Walter G. Griffith, Jr., MD, PA

General Psychiatry – Board Certified
5565 MLK Street North (9th St N)
St. Petersburg, FL 33703
Tel# 727-577-1203 Fax# 727-577-0983 Email: waltergriffithmd@gmail.com

Dear _____, Date:_____

Thank you for making an appointment for a psychiatric consultation with Dr. Walter Griffith. We want to welcome you to our office and inform you of our goal to provide both outstanding clinical services and administrative support.

Enclosed you will find intake forms and a map with directions to our office. An essential part of the intake process is to complete the steps outlined below. Doing this will provide important information to our office in a timely fashion, protect your personal health information according to federal regulations, and ensure your insurance benefits can be properly utilized. Completed forms and requested information outlined in steps #1 and #2 must be received by our office at least one week before your scheduled appointment.

Step #1 – Please fill out and sign intake forms. Then mail, fax, email, or drop off the enclosed forms back to the office:

A) New Patient Questionnaire
B) Informed Consent for Treatment
C) Patient Consent Form (this pertains to the Notice of Privacy Practices form regarding federal HIPAA – Health Insurance Portability & Accountability – regulations)
D) Notice of Privacy Practices Acknowledgement (also regarding HIPAA regulations)
E) Financial Policy, page 1 & 2

Step #2 – Please determine if Dr. Griffith is a covered provider of your Mental Health Insurance Coverage

A) If you are intending to utilize your health insurance policy to pay for services by Dr. Griffith, then we recommend that you refer to the back of your insurance card and call the mental health coverage telephone # to determine Dr. Griffith's insurance provider status
B) Mental health insurance coverage is often "carved out" by general health insurance companies (like BCBS, Cigna, Aetna, United) to specialized mental health insurance companies (like Magellan, Value Options, Bradman, MHN, MHNet)
    1. It is your responsibility to contact your insurance company and ensure that Dr. Griffith is an approved provider for mental health services
    2. If your mental health insurance company requires pre-authorization for services, then please obtain the authorization number for our office by the time of your first visit
    3. You will be responsible for full payment if your claim is not covered or if it is out-of-network

*****PLEASE NOTE: The forms and information outlined above must be received by our office NO LATER THAN ONE (1) WEEK PRIOR TO YOUR SCHEDULED APPOINTMENT, or your appointment will automatically be cancelled. *****

Thank you in advance for your time and attention to these matters, and we look forward to seeing you at your appointment:

M T W Th _____ at _____AM // PM

Sincerely,

Intake Coordinator

NEW PATIENT QUESTIONNAIRE

Walter G. Griffith, Jr., MD, PA

5565 Dr. MLK Jr. St. North (9th Street N)
St. Petersburg, FL 33703
Tel# 727-577-1203 Fax# 727-577-0983

GENERAL INFORMATION

NAME_____ **DATE:** _____

STREET_____

CITY_____ **STATE**_____ **ZIP**_____

TEL#'s: (Home)_____**(Cell)**_____**(Work):** _____

Date of Birth_____ **Age**_____ **Religion**_____

JOB TITLE / EMPLOYER_____**#Yrs** _____

Ht_____**Wt**_____**(lbs.)** **SS#**_____ **INSURANCE**_____

# of Children & Ages_____

FAMILY DOCTOR_____ **DRUG ALLERGIES**_____

MARITAL STATUS

□ **Single** □ **Married (# times___)** □ **Divorced** □ **Separated** □ **Engaged** □ **Cohabitating** □ **Widowed** □ **Gay/Lesbian**

- **SIGNIFICANT OTHER:**
  #Yrs Together_____ **First Name**_____ **Age**_____ **JOB**_____

CURRENT LIFE SITUATION

- **What are you seeking help for during your appointment?**

_____

_____

- **What issues are now causing the most stress in your life?**

#1) _____

#2) _____

#3) _____

- **Who, or what means do you now use for emotional support?**

#1) _____

#2) _____

#3) _____

DEVELOPMENTAL HISTORY

● Where were you born? _____ Where did you grow up? _____

● How many brothers/sisters did/do you have, and what # were you in order? _____

● Did your parents stay together while you were growing up? □ Yes □ No □ I was Adopted

● If your parents split up, who did you live with, or who raised you? _____

● WHEN YOU WERE GROWING UP what work did your parents (or parental substitutes) do, and what were their personalities like? —please complete the table below:

Parental Figure	Occupation	Description of Personality
▪ Father	_____	_____
▪ Father Substitute	_____	_____
▪ Mother	_____	_____
▪ Mother Substitute	_____	_____

● WHILE GROWING UP, as a youngster/teen, what was your family life like? _____

_____

● As a youngster did you suffer from abuse? □ NO □ YES— □ verbal □ physical □ sexual

EDUCATION HISTORY

● Did you complete HIGH SCHOOL?
□ Yes (what was your GPA? ____) □ No, I have a GED □ No—# yrs completed? _____

● Education beyond High School:

□ Assoc Degree Institution_____ _ Major_____

□ College Institution_____ Major_____

□ Grad School Institution_____ Major_____

● Please characterize yourself DURING your TEENAGE YEARS by circling the word(s) which best described you at that time in each line, 1), 2) and 3), below:

1) **Popular----Leader----Outgoing----Fit into mainstream----Follower----Shy----Loner**
2) **Worked hard----Motivated----Average effort----Just got by----Didn't care or study**
3) **Good citizen--Jock---Respectful---Mischief--Disruptive---Cut-class---Partier--Burn out--Fights**

OCCUPATIONAL HISTORY

● Please briefly outline your occupational history after the completion of education:

_____

_____

_____

PAST MEDICAL HISTORY

HOSPITALIZATIONS / SURGERIES

YEAR	HOSPITAL / LOCATION	NATURE OF ILLNESS

CURRENT MEDICATION INFORMATION

MEDICATION	Mg/Day	REASON ON MEDICATION

Are you NOW having any of the following problems?		Have you had any of these medical problems?	
□ Significant Weight gain	□ Significant Weight loss	□ Hypertension	□ Diabetes
□ Loss of consciousness	□ Eye pain, double vision	□ Stroke	□ Heart Attacks
□ Hearing loss, ringing	□ Dizziness	□ Thyroid problem	□ Chronic Headaches
□ Lightheaded standing	□ Shortness of breath	□ Arthritis	□ Ulcer
□ Chest pain	□ Ankle swelling	□ Kidney Stone	□ Seizures
□ Bloody or pink urine	□ Severe abdominal pain	□ Cancer-type_____	□ Other_____
□ Frequent heartburn	□ Tar-colored stools		

Does anyone in your family have a history of the following?	Which family member? (**please specify maternal or paternal)
□ Cancer – which type _____	_____
□ Stroke	_____
□ Hypertension (high blood pressure)	_____
□ Diabetes	_____

Additions/Comments_____

_____

PAST PSYCHIATRIC HISTORY

Please complete the following table regarding HISTORY of PSYCHIATRIC ILLNESS for YOURSELF and BLOOD RELATIVES (use checkmarks where applicable)

PSYCHIATRIC HISTORY	SELF	Father	Mother	Grand-parents	Brother /sister	Kids	Aunt/ Uncle	Cousin
Major Depression								
Anxiety Disorder								
Bipolar/Manic-Depression								
ADHD—Attention Deficit								
Schizophrenia								
Schizoaffective Disorder								
Alcohol or Drug Abuse								
Anorexia/Bulimia/Eating Disorder								
Suicide Attempt								
Psychiatric Hospitalization								
Under the care of Psychiatrist								
Treated with Psychiatric Medication								
Saw a Therapist / Counselor								
Probable disorder but never treated								
Criminal History								
Other								

Other Comments_____

_____

Your Recreational Substance Use Pattern

Name of Substance	Never Used	Past Use Only	Current Use	# Yrs of Use	Frequency or Amount Used (eg, drinks/day, joints/week)
Tobacco					
Caffeinated Drinks					
Alcohol					
Marijuana					
Pain Pills					
Benzodiazepines					
Cocaine					
Crack					
Acid/Mushrooms					
Ecstasy					
Speed					
Crystal Meth					
PCP					
Barbiturates					
Heroin					
Other:					

Your Psychiatric Medication History

(please complete the table below for medications you have been treated with or have tried)

Brand Name	Generic Name	Dose	Taken How long	Very Helpful	Mildly Helpful	Not Helpful	Side Effects
Prozac	Fluoxetine						
Paxil	Paroxetine						
Zoloft	Sertraline						
Luvox	Fluvoxamine						
Celexa	Citalopram						
Lexapro	Escitalopram						
Effexor	Venlafaxine						
Cymbalta	Duloxetine						
Pristiq	Desmethylvenlafaxine						
Remeron	Mirtazapine						
Fetzima	Levomilnacipran						
Viibryd	Vilazodone						
Wellbutrin	Bupropion						
Trintellix	Vortioxetine						
Elavil	Amitriptyline						
Tofranil	Imipramine						
Sinequan	Doxepin						
Pamelor	Nortriptyline						
Norpramin	Desipramine						
Desyrel	Trazodone						
Lithobid/Eskalith	Lithium						
Depakote	Divalproate						
Lamictal	Lamotrigine						
Trileptal	Oxycarbazepine						
Tegretol	Carbamazepine						
Neurontin	Gabapentin						
Latuda	Lurasidone						
Risperdal	Risperidone						
Zyprexa	Olanzapine						
Seroquel	Quetiapine						
Geodon	Ziprazidone						
Abilify	Aripiprazole						
Symbyax	Olanzapine/prozac						
Haldol	Haloperidol						
Saphris	Asenapine						
Trilafon	Perphenazine						
Xanax	Alprazolam						
Ativan	Lorazepam						
Klonopin	Clonazepam						
Valium	Diazepam						
Librium	Clordiazepoxide						
Restoril	Temazepam						
Halcion	Triazolam						
Ambien CR	Zolpidem						
Lunesta	Ezoplicone						
Sonata	Zaleplon						
Ritalin	Methylphenidate						
Concerta	Methylphenidate						
Adderall	Dexamphetamine						
Straterra	Atomoxetine						
Vynvase	Lisdexamfetamine						
Vrylar	Cariprazine						
Provigil	Modafinil						

Other Comments_____

Patient Signature_____ **Date**_____

Informed Consent for Treatment

Walter G. Griffith, Jr., MD, P.A.
5565 Dr. MLK Jr. St. North (9th Street N)
St. Petersburg, FL 33703-1203
Tel# 727-577-1203 Fax# 727-577-0983

I, _____, hereby voluntarily request diagnostic evaluation and medical treatment, which may include individual family, couples, and group therapies, medication management, consultation, education, and referral to other community resources, provided by Walter G. Griffith, Jr., MD.

I understand

- The purpose of this treatment
- Possible alternative treatments exist
- Treatment includes potential risks and benefits
- No diagnostic or therapeutic guarantees have been made
- My participation in treatment is voluntary and I may stop at any time

My signature below certifies my understanding and acceptance of the intent of this informed consent.

Patient Signature_____Date _____

Guardian/Power of Attorney_____ Date _____

Witness_____ Date_____

Notice of Privacy Practices

Walter G. Griffith, Jr., MD, P.A.
5565 Dr. MLK Jr. St. North (9th Street N)
St. Petersburg, FL 33703-1203
Tel# 727-577-1203 Fax# 727-577-0983

This Notice describes how medical information about you may be used to disclosed, and how you may have access to this information
(PLEASE REVIEW CAREFULLY)

Introduction - The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, remain properly confidential. This act gives you, the patient, rights to understand and control how your health information is used. As required by HIPAA, we have prepared this explanation of the privacy of your health information and how we may use and disclose your health information.

Three ways we may use and disclose health information about you:

- Treatment means providing, coordinating, or managing health care and related services by one or more providers, e.g., performing an evaluation or follow-up appointment, or phoning your prescription refill to the pharmacy.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collections activities, and utilizations review, e.g., sending a bill to your insurance company for an appointment.
- Health Care Operations include the business aspects of running our practice, such as conducting quality assessment activities, auditing functions, cost-management analysis, and customer service, e.g., Staff training meetings.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. If you revoke consent for the above activities, we may not be permitted to use or disclose information for the purpose of treatment, payment, or health care operations, and we may therefore choose to discontinue providing you health care treatment and services.

Special situations in which we may disclose health information about you without your permission: To avert serious threat or harm to your health or safety, to the public, or to another individual; as required by federal, state or local laws; to an organ or tissue bank if you are an organ donor; by command of military command or other government authorities if you are or were a member of the armed forces, national security or intelligence communities; for worker's compensation if you are seeking benefits for work-related injuries or illness; for public health risks to prevent or control disease, injury or disability, or to report births, deaths, suspected abuse or neglect, non-accidental injuries, reactions to medications or problems with products; to federal, state, and local health oversight agencies for audits, inspections, investigations, or licensing purposes; to a court or administrative order if you are involved in a dispute or lawsuit; to a law enforcement official in response to a court order, subpoena, warrant, summons subject to applicable requirements; de-identified health information (i.e., references to individually identifiable information removed); to coroners, medical examiners, and funeral directors to identify a deceased person or to determine cause of death.

Other uses and disclosures of health information require written authorization: Any other uses or disclosures, of your health information will be made only with your written authorization. You may revoke such authorization in writing at any time and we are required to abide by that written request except for previous disclosures made with your permission.

You have the following rights, which you can exercise by presenting a written request:

- To request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- To reasonable requests to receive confidential communications of health information involving alternative means or locations.
- To inspect and copy, upon submission of a written request, your protected health information (we may charge a fee for associated costs to supervision, copying, or handling).
- To amend your protected health information (we may charge a fee for associated costs to review and amend the record).
- To receive an accounting of disclosures of protected health information.
- To obtain a paper copy of this Notice of Privacy Practices upon request.

Miscellaneous - We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information. This notice is effective as of April 14, 2003. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain or receive in the future. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. If you believe your privacy rights have been violated, you may file a complaint with our office (at the above address) to Walter Griffith, MD, the Privacy Officer, or with the Secretary of the Department of Health and Human Services, Office of Civil Rights. We will not retaliate against you for filing a complaint.

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have the certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan, and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly**
- **Obtain payment from third- party payors**
- **Conduct normal healthcare operations such as quality assessments and physician certifications**

I have received, read, and understand you *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that Walter G. Griffith, Jr. MD, PA, has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

OFFICE USE ONLY

I attempted to obtain patient's signature on this *Notice of Privacy Practices*, but was unable to do so as documented below:

Date: _____ Initials: _____ Reasons: _____

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HIPAA PATIENT CONSENT FORM

I understand that, under the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- **Conduct, plan and direct my treatment and follow-up among multiple healthcare providers who may be involved in that treatment directly and indirectly**
- **Obtain payment from third-party payors**
- **Conduct normal healthcare operations such as quality assessments and physician certifications**

I have been informed by you of your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I have been given the right to review such *Notice of Privacy Practices* prior to signing this consent. I understand that Walter G. Griffith, Jr., MD, PA, has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices*.

I understand that I may request in writing that you restrict how my private information is used to or disclosed to carry out treatment, payment, or healthcare operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

Financial Policy

Walter G. Griffith Jr., MD, PA

Below represents our financial policy for clinical and administrative purposes. Please review and sign.

1) **PAYMENT DUE AT TIME OF SERVICE**: Co-payments are due at time of service. Nonpayment at time of service will result in a billing service fee of $12.00 for that date of service.
2) **APPOINTMENT CANCELLATION ADVANCE NOTICE**: It is very important to provide our office adequate appointment cancellation notice of 24 hours/one day to respect and accommodate other patients in crisis awaiting immediate access to care. Therefore, failure to provide adequate cancellation notice may result in a fee of $40. A continued pattern of non-compliance may result in termination from the practice.
3) **BOUNCED CHECKS**: A patient whose check is returned for non-payment will be assessed a $40 fee.
4) **FEES FOR INDIRECT CLINICAL SERVICES**: Indirect clinical services performed by Dr. Griffith and his staff will be billed at an hourly rate and will be the full financial responsibility of the patient on a prepaid basis. Indirect clinical services do not involve direct patient care, and usually occur when clinical information must be formulated into a written or verbal report to justify clinical status required by another party such as an insurance company, employer, a court, or government agency. These time-consuming services require the physician to review the chart thoroughly for clinical facts and complete a report. Indirect clinical services may include:
    - Disability forms and questionnaires for short term, long term, and social security
    - Letters for attorneys, courts, agencies, employers, academic institutions, etc.
    - Narrative summaries
    - Depositions and court appearances
    - Prior authorizations and medication overrides are sometimes required by your health insurance company to justify higher cost medications (please note: an override attempt is NOT a guarantee the insurance company will authorize the medication or treatment)
5) **PATIENT HAS FULL FINANCIAL RESPONSIBILITY WHEN UTILIZING MENTAL HEATLH INSURANCE**: When utilizing mental health insurance benefits, the patient will be fully financially responsible for payment if the insurance company does not pay, or does not pay in full, for any reason. Below is a list of some reasons why insurance may deny payment:
    - **Contractual Exclusions**: Pre-existing conditions, uncovered/excluded diagnoses, or an annual deductible
    - **Non-Approved provider or Unauthorized Services**: It is the responsibility of the patient to ensure that Dr. Griffith is both an approved provider and that services are authorized by the specific company administering the mental health benefits. If Dr. Griffith is NOT a provider, or the services are not approved or authorized, then it is the patient's full financial responsibility to pay for services.
    - **"Carve Out" Mental Health Services**: Mental health services sometimes involves two separate insurance companies – one is the general health insurance company for medical and surgical service, while the second is the mental health insurance company for mental health services. The general health insurance company – like Blue Cross, Cigna, Aetna, United, etc. – may "carve out" mental health services to a mental health insurance company – like Magellan, Value Options, Bradman, MHN, MHNet, CompCare, UniPsych, etc. Therefore, the general insurance company may have no role in authorizing or paying the mental health visit with Dr. Griffith. Payment denial may occur because, even though Dr. Griffith may be a provider for the general insurance company, he may NOT be a provider for the mental health "carve out" insurance company. Generally calling the 800 number on the back of the insurance card for mental health services will determine this matter.
    - **Correct Billing Information**: It is the patient's responsibility to provide accurate, up-to-date insurance and billing information prior to any appointment.
    - **Insurance Company Errors**: It is the patient's responsibility to rectify errors by the health insurance company, such as incorrect patient identification or group numbers, or disputes in contractual benefits, which result in partial payment or denial of payment.
    - **Change of Insurance Coverage Notification**: It is the patient's responsibility during any change of insurance coverage to update the office prior to the appointment.

I acknowledge I have read the above Financial Policies for Walter G. Griffith, Jr., MD, PA.

Name: _____ Initials: _____ Date: _____

HELPFUL HINTS FOR HOW OUR OFFICE OPERATES

Walter G. Griffith Jr., MD, PA

We strive to provide you the best clinical care we can with efficient administrative workflow required by a busy medical practice. To understand how our office operates in important clinical and administrative ways, please review the "road map" below which will help your care run smoothly. Thank you for choosing our practice.

Voicemail

Our office uses voicemail for incoming calls during business hours. Our staff retrieves messages several times per hour, then prioritizes and triages the matter to return your call in a timely manner. Leaving a voicemail is easy:

Step #1 – provide your first and last name
Step #2 – briefly describe the nature of your call
Step #3 – provide your direct return phone numbers where you can be reached throughout the day
Step #4 – if calling for a prescription refill, provide both the name of the medication and pharmacy phone number

(Due to HIPAA confidentiality laws please do not email or text message Dr. Griffith.)

Responsible Medication Use

Responsible medication usage is a critical part of quality care, so please adhere to the following:

- Take your medication consistently and in the dose prescribed
- Do not overuse or abuse medication
- Keep medication safe, and protected from being lost, stolen, damaged, borrowed, or accessed by others
- Attend follow-up appointments to ensure timely refills – do not miss or forget appointments, or let your supply run short
- Avoid driving and operating equipment if your medication makes you drowsy, clumsy, or impairs judgment
- This office does not fax mail order prescriptions – a written prescription will be provided for you to mail in a timely manner (please mail off with at least two weeks current supply on hand)
- Avoid substance abuse because it causes psychiatric symptoms and interferes with medications
- To ensure compatibility & safety with psychiatric medications update our office of medication changes by other doctors
- Some controlled substances require an in-office appointment for refills by law

How to get Medication Refills:

Three EASY Methods	1) Attend recommended follow-up appointments to avoid running out of medication 2) Mail your 90-day Rx's on-time, with at least two weeks current supply on hand 3) Call to request interim refill with at least at two business days advance notice
Four STRESSFUL Methods	1) Forget you are low, or miss your last appointment, and call for a last minute, immediate refill 2) Call the doctor's cell after hours or weekends for a refill when our office is open 40hours/week 3) Delay or forget to mail your 90-day Rx's on time, and run out of your supply on hand 4) Tell the pharmacy to fax or call for your refill – we need to hear from YOU—pharmacies fax countless bogus refill requests forcing doctors' offices to ignore them

Attending Appointments

Please keep your scheduled appointments, which are reserved for you alone, to facilitate quality clinical care, proper evaluation of symptoms, treatment outcome, side effects, timely refills, etc. If a schedule conflict arises our office is happy to reschedule appointments. It is very important to provide our office adequate notice (24hours/one day) of appointment cancellation to respect and accommodate patients in crisis, needing immediate access to care. Therefore, failure to provide adequate cancellation notice may result in a fee of $40. A pattern of noncompliance with scheduled appointments adversely affects clinical care and may result in termination of care.

Time Management of the Doctor's Schedule

We appreciate the valuable time from your busy schedule to attend appointments. If you are running significantly late, please call us, and perhaps another patient can exchange appointment times. Various factors cause our schedule to run approximately 15 minutes late, so if your schedule requires absolute punctuality by the doctor's schedule, then you are respectfully advised to consider finding an alternate provider in order to reduce your stress and ours.

Co-pay Due at Time of Service

Copays are due at time of service, and appointments may be rescheduled if no means of payment is provided. In the event you are unable to keep your appointment due to finances, please avoid no-showing, and provide our office adequate cancellation notice (24hrs/one business day) to respect patients in crisis on the waiting list needing immediate access to care.

Thank you for reviewing the above guidelines of our practice.

Name: _____ Initials: _____ Date: _____