Greetings!

We want to thank you for choosing *Alpha Psychiatric Services* for your mental health care. In our efforts to serve you, it is important that all items in this packet are complete, and **ALL** requested items are returned with the packet. Failure to do so will result in your packet being discarded.

***If you are seeking medication for ADHD, you must sign the controlled substance agreement attached. Please be aware that stimulant medication (Adderall) is not guaranteed to be given on the first visit. We conduct drug screens, check the national prescription monitoring program, and require a documented diagnosis. If you do not have a documented diagnosis, we will seek testing for you or conduct the assessment in our office. ***

A **picture ID** and a **copy of the front AND back of your insurance card** MUST be returned with the packet. All forms **MUST** be completed, initialed, and signed.

When returning the packet, you may:

1. Mail it back to us at:
Alpha Psychiatric Services
2010 Old Greenbrier Rd., Suite J
Chesapeake, VA 23320 OR

2. Email it back to info@alphapsychservices.com

We will call to get you scheduled in the order that your paperwork is received. Please do not call the office to schedule, we will call you.

If you have a question about the paperwork, you may contact us at 757-413-5444.

Thank you,
Alpha Psychiatric Services

(Please print clearly. The following information should pertain to the client.)

LAST NAME: _____ ***FIRST NAME:*** _____ ***MI:*** _____

DATE OF BIRTH: _____ ***LEGAL GENDER:*** *Male* _____ *Female* _____

ADDRESS: _____

CITY: _____ ***STATE:*** _____ ***ZIP:*** _____

PREFERRED PHONE: _____ ***ALTERNATIVE PHONE:*** _____

SOCIAL SECURITY #: _____ ***EMAIL:*** _____

SPOUSE / PARENTS NAME: _____

EMPLOYER: _____ ***OCCUPATION:*** _____

EMERGENCY CONTACT NAME & RELATIONSHIP: _____ ***PHONE NUMBER:*** _____

ETHNICITY: _____ ***PREFERRED LANGUAGE:*** _____ ***RACE:***

_____

RESPONSIBLE PARTY INFORMATION

LAST NAME: _____ ***FIRST NAME:*** _____ ***MI:*** _____

ADDRESS: _____

CITY: _____ ***STATE:*** _____ ***ZIP:*** _____

PHONE: _____ ***RELATIONSHIP TO PATIENT:*** _____

ARE YOU CURRENTLY A PATIENT AT APS: YES NO

INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY: _____

POLICY #: _____ **GROUP #:** _____

SUBSCRIBER NAME: _____ **SUBSCRIBER SSN#/DOB:** _____

SUBSCRIBER EMPLOYER: _____ **SUBSCRIBER RELATIONSHIP TO PATIENT:**

_____

SECONDARY INSURANCE COMPANY (IF APPLICABLE): _____

POLICY #: _____ **GROUP #:** _____

SUBSCRIBER NAME: _____ **SUBSCRIBER SSN#/DOB:** _____

SUBSCRIBER EMPLOYER: _____

SUBSCRIBER RELATIONSHIP TO PATIENT: _____

Regarding Your Privacy

Alpha Psychiatric Services LLC. abides by the Health Information Privacy Protection Act that governs how your medical information may be used and disclosed. Please read the attached Notice of Privacy Practices to learn how your information may be used. You may keep the notice for your records.

I _____ acknowledge that I have read the Notice of Privacy Practices regarding my right to privacy while receiving services in this office.

Signature: _____ **Date:** _____

(Parent or legal guardian if client is under the age of 18.)

Patient Name*(print)***:** _____

Credit Card Authorization Agreement

I _____, authorize Alpha Psychiatric Services to use my credit card information to charge my credit card for co-payments, outstanding balances, and if I do not notify the office of my inability to attend scheduled appointments and/or do not cancel my appointment at least 24 hours in advance. The set cancellation fee is $50 unless otherwise agreed upon with my provider. I will not dispute charges ("Charge Back") for sessions I have received or commitments I have missed according to the above policy. I understand that I can also choose to add my credit card to the electronic health record vault for this same purpose.

Card Type (circle one):

VISA MasterCard Discover American Express

Credit Card #:_____ Expiration Date:_____

Name as Printed on Card: _____

Verification/Security Code (3-digit code on back of card by signature line): _____

*I would rather add my credit card information to the electronic vault: Yes: ☐ No: ☐

Billing Address: _____

City: _____ State:_____ Zip: _____

Phone Number: _____ Email Address: _____

By signing below, I am authorizing Alpha Psychiatric Services to charge for missed scheduled appointments with email confirmation and receipt.

Signature: _____ Date: _____

Credit Card Authorization Agreement DENIAL

I DO NOT feel comfortable sharing my credit card information with Alpha Psychiatric Services to be stored in their secure Electronic Health Record for the purpose of billing. I agree to receive paper and/or electronic statements for any charges that may be outstanding on my account. I agree to pay any unresolved balances once notified or make appropriate payment arrangements with their billing staff. Any balance that remains unresolved beyond 30 days is subject to past due penalties.

Signature: _____ Date: _____

Consent for Release of Information

Patient: _____ **Date**: _____

Patient Date of Birth: _____

Information to be released:

To:

_____

_____

_____

_____

From:

_____

_____

_____

_____

Phone: _____

Fax: _____

Phone: _____

Fax: _____

Check One OR Both:

_____ Alpha Psychiatric Services, L.L.C. is hereby authorized to release to the above person and/or facility the following (Check all that apply):

_____ You are hereby requested to furnish Alpha Psychiatric Services with the following (Check all that apply):

- _____ Evaluations
- _____ Psychological and/or education testing
- _____ Progress Notes
- _____ Medical Reports
- _____ Correspondence
- _____ Telephone Communications
- _____ Assessment/Treatment of Substance Abuse
- _____ Other: _____

Note: This authorization may be revoked at any time, except to the extent that action has been taken in reliance on it. If not otherwise specified, this authorization will expire one year from the date of signature of the patient/responsible party.

_____ _____

Patient / Responsible Party Signature Date / Time

_____ _____

Witness Signature Date / Time

_____

Therapist Requesting/ Sending Information

Financial Agreement

(Please initial each applicable section)

Insurance Information

As a courtesy, we will verify your insurance benefits before your initial visit. Any co-payment, coinsurance, or deductible we charge is based on the benefits provided by your insurance company(s). **Patients are responsible for any outstanding balance** if the insurance carrier denies benefits, changes co-payment, alters your deductible, retracts a payment, or does not provide benefits as estimated. **Patients or the Responsible Party must pay the balance regardless of the reason the insurance company denies coverage.**

_____ (initial) I agree to pay my co-payment, coinsurance, and/or deductible at the time of service. I understand that services may be refused if payment is not made.

_____ (initial) I agree to notify Alpha Psychiatric Services of any changes to my insurance policy. If I fail to do so; I understand that I may be responsible for the FULL standard fee for the appointment.

_____ (initial) I agree to pay the $75.00 fee if I miss my appointment and fail to give at least 24 hours' notice of a cancellation. I understand that insurance companies do not cover the cost of late cancellations or missed appointments.

_____ (initial) I agree to pay my balance in full once it comes to my attention, or I will follow the agreed upon payment plan on time until the balance is paid in full. I understand that failure to do so may result in suspension of services. I understand that my provider may be willing to work within my financial constraints and discussion of options is always the first option.

_____ I agree to pay a $50.00 returned check fee in any instance where my check may be returned from my financial institution. I also agree that checks will no longer be accepted if this should occur.

Self-Pay Information:

_____ (initial) **I agree to pay the self-pay rate as listed below (i.e., no insurance or insurance is not accepted)**

Psychiatric Evaluation: $250
Medication Management Follow Up: $125
Initial Therapy Session: $250
Therapy Follow-Up: 175
Assessment/Psychological Testing: $500

Additional Charges:

_____ (initial) Services offered that incur additional charges are based upon time spent to complete the service include, but are not limited to:

- Letters (1-3 pages): $25.00-$50.00
- FMLA / Disability Paperwork: Starts @$75.00
- Copying: $0.10 per page.
-Records $25.00 up to 50 pages, then 0.10 per page

*Payment for additional charges is due upon completion of the service.

Signature: _____ **Date:** _____

(Parent or legal guardian if client is under the age of 18.)

Patient Policies and Procedures

Late Policy: We will allow a fifteen-minute window for all new patients and a six-minute window for all follow-up appointments. After the allotted time, you will be marked a no-show and will be charged a $50.00 no-show appointment fee.

Refill Policy: Patients are usually scheduled in 30, 60, or 90-day increments. **There will be NO refills provided without an appointment**. **If you miss your appointment, you may go to the ER or your PCP.** Please make sure you receive enough medication to make it in between each appointment. If you are going out of town, it is your responsibility to secure refills at least 72 hours in advance.

Paperwork Policy: The fee schedule for paperwork is in the Financial Agreement. You must be an established patient, which means at least **3** office visits prior to any FMLA, or Disability paperwork being filled out for you. It is always at the discrepancy of the provider whether paperwork will be filled out. **Any patient who takes themselves out of work without the consent of their provider, will NOT have FMLA paperwork filled out for them.**

After-Hours: You may call the after-hours line for any emergencies after business hours. Refill requests are not emergencies. **Please note that if you require a phone call back and it is not an emergency, you will be charged a fee of $35.** No after-hours calls will be accepted for appointments, refills, or prior authorizations.

Prior Authorization(s): Please understand our office has 72 hours to process a prior authorization for your medication. Prior Authorizations for stimulant medications may require a drug screen. Also, it may take an additional 72 hours for your insurance to respond.

Thank you,
Alpha Psychiatric Services

Signature: _____ Date: _____

Definitions: With respect to this document, the following terms will apply:

I (patient): _____

My Provider: _____

Controlled Substance (Medications): _____

CONSENT TO TREATMENT AND/OR DRUG THERAPY:

I voluntarily request my provider to treat my condition which has been explained to me as _____ (condition). I hereby authorize and give my consent to administer or prescribe the prescription(s) for dangerous and/or controlled substance(s) (medication(s)) as part of therapy or treatment for my condition.

It has been explained to me that these medication(s) may include opioid/narcotic, anti-anxiety, insomnia, ADHD, etc. drug(s), which can be harmful if taken without medical supervision. I further understand that these medication(s) may lead to physical dependence and/or addiction and may, like other drugs used in the practice of medicine, produce adverse side effects or results. Alternative methods of treatment, possible risks involved, and the possibilities of complications have been explained to me as listed below. I understand that this listing is not complete, and that it only describes the most common side effects or reactions, and that death is also a possibility as a result from taking these medication(s).

I HAVE BEEN INFORMED and understand that I will undergo medical tests and examinations before and during my treatment. Those tests include random unannounced checks for drugs on less than 24-hour notice and psychological evaluations if and when it is deemed necessary, and I hereby give permission to perform the tests or my refusal may lead to termination of treatment. The presence of unauthorized substances or the absence of authorized medication(s) may result in my being discharged from my provider's care.

For female patients only:

_____ To the best of my knowledge I am not pregnant.
initials

If I am not pregnant, I will use appropriate contraception/birth control during my course of treatment. I understand the possible side effects of medication(s) and that, at present, there have not been enough studies conducted on the long-term use of many medication(s) i.e., opioids/narcotics to assure complete safety to my unborn child(ren). With full knowledge of this, I consent to its use. If I am pregnant or am uncertain, I WILL NOTIFY MY PROVIDER IMMEDIATELY.

For ALL patients:
I UNDERSTAND THAT THE MOST COMMON SIDE EFFECTS THAT COULD OCCUR IN THE USE OF THE DRUG(S) USED IN MY TREATMENT INCLUDE BUT ARE NOT LIMITED TO:

1. Constipation
2. Nausea or vomiting
3. Excessive drowsiness or sleepiness
4. Itching
5. Urinary retention (inability to urinate)
6. Orthostatic hypotension (low blood pressure)
7. Irregular heartbeat
8. Insomnia (inability to sleep)
9. Depression
10. Impaired judgment &/or reasoning
11. Respiratory depression (slow or no breathing)
12. Impotence
13. Tolerance to medication(s)
14. Physical and emotional dependence, addiction and/or insomnia (inability to sleep)
15. Death

I UNDERSTAND that it may be dangerous for me to operate an automobile or other machinery while using the medication(s) and I may be impaired during all activities, including work.

The goal of this treatment is for the management of my condition to live a more productive and active life. I realize that I may have a chronic illness and there is a limited chance for complete cure, but the goal of taking medication(s) on a regular basis is to manage (but probably not eliminate) my condition so that I can enjoy an improved quality of life. I realize that the treatment for some will require prolonged or continuous use of medication(s), but an appropriate treatment goal may also mean the eventual withdrawal from the use of all medication(s). My treatment plan will be tailored specifically for me. I understand that I am expected to participate in a functionally restorative program that may include physical/occupational therapy and/or other psychological counseling as prescribed by my doctor. I understand that I may withdraw from this treatment plan and discontinue medication use. I further understand that I will be provided medical supervision if needed when discontinuing medication use.

I UNDERSTAND that no warranty or guarantee has been made to me as to the results of any drug therapy or cure of any condition. The long-term use of medications to treat my condition may be controversial because of the uncertainty regarding the extent to which they provide long-term benefit. I have been given the opportunity to ask questions about my condition and treatment, risks of non-treatment and drug therapy, medical treatment or diagnostic procedure(s) to be used to treat my condition and the risks and hazards of such drug therapy, treatment and procedure(s), and I believe that I have sufficient information to give informed consent.

CONTROLLED SUBSTANCE AGREEMENT:

The following agreements are made between the Patient and Provider, as identified above, and outline the duties and expectations of each party and will be considered a binding agreement. This agreement will be part of the patient's medical records.

I UNDERSTAND AND AGREE TO THE FOLLOWING: *(please initial each after reading)*

_____ 1. This Controlled Substance Agreement relates to my use of <u>any and all medication(s)</u> to manage my condition as prescribed by my provider.

_____ 2. All medication(s) and prescriptions for the treatment of my condition will be obtained from only my provider.

_____ 3. Medication(s) for the management of my condition will be provided by my provider so long as I follow the rules, terms and conditions specified in this agreement. Failure to comply with any of the rules, terms, and / or conditions of this agreement may result in discontinuation of the medication(s) and / or my discharge from my provider's care and treatment.

_____ 4. Discharge from my provider's care and treatment may be immediate for any criminal behavior.

_____ 5. All medication(s) prescribed by my provider and other medication(s) prescribed by other providers must be obtained at only one (1) pharmacy. I will provide my pharmacist with a copy of this agreement at the request of my provider.

_____ 6. I will use the medication(s) exactly as directed by my provider.

_____ 7. My progress will be periodically reviewed and, if the medication(s) are not improving my quality of life, the medication(s) may be discontinued by my provider.

_____ 8. Use of illegal substances, alcohol, and other mood-altering drugs can lead to dangerous side effects. I agree to submit to urine and / or blood screens to detect the use or non-use of non-prescribed and prescribed medication(s) at any time and without prior warning on less than 24-hour notice. Any evidence of use of illegal substances will lead to discontinuation of the medication(s).

_____ 9. My provider may at any time choose to discontinue the medication(s) for the treatment of my condition.

_____ 10. I will disclose to my doctor all other medication(s) that I take at any time, prescribed by any doctor other than my provider.

_____ 11. I agree that I shall inform any doctor who may treat me for any other medical problem(s) that I am taking medication(s) for the management of my condition since the use of other medication(s) may cause harm.

_____ 12. I will stop all other medication(s) for the management of my condition unless otherwise directed by my provider.

_____ 13. I agree to inform my provider of any scheduled surgeries and / or procedures in a timely manner to allow any alterations of the medication(s) dosage.

_____ 14. I will not share, sell, or otherwise permit others, including my family and friends to have access to my medication(s).

_____ 15. I will keep my medication(s) and prescriptions in a secure place to prevent theft or loss. I will not allow or assist in the misuse / diversion of my medication(s); nor will I give or sell them to anyone else. Lost or stolen medication(s) and / or prescriptions may not be replaced.

_____ 16. I agree not to obtain or seek to obtain any other medication(s) from any other source (including Emergency Department, "urgent care clinic," etc.) without first contacting my provider. Information that I have been receiving other medication(s) prescribed by other doctors that has not been approved by my provider may lead to a discontinuation of the medication(s) and treatment.

_____ 17. I understand that the State of Virginia tracks information provided by pharmacies regarding all controlled substance prescriptions. My provider may access this data at any time if there is concern that I may be violating this Controlled Substance Agreement.

____ 18. I will notify my provider's office during office hours at least three (3) business days in advance before running out of medication(s) so the appropriate refills can be made. No controlled medications will be ordered when the office is closed.

_____ 19. I understand that refills will NOT be ordered before the scheduled refill date even if my medication(s) runs out. When traveling, arrangements may be made in advance of planned departure date.

_____ 20. If it appears to my provider that there are no demonstrable benefits to my daily function or quality of life from the medication(s), my provider may try alternative medication(s) or may taper me off all medication(s). I will not hold my provider liable for problems caused by the discontinuance of the medication(s).

_____ 21. I recognize that my condition represents a complex problem which may benefit from other therapies (i.e., physical therapy, psychotherapy, alternative medical care, etc.). I also recognize that my active participation in the management of my condition is extremely important. I agree to actively participate in all aspects of the management program recommend by my provider to achieve increased function and improved quality of life.

_____ 22. I understand and agree that a consult with or referral to, an expert may be necessary such as submitting to a psychiatric or psychological evaluation by a qualified provider.

_____ 23. I hereby give my provider permission to discuss all diagnostic and treatment details with my other provider(s) and pharmacist(s) regarding my use of other medication(s) prescribed by other doctor(s).

_____ 24. I must keep all follow-up appointments as recommended by my provider or my treatment and / or medication(s) may be discontinued.

PREFERRED PHARMACY:

Name: _____

Location: _____

Phone: (_____) _____ Fax: (_____) _____

I certify and agree to the following:

1. I am not currently using illegal drugs or abusing prescription medication(s) and I am not undergoing treatment for substance dependence (addiction) or abuse. I am reading and signing this informed consent and controlled substance agreement while in full possession of my faculties and not under the influence of any substance that might impair my judgment.

2. I have been given an opportunity to ask questions about my condition, alternative forms of treatment and risks of non-treatment, the medication(s) to be used, the risks and hazards involved, and all other provisions contained in this Controlled Substance Agreement. All my questions have been answered to my satisfaction and that I have sufficient information to give this informed consent.

3. I certify this form has been fully explained to me, that I have read it or have had it read to me, that the blank spaces have been filled in, and that I understand its contents.

4. I agree to the use of the medication(s) in the treatment of my condition and to the terms of this informed consent and Controlled Substances Agreement.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON:

_____ _____

Signature Print Name

Date: _____ Time: _____ A.M. / P.M.

WITNESS/PROVIDER:

_____ _____

Signature Print Name

Definitions: With respect to this document, the following terms will apply:

I (patient): _____

My Provider: _____

Telepsychiatry Contract and Informed Consent:

Telepsychiatry is the delivery of psychiatry (or psychotherapeutic) services using interactive audio and visual (video) electronic systems where the provider and the patient are not in the same physical location. The interactive electronic systems incorporate network and software security protocols to protect patient information and safeguard the data exchanged.

Requirements:

- A computer and a webcam with microphone to video conferencing using a HIPAA compliant online company specializing in telemedicine.

Potential Benefits:

- Telepsychiatry eliminates barriers to accessing healthcare and provides alternative means to obtain behavioral health services for patients who may otherwise have limited accessibility or encounter prolonged waiting lists in the community.
- In addition to removing the burden of travel time to a physical medical office as well as the risks and costs associated with transportation, telemental health allows for flexible scheduling.
- Telemental health offers a reduction of stigma by providing private treatment in the comfort of the patient's personal space.
- Telemental health can provide treatment to patients with disabilities and limited mobility without requiring extensive planning for transport.

Potential Risks:

- Telepsychiatry audiovisual equipment may experience technical difficulties.
- While every precaution is taken to secure patient data and maintain confidentiality, the nature of electronic appointments results in additional exposure to security breaches.
- Telepsychiatry may not be suitable for certain illnesses that require higher levels of care.
- Certain illnesses may not be adequately treated by telepsychiatry.
- It is the discretion of the mental health provider regarding continuation of telemental health services.

Medication Prescribing:

- All medications prescribed by the mental health provider will be sent electronically to the pharmacy on file.
- Controlled substances such as stimulants, benzodiazepines, and hypnotics will be prescribed at the provider's discretion. A Controlled Substance Contract must be completed by the client and faxed/mailed/delivered to APS prior to controlled substance prescriptions being provided.
- All clients prescribed controlled substances must present in person either at APS or an affiliate lab entity to complete a set of vital signs and urine drug screen prior to prescriptions being sent to the pharmacy.

Required Information at Every Visit:

- Name, location, and telephone number of the patient at the time of session. This is to ensure that your provider is aware of alternative means of treatment should an emergency occur.

Activities Permitting During Telemedicine Services

- Prescription refills will be permitted at the time of the appointment.
- Appointment scheduling can be done outside of the appointment by calling our office at 757-413-5444.

Responsibilities of the Provider:

1. APS reserves the right to assess suitability and appropriateness of telepsychiatry candidates due to the potential limitations of the treatment modality mentioned above.
2. In the event of imminent danger, the provider is legally and ethically bound to report information to authorities, family members, or others, to minimize potential harm.

Responsibilities of the Patient:

- I agree to take full responsibility for the security of any communications or treatment information involved with my own computer and with my own physical location.
- I understand that I, NOT the provider, am responsible for providing and configuring any electronic equipment used on my computer which is used for telepsychiatry. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
- **I understand that I must be seen face-to-face at least one time per year.**
- I understand that it is my responsibility to verify insurance coverage/eligibility for telepsychiatry treatment.
- I agree to either provide the office with vital signs obtained from a primary care physician's office or appear to APS within one week before or after the scheduled telepsychiatry appointment for vital signs.

For ALL patients:

I UNDERSTAND THAT I HAVE THE FOLLOWING RIGHTS WITH RESPECT TO TELEMEDICINE:

1. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment nor risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my medical information also apply to telemedicine. As such, I understand that the information disclosed by me during my treatment is generally confidential. However, there are both mandatory and permissive exceptions to confidentiality, including, but not limited to reporting child, elder, and dependent adult abuse; expressed threats of violence towards an ascertainable victim, and where I make my mental or emotional state an issue in a legal proceeding.
3. I understand that I have a right to access my medical information and copies of medical records in accordance with Virginia law.
4. I understand that all of the clinic policies of APS apply to all telemedicine visits as well as all in-person visits.

Cancellation and Late Policy:

- All appointments must be cancelled twenty-four (24) hours in advance of the scheduled appointment.
- A charge of $75 will be applied to the clients account for lack of or inappropriate notification of a missed appointment.
- Missed appointments are disadvantageous to your provider and APS. Multiple missed/no-show appointments may result in discharge.

I certify that I have read and understand the entirety of this document, titled "Telepsychiatry Contract and Informed Consent." By signing below, I am agreeing with this document, put forward by APS, and I am also authorizing APS to use telepsychiatry for my evaluation and treatment.

PATIENT/OTHER LEGALLY RESPONSIBLE PERSON:

_____ _____

Signature Print Name

Date: _____ Time: _____ A.M. / P.M.

WITNESS/PROVIDER:

_____ _____

Signature Print Name

Alpha Psychiatric Services

Teaching Facility Acknowledgement

Dear Patient,

Alpha Psychiatric Services is a teaching facility. During your treatment you may encounter students on their various journeys in a variety of titles. Please understand that your care is our number one priority, and the quality of care provided will continue to be excellent. All students will be under direct supervision and will never be allowed to practice independently. The types of students you may encounter are Doctor of Nursing Practice (DNP), Psychiatric Mental Health Nurse Practitioner (PMHNP), Physician Assistant (PA), Resident in Counseling (LPC), and Supervisee in Social Work (LCSW). Thank you for your understanding in this matter and in our desire to prepare and mentor future mental health professionals.

_____

Patient Acknowledgement

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

Rapid Mood Screener (RMS)

Are you among the millions of people who have depressive symptoms? Answer the following questionnaire about your medical history and provide it to your doctor or nurse to assist in an important conversation about your mood.

Please select one response for each question. You can complete the **RMS** in less than 2 minutes.

Patient Name _____ Date _____

	YES	NO
1. Have there been at least 6 different periods of time (at least 2 weeks) when you felt deeply depressed?	☐	☐
2. Did you have problems with depression before the age of 18?	☐	☐
3. Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?	☐	☐
4. Have you ever had a period of at least 1 week during which you were more talkative than normal with thoughts racing in your head?	☐	☐
5. Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy; unusually outgoing; or unusually energetic?	☐	☐
6. Have you ever had a period of at least 1 week during which you needed much less sleep than usual?	☐	☐