RMNA Rocky Mountain Neuropsychiatric Associates

Kevin Kilimann, M.D.
Richard D. Marciniak, M.D.

Welcome to our Practice. Please take a few moments to read and complete these forms. Our office staff will be glad to assist you and answer any questions you may have.

Treatment Philosophy

The focus of treatment at Rocky Mountain Neuropsychiatric Associates (RMNA) is on diagnostic evaluation and management of psychotropic medications. Your initial evaluation will generally be scheduled for one hour, with subsequent follow-up visits of 15-20 minutes. If your treatment would be enhanced by psychotherapy (counseling) then your RMNA psychiatrist will assist you in obtaining an appropriate referral to a therapist.

Initials: _____

Emergency Access

Practitioners are available after hours to handle emergencies. By calling the main office number (473-2346) afterhours, you will be instructed how to contact the on-call physician.

Initials: _____

Cancellation and Missed Appointment Policy

RMNA requires patients to provide a minimum of 24 hours notice to cancel an appointment. Failure to provide such notice will result in a $50 missed appointment fee for a follow-up visit and the full fee of $275 for an initial appointment. Repeated no-show or late cancel appointments will result in termination of care from our office and a referral back to your insurance company for a list of other providers who may be able to assist in you. Fees associated with missed appointments are the sole responsibility of the patient.

Initials: _____

New Patient Scheduling Policies

RMNA requires that all new patients secure their initial evaluation with a VISA or MasterCard. If you do not have either of these credit cards, we will gladly accept pre-payment in full by cash or certified funds. Your credit card will be processed or funds deposited if your initial appointment is not kept or less than 24 hours notice is given to cancel according to our policy outlined above. Please fill out your payment option and attach your payment if necessary. Personal checks are not accepted as a form of payment for initial evaluations.

Initials: _____

Please mark one: ◯ VISA ◯ MasterCard

Card # _____ - _____ - _____ - _____

Expiration: ___ ___ / ___ ___ CVV Code: ___ ___ ___

RMNA also asks that the patient contact his/her insurance company and obtain any required authorization needed for treatment. Our office will assist in scheduling an initial evaluation once the authorization information has been provided.

Initials: _____

Insurance Coverage and Co-Payments

RMNA agrees to bill your insurance company for services provided as a courtesy. All co-payment and deductible amounts are the responsibility of the patient and due at time of service. At any time during treatment should you become ineligible for insurance coverage, you are required to notify RMNA with the understanding that you will be 100% responsible for any charges incurred. All questions regarding your coverage, benefits, co-payments and deductibles should be directed to your insurance company.

Initials: _____

Services NOT Covered by Insurance

During the course of your treatment, it may be necessary to provide you with a service that is not typically covered by insurance. Some examples are (but not limited to): reports, staffing, phone conferences, legal issues, court testimony and non-emergent treatment oriented phone calls. Your doctor will notify you of any fees associated with a service not payable by your insurance company. These fees are payable 100% by the patient.

Initials: _____

Prescription Refill Policy

It is the policy of RMNA to provide enough refills to last until your next scheduled appointment. We realize that unforeseen events may occur that could make in interim refill necessary. If you need a refill, please call your pharmacy and ask them to fax us the request. This is the fastest way to refill your medications. Because we ask for a week's notice to refill your medications, it is your responsibility to make sure you do not run out of your prescription. Refill requests are not considered an emergency and will not be treated as such.

Initials: _____

Office Hour Policy

Office Hours are subject to change without notice.

Initials: _____

I have read and understand the above policies and information.

_____ _____

Patient Name Date

Rocky Mountain Neuropsychiatric Associates, PC
6160 Tutt Blvd., Suite 100
Colorado Springs, CO 80923
Office: (719) 473-2346 • Fax: (719) 577-9627 • Email: info@rmna.co

Patient Registration Form - Please complete entirely

Name_____ Date of Birth _____

Sex: M○ F○ Soc Sec #_____ Marital Status M○ S○ D○ W○

Address_____
City State Zip

Cell # _____ Email Address _____

Home Ph# _____ Employer_____ Work Ph#_____

Responsible Party Information:

Responsible Party Name_____

Address, if different from yours_____

Home Ph#_____ SS#_____ Date of Birth_____

Responsible Party Employer_____ Work ph#_____

Your relationship to responsible party (check): Self○ Spouse○ Child○ Other○

Emergency Contact Name and Ph# _____

Insurance Information

Primary Ins. Co_____ Phone #_____

Claims Address _____

Name of Insured _____ DOB _____ Relation to you_____

Insure ID/Policy # _____ Group # _____

Secondary Ins. Co. _____ Phone# _____

Claims Address _____

Name of Insured _____ DOB _____ Relation to you _____

Insure ID/Policy _____ Group# _____

Patient Information

Payment is expected at time of service.

Authorization: The above information is warranted to be true. I agree to be responsible for the charges incurred. If insurance is available, I authorize release of information for the purpose of filing claims. I also authorize payment of insurance benefits directly to _____.

_____ _____

Patient Name Date

_____ _____

Insured/Responsible Party Name Date
(If other than patient)

RMNA
Rocky Mountain
Neuropsychiatric Associates
6160 Tutt Boulevard Suite 100
Colorado Springs, CO. 80923
NOTICE OF HEALTH CARE INFORMATION 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.

Rocky Mountain Neuropsychiatric Associates is committed to the protection of patient's privacy and confidentiality of medical information. RMNA recognizes that patients depend upon us to safeguard their personal information and to uphold the privacy rights of patients. This notice, which is based upon state and federal law, as well as the RMNA code of ethics, confirms our commitment to preserving patient confidentiality and privacy and also confirms that RMNA will not use or disclose patient personal or health information except as described in this Notice. This Notice applies to all of the personal information gathered by and medical records generated by RMNA as well as records received from other providers.

USES AND DISCLOSURES FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS: Without your authorization, RMNA may use and disclose your personal and/or health information for the following purposes:

Treatment: RMNA may use your personal and/or health information in the provision and coordination of your healthcare. RMNA may disclose all or any portion of your personal and/or health information to your attending RMNA physician other RMNA psychiatrists, therapists and other affiliated health care providers who have legitimate need for such information to facilitate our care and treatment. Other ways we may use and disclose your information for purposes related to treatment are:

Laboratory Support: Name, diagnosis and contact phone number may be required by laboratory, imaging, and other medical resources for scheduling authorization and billing purposes.

Treatment Alternatives: To tell you about or recommend possible treatment options or alternatives that may be of interest to you.

Appointment Reminders: To contact you as a reminder that you have an appointment for treatment or medical care at RMNA.

Payment: RMNA may release personal and/or health information about you for the purposes of determining insurance coverage, billing claims management, medical data processing, and reimbursement. The information may be released to an insurance company, or other entity (or their authorized representatives) involved in the payment of your medical bill and may include copies or excerpts of your medical record which are necessary for payment of the account. For example, a bill may include information that identifies you, your diagnosis, and the procedures, time and supplies used. RMNA may also provide information to other care providers who have been involved in your care, such as a home health care agency or an ambulance company.

Healthcare Operations: RMNA may use and disclose your personal and/or health information during healthcare operations including quality assurance, utilization review, medical review, internal auditing, accreditation, certification, licensing activities of RMNA, medical research, and educational purposes. RMNA may engage outside companies to carry out certain aspects of healthcare operations. These entities are called “Business Associates”. RMNA may need to disclose your information to Business Associates to allow them to perform their duties. The Business Associates will, in turn, use and disclose your information as they conduct business on behalf of RMNA. Examples of Business Associates include, but are not limited to, a copy service used by RMNA to copy medical records, consultants, accountants, lawyers,

medical transcriptions and billing companies. RMNA requires their Business Associates to protect the confidentiality of your personal and health information in compliance with appropriate security laws and regulations.

OTHER USES AND DISCLOSURES THAT ARE REQUIRED OR PERMITTED WITHOUT AUTHORIZATION

Special situations and certain state and federal laws may require RMNA to use or release your information. For example, RMNA may be obligated to release your information for the following reasons:

RESEARCH: Under certain circumstances, RMNA may use and disclose your health information for approved clinical research. For example, a research project may involve comparing the health and recovery of patients who received one medication for their medical condition to those who received a different medication for the same condition.

REGULATORY AGENCIES: RMNA may disclose your personal and/or health information to government and certain private health oversight agencies, such as the Department of Public Health and Environment, the Federal Department of Health and Human Services, or the Board of Medical Examiners for activities authorized by law including, but not limited to, licensure certification, audits, investigations, and inspections. These activities are necessary to monitor compliance with the requirements of government programs.

LAW ENFORCEMENT/LITIGATION: RMNA may disclose your personal and/or health information for law enforcement purposes as required by law or in response to a court order.

PUBLIC HEALTH: As required by law, RMNA may disclose your personal and/or health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability. For example, RMNA is required to report the existence of several communicable diseases including, but not limited to acquired immune deficiency syndrome ("AIDS"), to the Department of Public Health and Environment to protect the health and well-being of the general public.

WORKERS' COMPENSATION: RMNA may release personal and/or health information about you to workers' compensation or similar programs. These programs provide benefits for work related injuries or illnesses.

MILITARY VETERANS: RMNA may disclose your personal and/or health information as required by military command authorities, if you are a member of the armed forces.

AS OTHERWISE REQUIRED BY LAW: RMNA will disclose your personal and/or health information in any situation where such disclosures are required by law (such as child abuse or domestic abuse).

USES AND DISCLOSURES REQUIRING YOUR AUTHORIZATION: Without your authorization, RMNA may not disclose your personal and/or health information to persons outside of RMNA for purposes other than treatment, payment, healthcare operations, or special circumstances as listed above. In addition, RMNA may not use or disclose specially sensitive information, such as AIDS, alcohol and drug abuse prevention and or treatment, or mental health information without your specific authorization unless legally required to do so.

FAMILY/FRIENDS: With your authorization, RMNA may disclose your personal and/or health information to a friend or family member who is involved in your medical care. RMNA may also provide information to someone who helps pay for your care. RMNA may also tell your family or friends of your condition and that you are in the hospital. In addition RMNA may disclose information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status, and location. RMNA also may disclose your information to other people outside RMNA who may be involved in your medical care after you leave RMNA, such as clergy and others used to providing services that are part of your care.

YOUR RIGHTS RELATED TO YOUR PERSONAL AND HEALTH INFORMATION

Although all records concerning your treatment obtained at RMNA are the property of RMNA, you have the following rights concerning your personal and health information.

CONFIDENTIAL COMMUNICATIONS: You have the right to request confidential communications of your information by alternative means or at alternative locations. For example, you may request that RMNA only contact you at work or by mail.

REQUEST TO REVIEW AND COPY: You have the right to request a review and/or a copy of your health information except as restricted by your physician or by law. This right does not obligate RMNA to grant you access to certain types of information.

AMEND: You have the right to request an amendment or correction to your health information. If RMNA agrees that an amendment or correction is appropriate, we will ensure that the amendment or correction is attached to your medical record.

AN ACCOUNTING: You have the right to obtain a statement of the disclosures that have been made of your personal and health information other than by your authorization, other than disclosures made by you, and other than for the purpose of treatment, payment or operational purposes.

REQUEST RESTRICTIONS: You have the right to request restrictions on certain uses and disclosures of your information. If RMNA is able to agree to your request, we will abide by the restrictions.

RECEIVE A COPY OF THIS NOTICE: If this Notice has been provided to you electronically, upon request you have the right to receive a paper copy of this Notice.

REVOKE AUTHORIZATION: You have the right to revoke your authorization to use or disclose your information except to the extent that action has already been taken in reliance on your authorization.

IF YOU BELIEVE THAT YOUR RIGHTS HAVE BEEN VIOLATED: You may file a complaint with RMNA or with the Secretary of the Department of Health and Human Services. To gain information on how to file a complaint with RMNA, contact the office at 473-2346. All complaints must be submitted in writing addressed to RMNA 2860 S. Circle Dr. Ste. 160 Colorado Springs, Co 80906. You may be assured there will be no retaliation for filing a complaint.

CHANGES TO THIS NOTICE: RMNA will abide by the terms of the Notice currently in effect. RMNA reserves the right to change the terms of this Notice at any time. Any new notice provisions will be effective for all protected health information that it maintains. Any new revision to this Notice will be posted at your RMNA facility.

NOTICE EFFECTIVE DATE: The effective date of the Notice is February 10, 2005.

RMNA
Rocky Mountain
Neuropsychiatric Associates
6160 Tutt Boulevard Suite 100
Colorado Springs, CO. 80923

Privacy Notice and Acknowledgement

_____ DOB: _____ / _____ / _____
Patient Name

Acknowledgment
I acknowledge that I have received the attached Notice of Privacy Practices.

_____ Date: _____ / _____ / _____
Signature of Patient or Personal Representative

If Personal Representative's signature appears above, please print name and describe Personal Representative's relationship to the patient:

_____

Rocky Mountain Neuropsychiatric Associates

Phone Message Consent Form

Notice of Privacy Practices – Patient Acknowledgement

We at Rocky Mountain Neuropsychiatric Associates are committed to safeguarding the privacy and confidentiality of your medical record including the personal information that you share with us. We comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

From time to time it may be necessary or desirable to contact patients by phone. To expedite your health care and in the interest of convenience, if you are not available to speak with us directly, we would like to leave a message whenever possible.

To assist us in protecting your privacy, please complete the following:

_____ DOB: _____ / _____ / _____

Patient Name (please print)

I wish to be contacted in the following manner (mark all that apply):

Home Phone: _____

Leave a detailed voicemail message? ◯ **Y** ◯ **N**

Leave a message with call back number? ◯ **Y** ◯ **N**

Cell Phone: _____

Leave a detailed voicemail message? ◯ **Y** ◯ **N**

Leave a message with call back number? ◯ **Y** ◯ **N**

Work Phone: _____

May we call you at work? ◯ **Y** ◯ **N**

Leave a detailed voicemail message? ◯ **Y** ◯ **N**

Leave a message with a call back number? ◯ **Y** ◯ **N**

Email: _____

May we email you with appt. time, date, doctor and location? ◯ **Y** ◯ **N**

Other requests_____

May we speak to someone else regarding your medical care? ◯ **Y** ◯ **N**

Name of Person: _____ Relationship_____

I understand that I may revoke this consent in writing at any time.

Print Name: _____ Date: _____ / _____ / _____

Relationship to the Patient: _____ Witness**:** _____

ROCKY MOUNTAIN NEUROPSYCHIATRIC ASSOCIATES / MEDICAL SCREEN - PAGE 1

NAME: _____ DATE: _____

AGE: _____ SEX: M_____ F_____ DATE OF BIRTH: _____

Family Physician: _____ Last seen: _____

Reason for visit: _____

All current medications and doses: _____

_____

List all **previous** psychiatric medications tried: _____

_____

_____

Sleep history:
Hours sleep per night _____ How long getting to sleep _____ Night wakings: Y_____ N_____

Sleep aids: Prescriptions_____ Over the Counter_____ Alcohol_____ Other drugs_____ None_____

Substance use/abuse:
Do you drink at all? _____ How often? _____ How much? _____ Where? _____

Do you use any "street" drug? _____ How often? _____ What drugs? _____

Do you use tobacco? _____ What kind?_____ How often? _____

Has either drugs or alcohol ever caused: (check) Arguments at home_____ Fights /brawls_____ Work problems/ lateness_____ Injury_____ Accident_____ Driving citation (DUI/DWAI) _____ Other legal problem_____.

Psychiatric hospitalizations:

When	Where	Why	How long and results

Outpatient treatments:

When	Where	Why	Outcome

PERSONAL MEDICAL HISTORY

MEDICATION ALLERGIES: _____

Cardiac___ Diabetes___ Respiratory___ Endocrine (thyroid, etc.) ___ Blood Pressure___ Anemia___ Other___

Describe: _____

_____

Surgical history: _____

_____

OB - GYN history: Pregnancies _____ Births _____ Hx. Postpartum depression/psychosis: Y___ N___

Premenstrual depressions, agitation or mood swings: _____

_____ Menopausal /postmenopausal: Y___ N___

Neurological history: Closed head injury, concussion, seizure, severe headaches or migraines: Y___ N___

Describe and treatments: _____

_____

History of developmental, learning or school problems: Y___ N___

FAMILY HISTORY- NOT PERSONAL HISTORY

Medical History: (check all applicable and add as needed):

Cardiac___ Diabetes___ Respiratory___ Inflammatory/Pain___ Endocrine___ Seizure___ Other___

Describe: _____

_____

Psychiatric history:
Depression or Bipolar Disorder: _____

Anxiety, panic or phobic illness: _____

Psychosis or Schizophrenia: _____

Suicides: _____

Substance abuse: _____

Other: _____

Depression Self-Rating Test

Nearly 20 million Americans experience depression but many will never seek treatment. The Depression Self-Rating Test is a simple 16-question quiz that can help identify common symptoms of depression and their severity. Remember- depression is more than just feeling down- it is a real medical condition that can be effectively treated.

Please complete the following questionnaire and return it to your healthcare provider.

Name: _____ Date of Birth: _____ Today's Date_____

Instructions: Please check the one response to each item that best describes you for the past seven days.

1. Falling asleep:
___ (0) I never take longer than 30 minutes to fall asleep.
___ (1) I take at least 30 minutes to fall asleep, less than half the time.
___ (2) I take at least 30 minutes to fall asleep, more than half the time.
___ (3) I take more than 60 minutes to fall asleep, more than half the time.

2. Sleep during the night:
___ (0) I do not wake up at night.
___ (1) I have a restless, light sleep with a few brief awakenings each night.
___ (2) I wake up at least once a night, but I go back to sleep easily.
___ (3) I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.

3. Waking up too early:
___ (0) Most of the time, I awaken no more than 30 minutes before I need to get up.
___ (1) More than half the time, I awaken more than 30 minutes before I need to get up.
___ (2) I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
___ (3) I awaken at least one hour before I need to, and can't go back to sleep.

4. Sleeping too much:
___ (0) I sleep no longer than 7-8 hours/night, without napping during the day.
___ (1) I sleep no longer than 10 hours in a 24-hour period including naps.
___ (2) I sleep no longer than 12 hours in a 24-hour period including naps.
___ (3) I sleep longer than 12 hours in a 24-hour period including naps.

5. Feeling sad:
___ (0) I do not feel sad.
___ (1) I feel sad less than half the time.
___ (2) I feel sad more than half the time.
___ (3) I feel sad nearly all of the time.

6. Decreased appetite:
___ (0) There is no change in my usual appetite.
___ (1) I eat somewhat less often or lesser amounts of food than usual.
___ (2) I eat much less than usual and only with personal effort.
___ (3) I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

7. Increased appetite:
___ (0) There is no change from my usual appetite.
___ (1) I feel a need to eat more frequently than usual.
___ (2) I regularly eat more often and/or greater amounts of food than usual.
___ (3) I feel driven to overeat both at mealtime and between meals.

8. Decreased weight (within the last two weeks):
___ (0) I have not had a change in my weight.
___ (1) I feel as if I've had a slight weight loss.
___ (2) I have lost 2 pounds or more.
___ (3) I have lost 5 pounds or more.

9. Increased weight (within the last two weeks):
___ (0) I have not had a change in my weight
___ (1) I feel as if I've had a slight weight gain.
___ (2) I have gained 2 pounds or more.
___ (3) I have gained 5 pounds or more.

10. Concentration/Decision making:
___ (0) There is no change in my usual capacity to concentrate or make decisions.
___ (1) I occasionally feel indecisive or find that my attention wanders.
___ (2) Most of the time, I struggle to focus my attention or to make decisions.
___ (3) I cannot concentrate well enough to read or cannot make even minor decisions

11. View of myself:
___ (0) I see myself as equally worthwhile and deserving as other people
___ (1) I am more self-blaming than usual.
___ (2) I largely believe that I cause problems for others
___ (3) I think almost constantly about major and minor defects in myself

12. Thoughts of death or suicide:
___ (0) I do not think of suicide or death,
___ (1) I feel that life is empty or wonder if it's worth living.
___ (2) I think of suicide or death several times a week for several minutes.
___ (3) I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life

13. General interest:
___ (0) There is no change from usual in how interested I am in other people or activities.
___ (1) I notice that I am less interested in people or activities.
___ (2) I find I have interest in only one or two of my formerly pursued activities.
___ (3) I have virtually no interest in formerly pursued activities

14. Energy level:
___ (0) There is no change in my usual level of energy.
___ (1) I get tired more easily than usual.
___ (2) I have to make a big effort to start or finish my usual daily activities (for example: shopping homework, cooking, or going to work).
___ (3) I really cannot carry out most of my usual daily activities because I just don't have the energy.

15. Feeling slowed down:
___ (0) I think, speak, and move at my usual rate of speed.
___ (1) I find that my thinking is slowed down or my voice sounds dull or flat
___ (2) It takes me several seconds to respond to most questions, and I'm sure my thinking is slowed.
___ (3) I am often unable to respond to questions without extreme effort

16. Feeling restless:
___ (0) I do not feel restless.
___ (1) I'm often fidgety, wringing my hands, or need to shift how I am sitting.
___ (2) I have impulses to move about and am quite restless.
___ (3) At times, I am unable to stay seated and need to pace around.

<u>This section is to be completed by your doctor.</u>

To Score:
_____ Enter the highest score on any 1 of the 4 sleep items (1-4)
_____ Item 5
_____ Enter the highest score on any 1 appetite/weight item (6-9)
_____ Item 10
_____ Item 11
_____ Item 12
_____ Item 13
_____ Item 14
_____ Enter the highest score on either of the 2 psychomotor items (15 and 16)
_____ TOTAL SCORE (Range 0---27)

Scoring Criteria: Normal 0-5 Mild 6-10 Moderate 11-15 Severe 16-20 Very Severe 21+
NOTE; The above cutoff points are based largely on clinical judgment rather than on empirical data.

References; I .National Institute of Mental Health website. Depression Research at the National Institute of Mental Health Fact Sheet Available at;
http;//www .nimh .nih.gov /publicat /depresfact.cfm . Accessed November 28,2002.
41-123032 SAP 8019

Name: _____ Date: _____ / _____ / _____

Mood Questionnaire

The questions you are about to answer will help your doctor provide a proper diagnosis. Please discuss the results of this questionnaire with your doctor.

Instructions for patients: Please check ONE BOX ONLY for each of the questions below. The following three questions will ask you about a history of mania.*

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self, or you were so hyper that you got into trouble?	☐	☐
..you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative and/or spoke much faster than usual?	☐	☐
... thoughts raced through your head and/or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
..you were much more active and/or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual-for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐

2. If you checked YES to more than one of the above, have you experienced several of these during the same period of time?

☐ YES ☐ NO

3. How much of a problem did any of these situations cause you (like being unable to work; having family, money, or legal problems; and/or getting into serious arguments or fights)?

☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem

*Reprinted with permission from Robert MA. Hirschfeld, MD.

Two questions about yourself

These questions will ask you about current feelings of depression.

1. During the past month, have you often been bothered by feeling down, depressed, or hopeless?

◯ YES ◯ NO

2. During the past month, have you often been bothered by little interest or pleasure in doing things?

◯ YES ◯ NO