Melissa Sullivan, MD
7982 New LaGrange Road, Ste. 3 Louisville, KY 40222 ❖ p: (502) 657-4551 ❖ f: (502) 919-9001 ❖ mmspsychiatry@gmail.com

Patient Name: _____ Date: _____

HISTORY OF PRESENTING PROBLEM

Please briefly describe the reason/symptons that led to making this appointment.

PAST HOSPITALIZATIONS, COUNSELING OR THERAPY

Have you received any type of hospitalization or office treatment by your family doctor, psychiatrist, psychologist or therapist for a nervous condition, substance abuse or a psychological, psychiatric, family, or marital problem? ❒ yes ❒ no
Please describe below.

Year of Treatment	Treating Therapist/ Physician	Diagnosis or Problem	Type of Treatment (meds, therapy)

PAST PSYCHIATRIC HISTORY

Have you ever been legally committed or admitted voluntarily to a mental hospital or psychiatric unit? ❒ yes ❒ no If yes, please describe:

Have you ever had episodes of racing thoughts, hyperactivity, elevated or irritable mood, not needing sleep and/or impulsive behaviors? ❒ yes ❒ no If yes, please describe:

Have you ever intentionally overdosed on drugs or medications? ❒ yes ❒ no If yes, please describe:

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Have you ever been discharged from any hospital Against Medical Advice (AMA)? ❒ yes ❒ no If yes, please describe:

Have you ever attempted to take your own life? ❒ yes ❒ no If yes, please describe:

Have you ever intentionally cut, burned or disfigured yourself? ❒ yes ❒ no If yes, please describe:

Do you have a history of an eating disorder, binge eating, bulimia or anorexia? ❒ yes ❒ no If yes, please describe:

PSYCHIATRIC MEDICATION HISTORY

If you have ever taken any type of psychiatric medication, please review the following list and indicate anything you can recall about the dosage, length and time of treatment, response and side effects.

Medication Brand (Generic)	Currently Taking	Previously Taken	Max Dose (mg)	Length of Treatment & Year(s) Taken	Response	Side Effects
ANTI-DEPRESSANTS						
Anafranil (clomipramine)						
Ascendin (amoxapine)						
Celexa (citalopram)						
Cymbalta (duloxetine)						
Desyrel (trazodone)						
Effexor (venlafaxine)						
Elavil (amitriptyline)						
Emsam (selegiline)						
Fetzima (levomilnacipran)						
Lexapro (escitalopram)						

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Patient Name: _____ Date: _____

Medication Brand (Generic)	Currently Taking	Previously Taken	Max Dose (mg)	Length of Treatment & Year(s) Taken	Response	Side Effects
Luvox (fluvoxamine)						
Nardil (phenelzine)						
Norpramin (desipramine)						
Pamelor (nortriptyline)						
Parnate (tranylcypromine)						
Pexeva (paroxetine)						
Paxil (paroxetine)						
Pristiq (desvenlafaxine)						
Prozac (fluoxetine)						
Remeron (mirtazapine)						
SamE						
Serzone (nefazadone)						
Silenor (doxepin)						
St. John's Wort (hypericum)						
Tofranil (imipramine)						
Trintellix (vortioxetine)						
Viibryd (vilazodone)						
Wellbutrin (buproprion)						
Zoloft (sertraline)						

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Patient Name: _____ Date: _____

Medication Brand (Generic)	Currently Taking	Previously Taken	Max Dose (mg)	Length of Treatment & Year(s) Taken	Response	Side Effects
MOOD STABILIZERS						
Depakote (valproic acid)						
Gabitril (tiagabine)						
Keppra (levetiracetam)						
Lamictal (lamotrigine)						
Lithium, Eskalith, Lithobid						
Neurontin (gabapentin)						
Symbyax						
Tegretol (carbamazepine)						
Topamax (topiramate)						
Trileptal (oxcarbazepine)						
NEUROLEPTICS						
Abilify (aripiprazole)						
Clozaril (clozapine)						
Geodon (ziprasidone)						
Haldol (haloperidol)						
Invega (paliperidone)						
Loxitane (loxapine)						
Mellaril (thioridazine)						
Moban (molindone)						

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Patient Name: _____ Date: _____

Medication Brand (Generic)	Currently Taking	Previously Taken	Max Dose (mg)	Length of Treatment & Year(s) Taken	Response	Side Effects
Navane (thiothixene)						
Prolixin (fluphenazine)						
Rexulti (brexpiprazole)						
Risperdal (risperidone)						
Serentil (mesoridazine)						
Seroquel (quetiapine)						
Stelazine (trifluoperazine)						
Thorazine (chlorpromazine)						
Trilafon (perphenazine)						
Vraylar (cariprazine)						
Zyprexa (olanzapine)						
ANTI-ANXIETY AGENTS						
Ativan (lorazepam)						
BuSpar (buspirone)						
Inderal (propranolol)						
Kava Kava						
Klonopin (clonazepam)						
Librium (chlordiazepoxide)						
Serax (oxazepam)						
Tranxene (clorazepate)						

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Patient Name: _____ Date: _____

Medication Brand (Generic)	Currently Taking	Previously Taken	Max Dose (mg)	Length of Treatment & Year(s) Taken	Response	Side Effects
Valerian						
Valium (diazepam)						
Vistaril Atarax (hydroxyzine)						
Xanax (alprazolam)						
PSYCHOSTIMULANTS						
Adderall (dextroamphetamine and amphetamine)						
Concerta (methylphenidate)						
Cylert (pemoline)						
Daytrana (methylphenidate patch)						
Dexedrine (dextroamphetamine)						
Focalin (dexmethylphenidate)						
Jornay (methylphenidate)						
Mydais (dextroamphet-amine and amphetamine)						
Provigil (modafinil)						
Ritalin (methyphenidate)						
Strattera (atomoxetine)						
Vyvanse (lisdexamfetamine)						

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Patient Name: _____ Date: _____

Medication Brand (Generic)	Currently Taking	Previously Taken	Max Dose (mg)	Length of Treatment & Year(s) Taken	Response	Side Effects
SLEEPING AGENTS						
Ambien (zolpidem)						
Dalmane (flurazepam)						
Halcion (triazolam)						
Lunesta (eszopiclone)						
Placidyl (ethchlorvynol)						
Prosom (estazolam)						
Restoril (temazepam)						
Rozerem (ramelteon)						
Somnote (chloral hydrate)						
Sonata (zaleplon)						

SUBSTANCE USE HISTORY

Describe any current or past alcohol problems in your life (DUIs, PIs, alcoholism, etc.):

Describe any medical treatment for alcohol problems:

Have you ever attended an AA or NA meeting? ❒ yes ❒ no

Have you ever taken a medication or drug that you received from friends or family or bought off the street? ❒ yes ❒ no

If yes, what medication(s)?

Have you ever received treatment for drug/substance abuse? ❒ yes ❒ no

Describe:

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Patient Name: _____ Date: _____

If you answered yes to using any drugs, list what type of illegal drugs you previously used:

Drug/Substance	Age at Use	How Long Used	Last Date Used

Do you drink coffee or tea? ❒ yes ❒ no How many cups per day?

Do you use tobacco now? ❒ yes ❒ no ❒ Not now but previously
Please explain tobacco use (type and duration).

MEDICAL HISTORY

List any permanent physical or mental problems since childhood:

Check any serious illness you have now or were treated for in the past. Please describe and give dates.

- ❒ Seizures
- ❒ Cancer
- ❒ Diabetes
- ❒ Thyroid Disease
- ❒ Anemia (low blood)
- ❒ High Blood Pressure
- ❒ Heart Disease
- ❒ Lung or breathing problems
- ❒ Joint or back disease
- ❒ Stomach or bowel disease
- ❒ Pregnancy problems
- ❒ Urinary Tract Problems
- ❒ Sexual Problems
- ❒ Prostrate Problems
- ❒ Sleep Apnea

Have you been injured in any motor vehicle accident? ❒ yes ❒ no If yes, please describe the injury:

Have you ever been knocked out or had a brain injury? ❒ yes ❒ no If yes, please describe what happened:

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Patient Name: _____ Date: _____

Primary Care Doctor:
List any other doctors you are seeing:

Are you now taking any medications? ❒ yes ❒ no If yes, please list the milligrams and how often you take your medicine.

Medications	Milligrams	Times Per Day

Are you taking any over-the-counter medicines, herbs or natural products (for which you do not need a prescription? ❒ yes ❒ no If yes, please list:

Who keeps track of your medications? ❒ you ❒ spouse ❒ other
Do you have any drug allergies? ❒ yes ❒ no If yes, please list:

FAMILY HISTORY

How many times have you been married?

How many times have you been divorced?

Are you now divorced? ❒ yes ❒ no Married? ❒ yes ❒ no Widowed? ❒ yes ❒ no

How long have you been divorced/married/widowed?

How many children do you have?

How many stepchildren do you have?

Describe your relationship with your children? ❒ close ❒ could be better ❒ distant ❒ poor

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Patient Name: _____ Date: _____

Please check if any of these illnesses or acts have occurred in any of your parents, siblings, children, grandparents, aunts/ uncles or cousins:

- ❒ Depression/Anxiety
- ❒ Eating Disorders (binge eating, anorexia, bulimia)
- ❒ Attention Deficit Disorder
- ❒ Bipolar (Manic/Depressive D/O)
- ❒ Alcohol/Drug Problems
- ❒ Child/Spouse Abuse
- ❒ Suicide
- ❒ Schizophrenia (or psychosis)

If you checked any of the above, please explain which relative had the illness, any medications the relative was on if known and/or who did the violent act:

THIS SECTION FOR WOMEN ONLY

How many pregnancies have you had? _____ How many living children have you had? _____
How many miscar-riages have you had? _____ Were you depressed after having a baby or a miscarriage? _____
If yes, when _____ Were you medically treated? _____ Could you be pregnant? _____
When was your last menstrual period? _____

SOCIAL HISTORY

How many sisters? brothers? Your birth order:

What did/does your father do for a living?

Is he still living? ❒ yes ❒ no If no, then how and when did he die?

What did/does your mother do for a living?

Is she still living? ❒ yes ❒ no If no, then how and when did she die?

Are/were your parents divorced? ❒ yes ❒ no If yes, when? How old were you at the time?

Who raised you? Was your home life happy? ❒ yes ❒ no Abusive? ❒ yes ❒ no

Have you ever been sexually abused? ❒ yes ❒ no If yes, please explain:

Have you ever been physically abused? ❒ yes ❒ no If yes, please explain:

Are you presently being sexually or physically abused by anyone? ❒ yes ❒ no If yes, who:

Have you ever been violent to or harmed a person or torn up property? ❒ yes ❒ no Describe:

Have you ever threatened to kill another person? ❒ yes ❒ no

Have you ever killed another person even by accident? ❒ yes ❒ no

Have you ever been in legal trouble for your sexual behavior? ❒ yes ❒ no

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Patient Name: _____ Date: _____

EDUCATION

What is the highest grade you **completed** in school?

If you did not finish high school, what was the reason?

What were your grades in high school? Did you require special education classes? ❒ yes ❒ no

In grade school or high school, did the teachers think you were hard to control or was it hard to get your attention? ❒ yes ❒ no If yes, please explain:

If you attended any college or trade school, please complete the following.

Degree/Diploma/Major	Graduation Date	College/University/Trade School

LEGAL HISTORY

Have you ever been in prison or jail? ❒ yes ❒ no If yes, then when and where? _____

_____

Have you had any criminal felony or misdemeanor convictions, drug arrests, DUIs or public intoxication arrests? ❒ yes ❒ no If yes, then please describe:

Has your spouse or anyone else ever filed a restraining order or emergency protection order against you? ❒ yes ❒ no If yes, then please describe:

Have you ever been charged with spouse abuse, child abuse or neglect, or terroristic threatening? ❒ yes ❒ no If yes, then please describe:

Have you ever filed a workers' compensation claim? ❒ yes ❒ no If yes, what was/were the work injury(ies):

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Patient Name: _____ Date: _____

EMPLOYMENT/VOCATIONAL HISTORY

Employment status (check one): ❒ full time ❒ part time ❒ unemployed ❒ student

If not currently employed, please describe the reason:

If employed, who is your employer:

Length of time at your last permanent job:

What is/are your position/job duties:

If you are disabled, please indicate year and reason for disability:

Were you ever fired or asked to resign from a job? ❒ yes ❒ no If yes, reason:

If you are not working, do you plan to return to work at any time in the future? ❒ yes ❒ no

If you have a spouse, where is he/she employed?

List past employment (beginning with your most recent job):

Employer	Job Title	Start Date	Finish Date	Reason for Leaving	Other

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Patient Name: _____ Date: _____

REVIEW OF SYSTEMS (*check those symptoms present*)

GENERAL

- ❒ Fever
- ❒ Shaking
- ❒ Chills
- ❒ Change in appetite
- ❒ Weight loss
- ❒ Weight gain
- ❒ Fatigue
- ❒ Change in sleeping patterns
- ❒ Soaking night sweats
- ❒ Nausea
- ❒ Vomiting
- ❒ Other general symptoms

Please explain:

FEMALE

- ❒ Menstrual irregularity
- ❒ Premenstrual distress
- ❒ Menopause symptoms
- ❒ Excessive female bleeding

Please explain:

MENTAL

- ❒ Depression
- ❒ Sadness
- ❒ Nervousness
- ❒ Panic
- ❒ Thoughts of suicide
- ❒ Poor concentration
- ❒ Memory loss
- ❒ Too happy
- ❒ Excessive energy
- ❒ Word-finding difficulty
- ❒ Confusion
- ❒ Inability to know month/year
- ❒ Hearing voices
- ❒ Seeing things
- ❒ Paranoid thoughts
- ❒ Irritability
- ❒ Excessive anger
- ❒ Arguing
- ❒ Crying for no reason
- ❒ Trouble thinking
- ❒ Flashbacks
- ❒ Thoughts of killing another person
- ❒ Counting things
- ❒ Checking things
- ❒ Afraid of germs
- ❒ Afraid to touch doorknobs
- ❒ Wash hands more than 10 times daily
- ❒ Take more than 2 baths/showers daily

Please explain:

NEUROLOGICAL

- ❒ Blackouts
- ❒ Seizures
- ❒ Double vision
- ❒ Partial blindness
- ❒ Headaches
- ❒ Numbness
- ❒ Tingling
- ❒ Weakness
- ❒ Poor balance
- ❒ Shaking or tremors
- ❒ Abnormal movements of face or body
- ❒ Poor coordination
- ❒ Paralysis
- ❒ Loss of reflexes
- ❒ Pain

Please explain:

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Patient Name:_____ Date: _____

REVIEW OF SYSTEMS (*check those symptoms present*)

SLEEP

- ❒ Cannot fall asleep
- ❒ Cannot stay asleep
- ❒ Wake up too early
- ❒ Fall asleep anytime
- ❒ Night terrors
- ❒ Nightmares
- ❒ Sleep walking
- ❒ Restless legs before sleep
- ❒ Cannot stay awake during/while sitting
- ❒ Severe snoring that bothers others
- ❒ Choking during sleep
- ❒ Cannot stay awake to drive
- ❒ Others have observed you stop breathing during sleep
- ❒ Fall or stagger if angry or laugh
- ❒ Hear things when falling asleep or waking up
- ❒ Paralyzed for short time after waking up

Please explain:

SEXUAL (MEN)

- ❒ Cannot get erection
- ❒ Cannot ejaculate
- ❒ Ejaculate too soon
- ❒ No sexual desire
- ❒ Partner does not meet needs

Please explain:

SEXUAL (WOMEN)

- ❒ Cannot lubricate
- ❒ Cannot have orgasms
- ❒ No sexual desire
- ❒ Partner does not meet needs

Please explain:

HIV

Have you been tested for HIV? ❒ yes ❒ no

If tested, what were the results? ❒ positive ❒ negative

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PATIENT INFORMATION/AUTHORIZATION/CONSENT

I, _____, give permission to Melissa Sullivan Psychiatry, PLLC to render treatment.

I authorize exchange of information between Melissa Sullivan Psychiatry, PLLC and my treating physician regarding my care.

My treatment and care will be confidential except under the following circumstances:

- Threat of imminent harm to self or others
- Allegations of recent or ongoing abuse to another individual
- A court-ordered subpoena of records

The documentation maintained about my case is the property of Melissa Sullivan Psychiatry, PLLC. Only with my written authorization can this information be released to another physician, service provider or agency. I understand that receiving psychiatric or psychological treatment and having a psychiatric diagnosis may adversely affect my ability to obtain life, disability or long-term insurance. I agree to release Melissa Sullivan Psychiatry, PLLC from any liability if I have difficulty obtaining insurance due to the contents of my medical records.

I authorize the release of any information requested by my insurance carrier or pharmacy regarding the dispensing of prescribed medications including, but not limited to, diagnosis and health history. I authorize the release of any clinical or demographic information required by a laboratory to perform test requested by Melissa Sullivan Psychiatry, PLLC.

I understand that if I have not been seen face-to-face by Melissa Sullivan Psychiatry, PLLC in over a year, I am no longer considered to be an active patient. I agree to release any form of medical liability for events occurring one year after the face-to-face content.

I understand that insurance is considered a method of reimbursing the patient for fees paid to the doctor and is not a substitute for payment. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charge. It is my responsibility to pay all fees in full. I authorize the release of any information necessary to determine liability for payment and to obtain reimbursement on any claim.

In order to control the costs of billings, I understand the charges for office visits are to be paid at the beginning of each visit.

I understand that if I have a balance on my account that is over 90 days old it will be subject to being referred to a collection agency. Any personal information needed to collect the debt will be provided to the collection agency. If this account is assigned to an attorney for collection and/or suit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original. I understand that I am financially responsible for all charges whether or not paid by said insurance.

I understand that I will be billed in full for missed appointments or appointments not canceled by giving 24-hour notice.

I understand that I may be billed for prescription phone calls and phone consultations.

I understand that interest at the rate of 18% per annum will be assessed to delinquent accounts.

_____ _____
Signature (patient or parent if under 18 years of age) Date

_____ _____
Witness Date

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Patient Name: _____ Date: _____

Primary phone number: _____

Please check all that apply:

- ❒ I give permission for information regarding appointments to be left on the answering system at the above phone number.
- ❒ I give permission for detailed messages including personal medical information to be left at the above phone number. This may include, but is not limited to, information about medication refills or answers to questions left for the doctor.
- ❒ I **DO NOT** give my permission for any messages to be left at the above phone number. I understand that this may result in not getting notifications about upcoming appointments which could result in a missed appointment fee.

In an effort to further safeguard your Protected Health Information (PHI), this office would like to extend to you the opportunity to list family members or friends whom you may chose to interact with our doctors or the office staff for various reasons on your behalf. For example, there may be people you might authorize to call the office to confirm or change your appointments for you, pick up prescriptions or samples from the office, pick up copies of your medical records, speak to the doctor about your condition, etc. You may revoke this authorization in writing at any time. If you do not choose to list anyone, please write "none" in the first box and then sign and date below.

Full Name and Address Of Contact	**Relationship To Patient**	**Phone Number**

Please list at least one person who could be contacted to check on your wellbeing in the event of an emergency including, but not limited to, a medical emergency in the office, suicidality, etc.

Full Name and Address Of Contact	**Relationship To Patient**	**Phone Number**

_____ _____
Patient Signature Date

_____ _____
Witness Date

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Patient Name:_____ Date:_____

Birthdate: _____ Age: _____ Gender:_____

CURRENT MEDICATION LIST

Medication	Dose (mg)	Frequency	Indication

For office use only

Reviewed by physician: _____ Date:_____

Updates by physician

Date	Medication Changes	No Change	Initial

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POLICIES AND PROCESDURES

The primary mission of Melissa Sullivan Psychiatry, PLLC is to provide the highest quality mental health and substance use services for individuals 18 years of age and older residing in Kentucky. The range of services provided include outpatient psychotherapy and psychopharmacology management. We endeavor to meet the needs of our patients and referral sources in a timely, efficient, courteous and professional manner.

In return for this conscientious care, we ask our patients to cooperate with the following guidelines:

Initial Visit

We will review intake paperwork prior to this visit and then interview patient to determine a diagnosis. A treatment plan will then be designed with the patient. It may include hospitalization, medications, routine lab tests, individual therapy or family therapy. There are times that the needs of the patient may be in excess of the resources available in this practice. If this is the case, appropriate referrals will be suggested.

Office Hours

Standard appointments are scheduled Tuesdays through Thursdays from 9:00 a.m.-4:30 p.m. New patient evaluations and emergency appointments are reserved for Mondays and Fridays.

Appointments

Patient visits are by appointment only. Our office will make every effort to adhere to our schedule so that you are seen on time. However, emergencies do occur and you will be advised if the doctor is running behind. In turn, we ask you to be punctual. If you are late by more than 10 minutes of the scheduled appointment time, you may be rescheduled. **This will be considered a less than 24-hour cancellation.**

If you cannot keep an appointment, please call our office as soon as possible. Failure to keep an appointment or cancel 24 hours in advance will result in a charge of $130. Please note that insurance companies do not pay for missed appointment charges. Such charges are the responsibility of the patient. We have a voicemail system that takes messages 24 hours a day. Patients who frequently miss scheduled appointments may be terminated from the practice for noncompliance.

Emergencies

If you have a medical or psychiatric emergency (such as suicidality), call 911 immediately. If you have an urgent matter, please call the office at (502) 657-4551 24 hours a day/7 days a week.

Fees and Billing

Please refer to the financial policy enclosed in this packet.

Medications

Refills for controlled substances and/or schedule II medications will not be given early for any reason including theft or loss of medication.

Hospitalization

Dr. Sullivan will see patients in the office only. If hospitalization is required, the patient will be referred to the hospital that is covered by his or her insurance company. The admission and ongoing treatment while in the hospital will be at the discretion of the on-call physician at the hospital, but Dr. Sullivan will be available for a phone consultation with the physician, should that physician request it. Upon discharge, the patient is encouraged to schedule a return appointment with Dr. Sullivan as soon as possible.

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Medical Records (Protected Health Information)

We request that all patients advise us before treatment if they are involved in a lawsuit. Our records concerning your treatment are strictly confidential. Such information is available to referring and treating physicians so that your care can be complete. We will ask you to sign a release of information to do these positions at your first visit. However, your information may be disclosed to your insurance carrier as part of the insurance contract for payment and may be disclosed to your pharmacy or laboratory as needed. A full notice of privacy practices is to be posted in the office and you may request a copy.

Forms and Phone Calls

Patients will be billed for time spent completing forms not relating to billing of charges for services received in this office.

Patients may also be billed for phone calls involving the doctors. Insurance companies do not pay for phone calls.

Patient Responsibility

To assure that your receive the quality care you deserve, please assist us by doing the following:

- Notify our business office of any changes in your residence, phone number or insurance.
- Keep your appointments as scheduled or notify the office at least 24 hours in advance of any change.
- Be prepared to pay for your office appointment on the day in which you are seen or arrange a payment plan prior to your visit.
- Monitor your medication so that you do not run out between appointments.
- Notify us in advance of any need to release your records for legal or other purposes. It could take up to 10 business days to compile the needed records/information.
- Be truthful with the doctors and staff.
- Follow the agreed treatment plan.

Termination of Care

Either the patient or the doctor can terminate the doctor/patient relationship for any reason he or she deems appropriate.

Reasons for termination could include:

- Providing misleading or untruthful information
- Not following the agreed treatment plan
- Using medication outside the prescribed directions resulting in request for early refills
- Excessive, unwarranted phone calls during workday and/or after hours
- Repeated failure to keep appointments
- Failure to tell us that you were in a lawsuit or facing criminal charges
- Failure to comply with the financial policy
- Aggressive or inappropriate behavior towards doctors/staff

Patient Signature: _____

Parent or guardian: _____

Date: _____

Melissa Sullivan, MD
7982 New LaGrange Road, Ste. 3 Louisville, KY 40222 ❖ p: (502) 657-4551 ❖ f: (502) 919-9001 ❖ mmspsychiatry@gmail.com

FINANCIAL POLICY

It is the goal of Melissa Sullivan Psychiatry, PLLC to provide the highest quality of psychiatric care. It is also our desire to assist you in the financial agreements related to care. Therefore, it is important for you to fully understand that our financial, credit, and collection policies are a necessary part of assuring the financial resources needed to maintain this healthcare facility for our patients and community. Please read this policy statement carefully and feel free to ask any questions regarding any area. Please sign the statement indicating that you have read and understand each point. A copy of the signed statement will be given to you and a copy will be maintained in your chart.

Payment must be made at the time of your visit. If you have insurance coverage, you will be responsible for payment in full at the time of your visit, but our office will provide you with a completed claim form for you to submit to your insurance carrier to assist you in obtaining your reimbursement. If unusual circumstances make it impossible for you to meet our credit terms, we invite you to discuss these with our office manager before you visit. If you have a balance on your account that is over 90 days old, it will be subject to being referred to a collection agency. Any personal information needed to collect the debt will be provided to the collection agency. If this account is assignment to an attorney for collection and/or lawsuit, the practice shall be entitled to reasonable attorney's fees and costs of collection.

Fees for Service

New patient evaluation	$350
Established 20 minute follow up	$125
Established 30 minute follow up	$140
Urgent after hours medication refills	$30
Intermediate phone call	$75 (no charge for calls regarding adverse side effects)
Complex phone call	$125
Report preparation (per 15 minutes)	$50
Missed appointment fee	$130 (no show or less than 24 hour cancellation notice)

Please feel free to contact our office at (502) 657-4551 if you have any questions.

I have read, understand and agree to comply with the above financial policy.

Patient Signature: _____

Parent or guardian: _____

Date: _____

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NOTICE OF PRIVACY PRACTICES

This Notice describes how your medical information may be used and disclosed and how you may access your information. Please review it carefully. If you have any questions about this Notice, please contact our office manager. This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment of health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control you protected health information. "Protected health information" hereafter referred to as PHI) is information about you, including demographic information, that may identify you and that related to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy. We may change the terms of our notice at any time. The new notice will be effective for all PHI that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

Uses and Disclosures of Protected Health Information Based Upon Your Written Consent

You will be asked by your physician to sign a treatment authorization form, which indicates that you consent to use and disclosure of your PHI for treatment, payment and health care operations. Your PHI may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you. Your PHI may also be used and disclosed to pay your health care bills and to support the operation of the physician's practice. Following are examples of circumstances where use and disclosure of your PHI are permitted (this list is descriptive but not exhaustive):

- The coordination or management of your health care with a third party, such as a home health agency, the physician who referred you to our office or to whom our doctors have referred you.
- Diagnoses and billing information provided to laboratories for requested testing.
- Diagnoses, billing information and medication prescribed made available to pharmacies.
- Determination of eligibility and insurance benefit coverage, medical necessity review and utilization reviews activities.
- We may call you by name in the waiting room when your physician is ready to see you.
- We may leave a message for you on your voice mail system or answering machine concerning an aspect of your treatment or reminding you of an appointment.
- We will share your PHI with third party "business Associates" that perform various activities (e.g., billing, transcription services) for the practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your PHI, we will have a written contract that contains terms that will protect the privacy of your PHI.

Uses and Disclosures of Protected Health Information Based Upon Your Written Authorization

Other uses and disclosures of your PHI will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization, at any time, in writing except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Consent, Authorization or Opportunity to Object

We may use or disclose your PHI in the following situations without your consent or authorization.

These situations include:

- **Required by law:** We may use or disclosure your PHI to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, as required by law, of any such uses or disclosures.
- **Public Health:** We may disclose your PHI for public health activities an purposes to a public health authority that is permitted by law to collect or receive the information. The disclosure will be made for the purpose of controlling disease, injury or disability. We may also disclose your PHI, if directed by the public health authority, to a foreign government agency that is collaborating with the public health authority.
- **Communicable Diseases:** We may disclose your PHI, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.
- **Health oversight:** We may disclose to a health oversight agency for activities authorized by law such as audits, investigations and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.
- **Abuse or Neglect:** We may disclose your PHI to a health authority that is authorized by law to receive reports on child abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.
- **Food and Drug Administration:** We may disclose your PHI to a person or company required by the Food and Drug Administration to report adverse events, product defects or problems, biologic product deviations, track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.
- **Legal Proceedings:** We may disclose PHI in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), in certain conditions in response to a subpoena, discovery request or other lawful process. Law Enforcement: We may also disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include:
- Legal processes and otherwise required by law
  - Limited information requests for identification and location purposes
  - Pertaining to victims of a crime
  - Suspicion that death has occurred as a result of criminal conduct
  - In the event that a crime occurs on the premises of the practice
  - Medical emergency (not on the Practice's premises) and it is likely that a crime has occurred
- **Coroners, Funeral Directors and Organ Donation:** We may disclosure PHI to a coroner or medical examiner for identification purposes, determining cause of death or for one coroner or medical examiner to perform other duties authorized by law. We may also disclose PHI to a funeral director, as authorized by law. In order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death.
- **Research:** We may disclose your PHI to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your PHI.
- **Criminal Activity:** Consistent with applicable federal and state laws, we may disclose your PHI, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose PHI if it is necessary for law enforcement authorities to identify or apprehend an individual.

Other Permitted and Required Uses and Disclosures That May Be Made With Your Consent, Authorization or Opportunity to Object

We may use and disclose your PHI in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your PHI.

If you are not present or able to agree or object to the use or disclosure of the PHI then your physician may, using professional judgment, determine whether the disclosure is in your best interest. In this case, on the PHI that is relevant to your health will be disclosed.

- **Others Involved In Your Healthcare:** Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that persona's responsibility for your care of your location, general condition or death. We may use of disclose your PHI to an authorization public or private entity to assist in disaster relief efforts and to coordinate uses and disclosures to family or other individuals involved in your health care.
- **Emergencies:** If your physician or another physician covering for the practice is required by law to treat you and the physician has attempted to obtain your consent but is unable to obtain your consent, he/she may still use or disclose your PHI to treat you.
- **Communication Barriers:** We may use and disclose your PHI if your physician or another physician in the practice attempts to obtain consent from you but is unable to do so due to substantial communication barriers and the physician determines, using judgment, that you intend to consent to use or disclosure under the circumstances.
- **Military Activity and National Security:** When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel
  - For activities deemed necessary by appropriate military command authorities
  - For the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits
  - To foreign military authority if you are a member of that foreign military services. We ay also disclose your PHI to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.
- **Worker's compensation:** Your PHI may be disclosed by us as authorized to comply with workers' compensation laws and other similar legally-established programs. Inmates: we may use or disclose your PHI if you are an inmate of a correctional facility and your physician created or received your PHI in the course of providing care to you.
- **Required Uses and Disclosure:** Under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164/500et. Seq.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Following is a statement of your rights with respect to your PHI and a brief description of how you may exercise these rights.

- You have the right to inspect and copy your PHI. This means you may inspect and obtain a copy of PHI about you that is contained in a designated record set for as long as we maintain the PHI. A "designated record set" contains medical and billing records and any other records that your physician and the practice use for making decisions about you. Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and PHI that is subject to law that prohibits access to PHI. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our office manager if you have questions about access to your medical record.

- You have the right to request a restriction of your PHI. This means you may ask us not to use or disclose any part of your PHI for the purposes of treatment, payment or healthcare operations. You may also request that any part of your PHI not be disclosed to family members or friends who may be involved in your care for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your PHI, your PHI will not be restricted. If your physician does agree to the requested restriction, we may not use or disclose your PHI in violation of the restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician.
- You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation for you as to the basis for the request with your physician.
- You may have the right to have your physician amend your PHI. This means you may request an amendment of PHI about you in a designated record set for as long as we maintain this information. In certain cases, we may deny your request for an amendment. If your request is denied, you have the right to file a statement of disagreement with us and we may prepare a rebuttal for which we will provide you with a copy. Please contact our office manager to determine if you have questions about amending your medical record. You have the right to receive an accounting of certain disclosures we have made, if any, of your PHI. This right applies to disclosures for purposes other than treatment, payment or healthcare operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you, for a facility directory, to family members or friends involved in your care, or for notification purposes. You have the right to receive specific information regarding these disclosures that occurred after April 14, 2003. You may request a shorter timeframe. The right to receive this information is subject to certain exceptions, restrictions and limitations.
- You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this electronically.

COMPLAINTS

You may complain to us or the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our office manager of your complaint. We will not retaliate against you for filing a compliant.

You may contact our office manager at (502) 657-4551 for further information about the complaint process. The notice was published and became effective on July 17, 2019.

I acknowledge that I have read and understand the Notice of Privacy Policies posted for the office of Melissa Sullivan Psychiatry, PLLC.

_____

Printed Name

_____ _____

Signature Date

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PATIENT INFORMATION

PATIENTS NAME	SOCIAL SECURITY #	BIRTHDATE	AGE
PATIENTS ADDRESS			
CITY	COUNTY	STATE	ZIP
HOME PHONE	WORK PHONE	CELL PHONE	EMAIL
GENDER	MARITAL STATUS ❒ SINGLE ❒ MARRIED ❒ SEPARATED ❒ DIVORCED ❒ WIDOWED PARTNER'S NAME:		
PRIMARY CARE PHYSICIAN			
PRIMARY CARE PHYSICIAN'S ADDRESS		PHONE	
EMPLOYER'S NAME & ADDRESS			
EMPLOYMENT STATUS ❒ FULL TIME ❒ PART TIME ❒ RETIRED ❒ DISABLED ❒ NOT EMPLOYED			
STUDENT STATUS (if 19 years or over) ❒ FULL TIME ❒ PART TIME ❒ NOT A STUDENT			