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

Support@SerenityHC.net

Hello and welcome to our office.

The following paperwork is everything you need to fill out and either **fax, email, or upload within 2 days of receiving it.** To guarantee your appointment, ONLY those with fully COMPLETED paperwork received **PRIOR to** the appointment will be guaranteed. PLEASE arrive **45 minutes PRIOR** to your scheduled appointment time. Every document is essential and has a purpose, please fully complete each page, prior to our first meeting with you or your child.

Documents needing to bring with you: *Appointment Time:*_____ *Appointment Date :*_____

- ☐ 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 seek or any medication. 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 45 minutes prior** to your appointment time, if you have **completed** all your New Patient paperwork, and have sent it to: **email:** *Support@SerenityHC.net*, ***or faxed to 352-241-4282*** within 48 hours of receiving it.
- ❖ Please bring in your medication list and bottles of your medications.
- ❖ Please ensure you **CONFIRM** your appointment at least 24 hours in advance of every visit to avoid a **$50 Fee**

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 ***adopted:*** Legal court paperwork is required.

Thank You,
Serenity Health Centers

Patient Name:_____

Patient/ Guardian Signature:_____ Date_____

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? _____

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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 contact 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: _____

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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: _____

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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.

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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/ocr/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

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

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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

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(21)

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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:_____

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

Patient Name:_____ Date: _____

Past Psychiatric Medication list

Treatment Type	Brand Name	Dose	Adverse Effects
Amitriptyline	Elavil®, Endep®	200 mg	
Imipramine	Tofranil®	200 mg	
Desipramine	Norpramin®, Pertofrane®	200 mg	
Trimipramine	Surmontil®	200 mg	
Clomipramine	Anafranil®	200 mg	
Maprotiline	Ludiomil®	200 mg	
Doxepin	Sinequan®	200 mg	
Nomifensine	Merital®	75 mg	
Nortriptyline	Pamelor®, Aventyl®	40 mg	
Protriptyline	Vivactil®		
Fluoxetine	Prozac®	20 mg	
Citalopram	Celexa®	20 mg	
Fluvoxamine	Luvox®	200 mg	
Paroxetine	Paxil®	20 mg	
Paroxetine CR	Paxil CR®	25 mg	
Sertraline	Zoloft®	100 mg	
Escitalopram	Lexapro®	10 mg	
Venlafaxine (incl. IR	Effexor® (incl. IR & XR)	225 mg	
Duloxetine	Cymbalta®	40 mg	
Desvenlafaxine	Pristiq®	50mg	
Levomilnacipran	Fetzima®	40mg	

Treatment Type	Brand Name	Dose	Adverse Effects
Bupropion (incl. IR, SR, & XL)	Wellbutrin® (incl. IR, SR, & XL), Aplenzin®	300 mg, Aplenzin: 2 pills are equivalent to	
Mirtazapine	Remeron®	30 mg	
Nefazodone	Serzone®	300 mg	
Trazodone (Incl. XR)	Desyrel®, Oleptro®	400 mg, Oleptro: 200 mg	
Amoxapine	Asendin®	400 mg	
Vilazodone HCL	Viibryd®	40 mg	
Vortioxetine	Brintellix®	20 mg	
Phenelzine	Nardil®	60 mg	
Selegiline	Eldepryl®	40 mg	
Selegiline transdermal patch	Emsam®	6 mg	
Tranylcypromine	Parnate®	40 mg	
Isocarboxazid	Marplan®	40 mg	
Atypical Antipsychotics	Abilify®, Geodon®, Risperdal®, Seroquel®, Zyprexa®, Invega®, Saphris®,	any dose	
Lithium	Eskalith®, Lithobid®, others	any dose	
Thyroid Hormone	Synthroid®, Levoxyl®, others	any dose	
Olanzapine/Fluoxeti	Symbyax®	any dose	
Unilateral, bilateral or unknown		≥7 treatments total during one episode	

Patient Health Questionnaire (PHQ-9)

Name: _____ Date: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?	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: Total Score _____ = _____ ÷ _____ ÷ _____

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