Have been previously diagnosed with a learning disability or ADHD?	

Current GPA:_____ Grades:_____ Major/ Minor: _____

Name: _____ Date: _____

Mark an "X" in the answer that best describes:

Substance Use	Currently	In Last 6 months	More than 6 months ago	Never
Tobacco				
Marijuana				
IV Drugs				
Cocaine				
Heroin				
Ecstasy				
Selling or trading prescription medication prescribed to you				
Prescription medication for recreational use				
Overuse of a prescription medication				
Taking prescription medication for reasons other than it was prescribed for				

Do you drink alcohol? YES NO **Do you drink caffeinated beverages? YES NO**

How many days of the month do you drink?_____ How many drinks in an average day?_____

How many drinks do you drink on one day/ night?_____

Do you drink to get drunk or to get away from stressors? **YES NO**

Has your alcohol intake increased over the past month? **YES NO**

Have you had problems in your relationships due to alcohol use? **YES NO**

Have you had problems at work or at home due to alcohol use? **YES NO**

Have you blacked out in the past from drinking alcohol? **YES NO**

Have you received treatment for use of alcohol? (including Alcoholic Anonymous) **YES NO** **Where/ When**_____

Do you drive after drinking alcohol? **YES NO**

Have you had trouble with the law due to alcohol use? (e.g. DUI, public intoxication) **YES NO** _____

I understand the questionnaire information I have provided is important in assessing the health care I may need.

I certify that the information on this form is true and correct to the best of my knowledge.

Patient Signature:_____ Date:_____

Witness/ Provider Signature:_____ Date:_____

Serenity HEALTH CENTERS

PSYCHIATRIC HISTORY CHECKLIST

Please answer each question by circling Y (Yes) or N (No) as indicated.

Where were you born? _____
Since what year have you lived continuously in this area? _____
How many years of school did you complete? _____

Y N When you first started school, did you have trouble separating from your mother or did you have discomfort from being away from home?

Y N In school, did you have difficulty sitting still or paying attention more than other kids, or were you ever diagnosed as being hyperactive or having attention-deficit disorder?

Y N Did you have any specific learning problems, such as with spelling, reading, math, or speech; were you labeled a slow learner; or were you placed in special classes?

Y N As a child, did you frequently wet your bed after the age of 5?

Y N Were you ever the victim of physical or sexual child abuse; violent crime; sexual assault; molestation, or harassment; natural disaster; motor vehicle or industrial accident; combat injury; discrimination or persecution based on gender, race, ethnicity, religion, sexual orientation, etc.? ***(If Yes, please circle which one(s).)***

Y N Did you ever serve in the Armed Forces, active duty or reserves?

Y N If so, did you receive a service-connected disability rating?

Y N Have you ever assaulted anyone or been in jail?

Y N Have you ever attempted suicide or harmed yourself on purpose without intending suicide, such as to get a sense of relief or someone's attention?

How often do you gamble (cards, casinos, racetracks, Jai Alai, etc.)? _____
What's the most you lost in one day? _____

Y N Have you ever been markedly overweight?

Y N Have you ever felt fat or tried to lose weight despite family or friends saying that you were not over overweight?

Y N To lose weight, have you ever made yourself vomit or taken laxatives, diuretics (water pills), or diet pills?

Y N Have you frequently eaten large amounts of food in binges and felt guilty afterwards?

Y N If yes, did you then vomit?

Y N Have you ever had a period of confusion, for example, while hospitalized or ill, during which you became confused and lost track of where you were or what day it was or could not recognize people you knew?

Y N Do you often forget where you put things, have trouble finding your way home, or forget what people tell you unless you write it down?

Y N Have you ever before consulted a Psychiatrist?

Y N Have you ever consulted a Psychologist, Social Worker, or any other type of therapist?

Serenity HEALTH CENTERS

PSYCHIATRIC HISTORY CHECKLIST

Y N Have you ever been hospitalized for psychiatric reasons or for detoxification?

Y N Have you ever received shock treatments (ECT / electroconvulsive therapy)?
If so, Where/when: _____

Y N Have you ever received TMS treatments before (Transmagnetic Stimulation Therapy)?
If so, Where/ When: _____

Y N Have you ever felt depressed almost every day for at least two weeks?

Y N Have you ever had a period of time lasting days to weeks when you felt clearly different than your usual self; your mood was euphoric or irritable; you felt more energetic, talkative, sociable, or creative; thoughts raced through your mind; you felt little need for sleep; you bought things without considering whether you could afford them; your sex drive was increased; and you felt you could conquer the world? ***(If yes, please circle which one(s).)***

Y N Have you ever had compulsions (repetitive seemingly purposeful but unnecessary) behaviors such as checking the doors several times before leaving home, frequent handwashing, counting things repeatedly, etc.?

Y N Have you ever had sudden attacks of anxiety or nervousness?

Y N Have you ever had phobias (fears of specific situations or things such as heights, enclosed placed, open places, driving, flying, roaches, etc.)?

Y N Do you become so anxious in social situations or when called upon to talk or perform that you have difficulty speaking or performing?

Y N Have you frequently found yourself in places without knowing how you got there, found personal belongings in places you did not recall having placed them, been greeted by people who seemed to know you but you did not know them, or been unable to account for what you had been doing for some period of time? ***(If yes, please circle which one(s).)***

Y N While you were fully awake, have you ever heard voices talking to you or about you that did not come from anyone near you?

Y N Have you ever seen things, such as faces, animals, or ghosts, that other people could not see?

Y N Have you ever tasted or smelled things or felt things touching you or crawling on you when nothing was there?

Y N When you were in public, have you often felt that people were watching you, following you, talking about you, reading your mind, putting thoughts into your mind, trying to hurt or control you in some way, or plotting against you?

Y N Has it often happened that things you've seen appeared larger, smaller, closer, or farther away than you knew them to be?

Y N In familiar places, have you often felt that you've been there before, or have familiar places often seemed strange, different or unfamiliar?

Y N Have you ever injected anything into your veins?

How many cups, glasses, or cans of beverages containing caffeine (coffee, tea, colas) do you drink in a day? _____

Serenity HEALTH CENTERS

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MEDICAL HISTORY / REVIEW OF SYSTEMS CHECKLIST

PLEASE CIRCLE EACH ITEM YOU HAVE HAD OR EXPERIENCED:

Head Injury | Seizure/ Convulsion | Loss of consciousness | Stroke
Recurrent headaches | Encephalitis | Meningitis | Dizziness
Weakness | Numbness/ Tingling | Other Neurological disorder:_____

Glaucoma | Cataract | Loss of vision | Retina/ Macular disease
Hearing Loss | Tinnitus / Persistent ringing in the ears

Itching | Psoriasis | Other persistent skin rash:_____

OsteoArthritis | Rheumatoid Arthritis | OsteoPorosis | Lupus | Fibromyalgia | Back problems:_____

Asthma | Emphysema | Chronic Bronchitis | Pulmonary Embolism | COPD | Shortness of breath
Wheezing | Wear CPAP machine | Other Lung Disease:_____

High Blood Pressure | Low blood pressure | Fainting spells | Rheumatic Fever | Heart Murmur
Mitral valve prolapse | Congestive Heart Failure | Angina / Chest pain | Heart attack | Pacemaker
Endocarditis / Heart valve infection | Arrhythmia / abnormal heartbeat / Atrial Fibrillation | High Cholesterol/ triglycerides
Other Heart Condition:_____

Esophageal spasm | Peptic / duodenal Ulcer | Irritable Bowel Syndrome | Persistant constipation/ diarrhea
Crohn's Disease | Ulcerative Colitis | Diverticulosis / Diverticulitis | Pancreatitis | Hepatitis | Jaundice
Gallstones | Abdominal pains | Persistent nausea / vomiting | Hernia
Other stomach/ intestinal issues :_____

Kidney Failure | Kidney Stones | Recurrent Urinary Infections | Urinary Blockage | Incontinence
Other bladder / kidney issues :_____

Diabetes | Hypoglycemia | Hyperthyroid | Hypothyroid | Infertility | Other thyroid:_____

Anemia | Bleeding tendency | Porphyria | Cancer:_____

Positive HIV test | Herpes _____ | Syphilis | Mononucleosis | Malaria | Lyme Disease
Positive TB Test | Other Infectious Disease :_____

Poisoning | Traumatic Injury:_____ | COVID Vaccine _____ | Boosters X _____ | Type_____

MEN ONLY: Prostate issues _____ | Vasectomy | Breast surgery | Mastectomy

Women ONLY: # of Pregnancies: _____ # of Cesarean sections (C-Sections) _____ # of Abortions _____
# of Live births _____ # of Stillbirths _____ # of Miscarriages _____
D&C # _____ | Hysterectomy | Tubal Ligation | Ovary Removed | Right | Left
Age first began Menses_____

Surgery: Tonsils:_____ Adenoids:_____ Appendix :_____ Gallbladder :_____ Hernia :_____
(Date/Yr) Hemorrhoids :_____ Abdominal:_____ Heart / CABG::_____
Breast Surgery :_____ Mastectomy Right Left :_____ Hysterectomy: _____
Tubal Ligation: _____ Ovary Removed Right Left :_____
Other (specify) _____

ALLERGIES TO MEDICATIONS:_____ **None**___

_____

Serenity HEALTH CENTERS

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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 /
Cocaine/ Crack
Quaaludes/ Barbiturates
Tobacco
Marijuana/ grass/ Pot/ Weed/ Hash/ Reefer
Psilocybin/ Mushrooms
Adderall/ Adderall XR
Methylin/ Methylphenidate
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

Serenity
HEALTH CENTERS

BDI (Beck Depression Inventory)

Instructions: On this questionnaire are groups of statements. Please read all the statements in a given group.Then pick out at least one statement in each group which describes you best in terms of this past week. Circle the number beside the statement you have chosen. If several statements in the group seem to apply equally well, circle each one. Be sure to read all the statements in each group before making your choice(s).

1.
0 I do not feel sad.
1 I feel sad
2 I am sad all the time and I can't snap out of it.
3 I am so sad and unhappy that I can't stand it.

2.
0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel the future is hopeless and that things cannot improve

3.
0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4.
0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything

5.
0 I don't feel particularly guilty
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6.
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7.
0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8.
0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens

9.
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance

10.
0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.

11.
0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.

Serenity
HEALTH CENTERS

12. **0** I have not lost interest in other people.

1 I am less interested in other people than I used to be.

2 I have lost most of my interest in other people.

3 I have lost all of my interest in other people.

13. **0** I make decisions about as well as I ever could.

1 I put off making decisions more than I used to.

2 I have greater difficulty in making decisions than I used to.

3 I can't make decisions at all anymore.

14. **0** I don't feel that I look any worse than I used to.

1 I am worried that I am looking old or unattractive.

2 I feel there are permanent changes in my appearance that make me look unattractive

3 I believe that I look ugly.

15. **0** I can work about as well as before.

1 It takes an extra effort to get started at doing something.

2 I have to push myself very hard to do anything.

3 I can't do any work at all.

16. **0** I can sleep as well as usual.

1 I don't sleep as well as I used to.

2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.

3 I wake up several hours earlier than I used to and cannot get back to sleep

17. **0** I don't get more tired than usual.

1 I get tired more easily than I used to.

2 I get tired from doing almost anything.

3 I am too tired to do anything

18. **0** My appetite is no worse than usual.

1 My appetite is not as good as it used to be.

2 My appetite is much worse now.

3 I have no appetite at all anymore.

19. **0** I haven't lost much weight, if any, lately.

1 I have lost more than five pounds.

2 I have lost more than ten pounds.

3 I have lost more than fifteen pounds

I am purposely trying to lose weight by eating less

Yes _____ **No** ____

20. **0** I am no more worried about my health than usual.

1 I am worried about physical problems like aches, pains, upset stomach, or constipation.

2 I am very worried about physical problems and it's hard to think of much else.

3 I am so worried about my physical problems that I cannot think of anything else.

21. **0** I have not noticed any recent change in my interest in sex.

1 I am less interested in sex than I used to be.

2 I have almost no interest in sex.

3 I have lost interest in sex completely.

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

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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 confidentional, 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: _____

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

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Jan 2, 2023

Serenity HEALTH CENTERS

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.

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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.

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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

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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 Rescedule 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 Contact's 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 to the patient not coming in to their scheduled appointments as determined by their provider. _____ ***(initial)***

Patient Signature:_____ Date: _____

Parent/ Guardian Signature:_____ Date: _____

Pritha R. Dhungana, MD, FAACAP
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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: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

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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.