Fig Tree Behavioral Wellness
Dr. Velma Vega-Hughes, DNP, APRN, PMHNP-BC
Board Certified Psychiatric Mental Health Nurse Practitioner
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NEW PATIENT REGISTRATION FORM

Today's Date:	How did you hear about our service?	
Person Filling Out Form:	Relationship to Patient:	
Patient's Name:		
Patient's DOB:	Patient's Age:	Phone:
Gender Identity:	Preferred Pronouns:	
Address/City/State/Zip:	Email:	
Current medical insurance:	Member ID:	Group #:
Primary Care Provider/ Family Doctor:		

Chief complaint/Reason for Appointment:

Diagnosed with a mental health condition: ____No ___Yes When?

List all current medications with dosage:

Allergies:

Currently seeing a Therapist:_____No _____Yes Therapist: How long?

History of psychiatric hospitalization or testing: _____No _____Yes
When & What for?

Medical History: Surgical History:

Substance abuse (illicit and/or prescribed drugs/alcohol/tobacco, etc) ____No ____Yes
Current/how long ago?

Suicidal ideations: ____No _____Yes Current/how long ago?

Thoughts of harming others ____No ____Yes Current/how long ago?

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

PHQ-9	**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
Add the score for each column				

Total Score (add your column scores): _____

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

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
***Please circle your answers*.**

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

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

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

Adult ADHD Self-Report Scale Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

PTSD CheckList – Civilian Version (PCL-C)

Client's Name: _____

Instruction to patient: Below is a list of problems and complaints that veterans sometimes have in response to stressful life experiences. Please read each one carefully, put an "X" in the box to indicate how much you have been bothered by that problem *in the last month*.

No.	Response	Not at all (1)	A little bit (2)	Moderately (3)	Quite a bit (4)	Extremely (5)
1.	Repeated, disturbing *memories, thoughts, or images* of a stressful experience from the past?					
2.	Repeated, disturbing *dreams* of a stressful experience from the past?					
3.	Suddenly *acting* or *feeling* as if a stressful experience *were happening* again (as if you were reliving it)?					
4.	Feeling *very upset* when *something reminded* you of a stressful experience from the past?					
5.	Having *physical reactions* (e.g., heart pounding, trouble breathing, or sweating) when *something reminded* you of a stressful experience from the past?					
6.	Avoid *thinking about* or *talking about* a stressful experience from the past or avoid *having feelings* related to it?					
7.	Avoid *activities* or *situations* because they *remind you* of a stressful experience from the past?					
8.	Trouble *remembering important parts* of a stressful experience from the past?					
9.	Loss of *interest in things that you used to enjoy?*					
10.	Feeling *distant* or *cut* off from other people?					
11.	Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
12.	Feeling as if your *future* will somehow be *cut short*?					
13.	Trouble *falling* or *staying asleep*?					
14.	Feeling *irritable* or having *angry outbursts*?					
15.	Having *difficulty concentrating*?					
16.	Being *"super alert"* or watchful on guard?					
17.	Feeling *jumpy* or easily startled?					

PCL-M for DSM-IV (11/1/94) Weathers, Litz, Huska, & Keane National Center for PTSD - Behavioral Science Division

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CREDIT CARD AUTHORIZATION

I, _____, am authorizing Fig Tree Behavioral Wellness to (Print Patient's Name or Guarantor's Name)

Charge my credit card if I fail to show for a scheduled appointment, or do not give notification of my inability to attend a scheduled appointment in advance.

Please remember that all appointments need to be cancelled at least ***24 business hours in advance*** in order to avoid and fees. All no shows/same day cancellations will be charged $100. **THERE ARE NO REFUNDS ONCE YOUR CREDIT CARD ON FILE HAS BEEN CHARGED FOR THESE FEES.**

Please note reminder calls/texts/e-mails is a courtesy. You are responsible for your appointment whether your reminder was received or not.

I further authorize Fig Tree Behavioral Wellness to disclose information about my attendance /cancellation to my credit card company if I dispute a charge.

Card Type **(circle one):** Visa MasterCard Discover American Express

Card #:_____CVV:_____Exp Date:_____

Name as Printed on Card: _____

Billing Address:_____
(Street, City, State & Zip)

Signature:_____ Date:_____
(Patient or financially responsible party)

This form will be securely stored in your clinical file and may be updated upon request at any time. Please note, your credit card will not be charged unless the following conditions apply: no-show for a scheduled appointment, cancellation of an appointment less than 48 business hours in advance, or participation in treatment (e.g. appointment or phone session) without payment rendered.

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CLINIC POLICIES

- It is your responsibility to notify the office in a timely manner when refills are necessary. Approval of your refill may take up to three business days so please be courteous and do not wait to call. If you use a mail order pharmacy, please contact us fourteen (14) days before your medication is due to run out.

- There will be a $40 charge for letters and/or FMLA paperwork requests. There will be a $25 charge for medical records request for the first twenty pages and $.50 per page for every page thereafter.

- Medication refills will only be addressed during regular office hours (Monday-Friday 9am-5pm). Please notify your provider on the next business day if you find yourself out of medication after hours. **Please do not reach out via Social Media messenger.** No prescriptions will be refilled on Saturday, Sunday or Holidays.

- Refills can only be authorized on medication prescribed by Dr. Hughes. We will not refill medications prescribed by other providers.

- Some medications require prior authorization. Depending on your insurance this process may involve several steps by both your pharmacy and your provider. The providers and pharmacies are familiar with this process and will handle the prior authorization as quickly as possible. Only your pharmacy is notified of the approval status. Neither the pharmacy nor the provider can guarantee that your insurance company will approve the medication. Please check with your pharmacy or your insurance company for updates.

- It is important to keep your scheduled appointment to ensure that you receive timely refills. Repeated no shows or cancellations will result in a denial of refills. All prescriptions require a follow up appointment every 1 to 3 months.

- **After the 3rd no call no show, we will discharge you from services and provide a courtesy 30 day fill of your medications except controlled medications**. If you fail to show or do not cancel in a timely manner to your initial appointment, you will not be rescheduled to see Dr. Hughes.

- Monthly drug screens may be required for controlled medication management.

- If you have any questions regarding medications, please discuss these during your appointment. If for any reason you feel your medication needs to be adjusted or changed please contact us immediately.

- New symptoms or events require a clinic appointment. Please call to set up an appointment for proper assessment.

_____ _____

Patient Signature Date

FIGTREE
Behavioral Wellness

Patient Name: _____

Date of Birth: _____

Medical Record #: _____

Informed Consent for Psychiatric Medications

PURPOSE OF THIS FORM: This form documents that you and your prescriber have discussed your medication(s) to your satisfaction.

Your prescriber has ordered the following medication(s) and has either told you about the medication(s) or given you written information or both. You are entitled to know the following information before deciding to take the medication(s):

1. What your condition or diagnosis is.
2. What symptoms the medication(s) should reduce and how likely the medications are to work.
3. What your chances are of getting better without the medication(s).
4. What other reasonable treatments are available.
5. The name, dosage, frequency, route of administration and the duration of the prescribed medication(s).
6. Side effects of the medication(s) known to commonly occur.
7. Any special indications about taking the medications.

Medications

- By signing this form, you indicate the medication(s) have been explained to you to your satisfaction.
- Even after signing, you can still refuse any dose or withdraw your agreement completely at any time.
- Upon request, you may receive a copy of this consent form.

PLEASE CHECK ONE OF THE FOLLOWING:

☐ I have had the opportunity to receive information about my medication(s) from the prescriber, and **CONSENT** to this treatment. I understant that I can ask questions about my medications at any time. (Informed Consent)

☐ I have had the opportunity to discuss information about the medications with the prescriber, and I **REFUSE** to consent to the medication(s) recommended. I understand that my doctor will continue to offer me the chance to take the medication(s), and information about it, but that I may still refuse the medication(s). (Informed Refusal)

	/ /		/ /
Patient Signature	Date	Provider Signature	Date

If applicable:

Legally Authorized Representative	Relationship to Patient

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PATIENT RIGHTS AND RESPONSIBILITIES

Patient Rights

1. You have the right to dignified and respectful care.
2. You have the right to know about and understand your physical condition.
3. You have the right to obtain any information requested by you to give informed consent before any treatment and/or procedure.
4. You have the right, at your own expense, to consult with another practitioner or psychiatrist.
5. You have the right to refuse treatment, as permitted by law, and to be informed of the consequences of your refusal.
6. You have the right to be treated in a safe environment that is free of physical and psychological threats.
7. You have the right to privacy regarding visitors, mail, and/or telephone conversations.
8. You have the right to expect that all communications and records regarding your care will be held confidential.
9. You have the right to expect continuity of care and that you will not be discharged or transferred to another facility without prior notice.
10. You have the right to request an itemized statement of all services provided to you through this practice.
11. You have the right to be informed of all practice rules and regulations governing your conduct as a patient and to understand the procedure for registering a complaint.
12. You have the right to treatment or accommodations required by your medical condition regardless of race, creed, sex, or national origin.

Patient Responsibilities

1. You are responsible for providing complete information about your health and for reporting the effects of your treatment.
2. You will be responsible for participating in the development of your plan of care.
3. No Show Policy: 1st No show No Charge, 2nd No Show $100, 3rd No Show $100, and the patient will be discharged from services and will be responsible for any balance if balance cannot be collected through Ivy Pay.
4. You will be responsible for considering the rights of other patients and office personnel during your treatment in this practice.
5. You are responsible for following practice rules and policies.

Concern/Complaint Procedure

We want to hear from you if you have any concerns, complaints, or compliments regarding your treatment and care in our practice. Please inform any staff member. Response to a concern/complaint will take place within 24-48 business hours. Concerns/complaints will be monitored, and the information utilized to improve our clinic.

I have been made aware of my rights and responsibilities and the concern/complaint procedure.

Patient Signature:_____ Date: _____

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HIPAA—PATIENT PRIVACY NOTICE

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW THE INFORMATION CAREFULLY.

- Your confidential healthcare information may be disclosed to other healthcare providers for the purpose of providing you with a continuum of quality healthcare.
- Your confidential healthcare information may be disclosed to your insurance provider for the purpose of receiving payment for providing you with healthcare services.
- Your confidential healthcare information may be disclosed to public official or law enforcement agencies in an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your confidential healthcare information may be disclosed to other healthcare professionals in the case of a healthcare emergency.
- Your confidential healthcare information may be disclosed to public health organizations or federal organizations in the matter of communicable diseases, defective devices, or a medication reaction.
- Your confidential healthcare information cannot be disclosed for purposes other than those, which are outlined in this notice.
- Your confidential healthcare information may only be disclosed after receiving written authorization from you. You have the right to revoke your permission to disclose confidential healthcare information at any time.
- You may be contacted by office personnel to remind you of appointments, healthcare treatment options or other health services that may be of interest to you.
- You have the right to restrict the use and disclosure of your confidential healthcare information to family members, friends, or others involved in your healthcare or payment for health care services. However, the practitioner may choose to refuse your restriction if it is in conflict of providing you with quality healthcare or in the event of a medical emergency.
- You have the right to receive confidential communication about your healthcare status.
- You have the right to review and request a copy of any and/or all portions of your healthcare information. Fees may apply.
- You have the right to request changes be made to your healthcare information.
- You have the right to have a copy of this Privacy Notice upon request.
- This office is required by law to protect the privacy of its patients.
- This office will abide by the terms of this notice. We reserve the right to make changes to this notice and continue to maintain the confidentiality of all healthcare information.
- You have the right to complain to the Privacy Officer of this office and to the Secretary of Health and Human Services if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to:

Attn: Sean Hughes
Fig Tree Behavioral Wellness, LLC
2211 W. Lincoln St Ste #313
Harlingen, Tx 78552
All complaints will be investigated. No issue will be raised for filing a complaint with this clinic.