

To new patients:

Welcome to Dr. Caroline Williams' mental health practice. We are looking forward to meeting you at your first appointment. The attached packet includes paperwork that can help the beginning of your treatment relationship with Dr. Williams flow more smoothly. It includes:

- 1) Identifying information and insurance information.
- 2) Explanation of office policies and procedures.
- 3) Medical and social history information.

Mental health practices have more stringent confidentiality regulations than most other types of doctors you have seen. The office policies section explains these for you.

The medical and social history forms may seem lengthy. Keep in mind that the more historical information you include in the forms ahead of time, the more time Dr. Williams can spend addressing your present concerns during the first appointment. If you have any questions as you go through the paperwork, let us know when you arrive and we will explain things.

We intend for your time with us to result in better mental health, less suffering, and more peace and happiness in your life.

Sincerely,



Caroline B. Williams, PhD, MP
Clinical Prescribing Psychologist



Valerie Fisher
Office Manager

PATIENT REGISTRATION
PLEASE PRINT IN BLACK INK
(Other colors and pencil do not scan well)

Patient Full Name: _____ Date ____/____/____

Residence Address: _____ City: _____ State: _____ Zip: _____

Mailing Address*: _____ City: _____ State: _____ Zip: _____

*If different from residence address.

SS# _____ DOB: ____/____/____ Gender assigned at birth: _____

Current Gender Identification: _____ Gender for insurance form filing: _____

Home Phone: (____) _____ Cell Phone: (____) _____

Email: _____

Patient Employer: _____ Work Phone: (____) _____

If Student: _____ H.S.: _____ College: _____

Referred By: _____

Person to contact in emergency: _____ Phone: (____) _____

PERMISSIONS:

Where may we leave a message? Home: yes no Work: yes no Cell: yes no Email: yes no

INSURED/RESPONSIBLE PARTY INFORMATION:

Responsible Party: _____

SS#: _____ DOB: ____/____/____

Employer: _____ Phone: (____) _____

Insured's Primary Ins. Co: _____ I.D.#: _____ Group #: _____

Secondary Insurance Company: ____ Yes ____ No

Company: _____ I.D.# _____ Group #: _____

OFFICE BILLING AND INSURANCE POLICY

1. I authorize use of this form on all of my insurance submissions.
2. I authorize the release of information to my insurance company(s).
3. I understand that I am responsible for the full amount of my bill for services provided.
4. I authorize direct payment to my service provider.
5. I hereby permit a copy of this to be used in place of an original.

Signature: _____

Date: _____

of person financially responsible (you)

Patient Name: _____ Date: _____

MENTAL HEALTH POLICIES AND PROCEDURES
Please Read Carefully!

Part I: ABOUT DR. WILLIAMS

- 1) Dr. Williams has received a New Mexico license for prescribing mental health medications. In addition to obtaining a PhD in clinical psychology, she has:
 - *completed a post-doctoral master's degree in psychopharmacology.
 - *completed a 100 patient, 400 hour practicum, under supervision.
 - * passed a national credentialing exam about mental health medications.
 - *completed a 24 month conditional prescribing period under supervision.

- 2) Dr. Williams may prescribe medications that are used for the treatment of mental health disorders. She cannot refill routine prescriptions for medical conditions, and cannot prescribe or monitor the use of opiates or suboxone.

- 3) New Mexico law requires that Dr. Williams coordinate her medication management of your mental health condition with your primary care physician. Thus, your consent for the exchange of information between Dr. Williams and your PCP is also required in order for her to provide this treatment. If you do not currently have a primary care physician (PCP), Dr. Williams will work with you to find medical services so that you can establish care.

My Primary Care Physician is: _____

City: _____ Phone Number: _____

_____ I do not have a primary care physician

Part II: PATIENT'S RIGHTS

1. You have the right to a confidential relationship with Dr. Williams. Within certain legal limits (see #4 and #5 below), information revealed by you during the course of treatment will be kept completely confidential and will not be revealed to any agency or other person without your written permission.
2. You have the right to receive a summary of your records, except in limited legal or emergency circumstances.
3. If you ask for it, any part of your records on file can be released to any agency or person you specify. At the time of your request, Dr. Williams may discuss with you whether or not releasing that information to that agency or person might be harmful to you in any way.
4. Under certain legally defined situations, Dr. Williams is required to reveal information to other agencies or persons. In such instances she is not required to notify you that such information has been released. These situations include:
 - a. If you reveal information about child abuse, or neglect or elder adult abuse, she is required by law to report this to the appropriate authority.
 - b. If you threaten death to another person, she is required by law to warn the intended victim and to notify law enforcement.

- c. If you threaten to seriously injure or kill yourself, she is required to notify the appropriate crisis intervention authorities.
 - d. If you are in treatment by court order, the results of the treatment or tests ordered may be revealed to the court, depending on the circumstances of the court order.
 - e. If you file a complaint or lawsuit against Dr. Williams, she may disclose relevant information regarding your treatment in order to defend herself.
 - f. If you have not paid your bill within 60 days, Dr. Williams may release *relevant* financial information to a collection agency in order to obtain payment.
5. You have the right to ask questions about Dr. Williams, or about procedures used in the course of your treatment. If you ask, she will explain her customary approach and methods to you.
 6. You have the right to choose NOT to receive treatment from Dr. Williams. If you choose this, she will provide you with names of other qualified professionals.
 7. You have the right to terminate treatment any time without any financial, legal, or moral obligations Other than those you have already incurred.

Part III: INTERNET AND SOCIAL MEDIA POLICY

Dr. Williams has adopted the following social medical policy in order to safeguard privacy and confidentiality for her and her patients, and to maintain treatment boundaries.

1. Friending: Dr. Williams does not accept friend or contact requests from current or former patients on any social networking site (Facebook, Linked In, etc.).
2. Communication: The following methods of electronic communication are not secure and may not be checked regularly by Dr. Williams: SMS (mobile phone text messaging), messaging on social networking (Twitter, Facebook, Linked In, etc.), wall postings, or @replies. Please avoid using these and other means of engaging with Dr. Williams in public online. The office manager will return texts to the main office number but such texts are not confidential or secure.
3. Business Review Sites: You may find Dr. Williams on such sites as Yelp, Healthgrades, Yahoo Local, Bing, or other places which list businesses. Some of these sites include forums where users rate their providers and add reviews. If you should find Dr. Williams listed on any of these sites, please know that her listing does not represent a request for a testimonial, rating, or endorsement, and is most likely listed without her knowledge. You have a right to express yourself on such sites if you so choose. However, due to confidentiality, Dr. Williams cannot respond to any review on these sites, either positive or negative. In fact, in most cases, Dr. Williams may never see these reviews. If you have a complaint or concern about the treatment you are receiving, please consider sharing it in person with Dr. Williams, so that it can be addressed and resolved.
4. Email: The e-mail option on Dr. Williams' website is not encrypted or confidential. Please use it for administrative purposes only. Be aware that all emails are retained in the logs of internet providers of both the sender and the recipient. These logs are theoretically available for reading by the system administrator(s) of the internet service provider. Any emails that Dr. Williams receives from you and any responses she sends will become part of your legal medical record. Dr. Williams provides an option for encrypted electronic messaging through her portal for established patients (see #5 below).
5. Secure (encrypted) electronic communication: Established patients can securely message through the encrypted patient portal online, and will receive login information at their first appointment. Any encrypted messages that Dr. Williams receives from you and any responses she sends will become part of your legal medical record.

6. Electronic appointment reminders: You can request appointment reminders through text, email, or by phone call. Complete the form in this packet to request this.

Part IV: THE TREATMENT PROCESS

1. Participating in psychological/psychiatric treatment can result in a number of benefits to you, including a better understanding of your personal goals and values, improved interpersonal relationships, and resolution of the specific concerns that led you to seek treatment. Working towards these benefits, however, requires effort on your part and may result in your experiencing considerable discomfort. Remembering and resolving unpleasant events through mental health treatment can bring on strong feelings of anger, depression, fear, etc. Attempting to resolve issues between marital partners, family members, and other individuals can also lead to discomfort and may result in changes that were not originally intended. Different medication trials may also result in unintended side effects or initial discomfort before you begin to feel better.
2. Dr. Williams provides a variety of treatment and diagnostic interventions. In addition to a general appointment, she may recommend formal psychological testing or genetic testing in order to improve treatment outcomes. These additional diagnostic interventions may generate additional costs and/or copayments, which will be explained to you ahead of time.

Part V: OFFICE POLICIES

1. Scheduling and Appointments:
 - a. Schedule appointments with Dr. Williams in person, by phone (505-819-0859), through her web site at www.carolinewilliamsphd.com, or through the patient portal for established clients.
2. Missed appointments: include not appearing for a scheduled appointment, cancelling an appointment without 24 hours' notice or arriving at an appointment more than 10 minutes late. If you arrive more than 10 minutes past your appointment time, Dr. Williams may not be able to see you and you may be rescheduled for another time.
 - a. Treatment may be discontinued if you miss an appointment three times without giving 24 hours' notice.
 - b. Please arrive at least 5 minutes early for your appointment to allow enough time to check in.
 - c. Face-to-face contact time during appointments scheduled for an hour usually lasts 50-55 minutes. Contact time for appointments scheduled for ½ hour usually lasts 20-25 minutes. Dr. Williams uses the remainder of the appointment time for completing tasks necessary for your treatment. This might include writing progress notes, communicating with the pharmacy about your prescription, communicating with your therapist and/or primary care doctor as needed, managing insurance and billing issues, and dealing with other management issues as they arise.
3. Children over the age of 24 months may not be present during an adult's session, and children under age 14 yrs may not remain in the waiting area unattended. Child care is not available at the office. Please make arrangements for supervision of your children during your appointment time. If you arrive for your appointment with children who need supervision, your appointment will be rescheduled.
4. Emergencies: If you have a clinical emergency, call 911, or Crisis Response of Santa Fe at 820-6333, or go to a hospital emergency room.
5. Non-Emergency Clinical Issues: For clinical issues between appointments, such as problematic side effects, contact Dr. Williams during business hours, 8 am-5 pm T-W-Th at 505-819-0859, or electronically through the patient portal.
6. Prescription Refill Policies: Please plan ahead when you need a medication refill so be sure to request a refill before your medication runs out.

- a. Remember that it may take up to 3 business days for Dr. Williams to generate a refill.
 - b. You are expected to attend all follow up appointments as requested by Dr. Williams. Clients on 'maintenance' medication are expected to attend a check-up appointment every three months. Clients who do not attend their appointments as requested may be tapered off medication or referred out.
 - c. If you have trouble obtaining your medication or medication refills, please contact the office directly rather than relying on the pharmacy to contact us.
7. Lab Work Policies: It is your responsibility, as the patient, to schedule and attend follow-up appointments with Dr. Williams following any laboratory or other tests ordered, in order to discuss the results of these tests. This ensures that abnormal test results are addressed in a timely manner.
 8. Random Drug Screens: You may be asked to participate in random drug screens (urine analysis) during your treatment with Dr. Williams. You may choose to decline such requests. However, your decision to decline a drug screen may affect Dr. Williams' decisions about your treatment, and may result in a referral to another treatment provider.
 9. One Provider: Your treatment will work best if you receive all of your mental health medications from one provider. This includes receiving medical cannabis for mental health reasons. If one of your other doctors prescribes you a mental health medication or cannabis, please discuss it with Dr. Williams. If you consistently obtain psychiatric medications or cannabis from multiple doctors over time, Dr. Williams may refer you to another provider.
 10. Treatment Participation: Your treatment will also work best if you follow Dr. Williams' requests and directions. She works to include you in the decision-making process and in treatment planning. Frequent disagreements with Dr. Williams' treatment recommendations, or lack of participation in treatment over time suggests that you may not be a good fit with Dr. Williams. Alternative providers and referrals will be provided in this case.

Part VI: FINANCIAL POLICIES

1. Responsible Party & Payment: The patient/responsible party is responsible for all fees. If Dr. Williams is a provider for your insurance plan, any deductibles or co-payments are expected at the time of your appointment. You are responsible for any balance on your account not paid by your insurance. Non-emergency treatment may be discontinued in response to a refusal to pay for services.
2. Co-pays and Coinsurance: Information initially obtained from your insurance about co-pays, deductible and coinsurance is not always correct. Once the first claims are paid, we can be more specific with you about your portion of the bill. A \$75 deposit may be requested at the 1st appointment if we are unable to obtain an estimate of your portion from your insurance.
3. Payment Options: Cash, check, credit and debit cards are accepted for payment. Payment is expected at the time of appointment. If you choose to pay in cash, please bring the correct amount as limited change is stored in the office.
4. Returned Checks: Returned checks are assessed a \$25.00 fee.
5. Collection Policy: You agree to pay any outstanding bills within 10 days of receipt. If payment is not received within 60 days, your account may be turned over to a collection agency. In such an event, the patient/responsible party will be responsible for all reasonable costs of collections, including attorney's fees, if any. The minimum collection fee will be 40% of the total account balance.
6. Records Requests: Records are copied at \$2.00 per page for the first 10 pages, then \$.20 per page, plus gross receipts tax, and billed directly to you. Federal law allows 30 days for processing records requests.

- 7. Letters: are often requested by patients (or their parents) for doctors, schools, employers, etc. Such letters may be provided with an administrative fee for this service, minimum \$25.00+gross receipt tax. Additional fees depend on the time involved with the specific request.
- 8. Gross Receipts Tax: applies to all charges except for deductibles, coinsurance and copays from managed care plans.

CONCLUSION:

Please feel free to discuss any questions or concerns with Dr. Williams before signing this form. You may obtain a copy of this form for reference and documentation.

I agree to participate in treatment under these conditions with Caroline B Williams, PhD MP.

Signature of Patient

Date

MEDICARE OPT OUT (Complete if you have Medicare)

Dr. Caroline Williams has “opted-out” of the Medicare program, which means that she is not a Medicare provider, and does not bill Medicare for her services. As a result,

- 1) Medicare billing limits do not apply to Dr. Williams’ charges.
- 2) Medicare may not reimburse for Dr. Williams’ services.
- 3) Medigap and other supplemental insurance plans may choose not to reimburse or make payments for Dr. Williams’ services.

You, as a Medicare recipient, have the option to obtain services from another provider who does accept Medicare. By signing below, you agree not to file a claim with Medicare for Dr. Williams’ services, and acknowledge receipt and understanding of the above information.

Signature of Insured

Date

MEDICAL & SOCIAL HISTORY

Patient Name: _____ Date of Birth _____

Date Completed: _____ Age: _____ Height: _____ Weight: _____

What pharmacy do you prefer? (please include street name) _____

Drug, medication or medical equipment allergies (latex, etc.): _____

List all medications, supplements, and herbals (including medical cannabis) that you take occasionally, as needed, or daily: **(including medical cannabis)**

| <u>Medication/supplement</u> | <u>Dose</u> <i>(example, 10 mgs)</i> | <u>Tablet or Capsule</u> | <u>Usage</u> <i>(example 2 times/ day)</i> | <u>Prescribed by</u> |
|------------------------------|---|--------------------------|---|----------------------|
| | | | | |
| | | | | |
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| | | | | |
| | | | | |
| | | | | |
| | | | | |

Please complete the following questions regarding your current and/or past medical history. Place a check mark or 'x' next to the medical conditions that you have had or have, indicating whether they occurred in the past or are happening presently. If you have never had trouble with a particular medical condition, leave that row blank.

| Now | Past | <u>GASTROINTESTINAL</u> | Now | Past | <u>GENITAL & URINARY SYSTEMS</u> |
|-----|------|------------------------------------|-----|------|--------------------------------------|
| | | Irritable Bowel Syndrome | | | Kidney Stones |
| | | Inflammatory Bowel Disease | | | Gout |
| | | Crohn's | | | Interstitial |
| | | Ulcerative Colitis | | | Cystitis |
| | | Gastritis or Peptic Ulcer Disease | | | Frequent Urinary Tract Infections |
| | | GERD (reflux) | | | Frequent Yeast Infections |
| | | Celiac Disease | | | Erectile Dysfunction |
| | | Other: | | | Other: |
| | | <u>CARDIOVASCULAR</u> | | | <u>MUSCULOSKELETAL PAIN</u> |
| | | Heart Attack (date: _____) | | | Osteoarthritis |
| | | Other Heart Disease | | | Fibromyalgia |
| | | Stroke (date: _____) | | | Chronic Pain |
| | | Elevated Cholesterol | | | Other: |
| | | Arrythmia (irregular heart rate) | | | <u>INFLAMMATORY/AUTOIMMUNE</u> |
| | | Hypertension (high blood pressure) | | | Chronic Fatigue Syndrome |
| | | Rheumatic Fever | | | Autoimmune Disease |

| | | | | | |
|------------|-------------|---|------------|-------------|--|
| | | Mitral Valve Prolapse | | | Rheumatoid Arthritis |
| | | Other: | | | Lupus |
| | | <u>METABOLIC/ENDOCRINE</u> | | | Immune Deficiency Disease |
| | | Type 1 Diabetes | | | Herpes-Genital |
| | | Type 2 Diabetes | | | Severe Infectious Disease |
| Now | Past | | Now | Past | |
| | | Hypoglycemia | | | Poor Immune Function (frequent infections) |
| | | Metabolic Syndrome (insulin resistance) | | | Food Allergies |
| | | Hypothyroidism (low thyroid) | | | Environmental Allergies |
| | | Hyperthyroidism (overactive thyroid) | | | Multiple Chemical Sensitivities |
| | | Endocrine Problems | | | Latex Allergy |
| | | Polycystic Ovarian Syndrome (PCOS) | | | Other: |
| | | Infertility | | | <u>RESPIRATORY DISEASES</u> |
| | | Weight Gain | | | Asthma |
| | | Weight Loss | | | Chronic Sinusitis |
| | | Frequent Weight Fluctuations | | | Bronchitis |
| | | Bulimia | | | Emphysema/COPD |
| | | Anorexia | | | Pneumonia |
| | | Binge Eating Disorder | | | Tuberculosis |
| | | Night Eating Disorder | | | Sleep Apnea |
| | | Eating Disorder (non-specific) | | | Other: |
| | | Other: | | | <u>SKIN DISEASES</u> |
| | | <u>CANCER</u> | | | Eczema |
| | | Lung Cancer | | | Psoriasis |
| | | Breast Cancer | | | Acne |
| | | Colon Cancer | | | Melanoma |
| | | Ovarian Cancer | | | Skin Cancer |
| | | Prostate Cancer | | | Other: |
| | | Other: | | | <u>NEUROLOGICAL DISEASES</u> |
| | | <u>PSYCHIATRIC DISEASES</u> | | | Mild Cognitive Impairment |
| | | Depression | | | Autism |
| | | Anxiety | | | Memory Problems |
| | | Bipolar Disorder | | | Parkinson's Disease |
| | | Schizophrenia | | | Multiple Sclerosis |
| | | Dissociative Disorder | | | ALS |
| | | Post-Traumatic Stress Disorder | | | Headaches |
| | | Obsessive-Compulsive Disorder | | | Seizures |
| | | Gambling Addiction | | | Migraines |
| | | | | | ADD/ADHD |
| | | | | | Learning Disability |

Other medical conditions not listed above: _____

Auto accidents: _____

Tobacco Use: _____

(Non-smoker, Ex-smoker, Light smoker, Moderate smoker, Heavy smoker, Chews tobacco, etc...)

Psychiatric Medications: Please mark any medications that you have tried in the past.

| Generic Drug Name | Brand Name | Past Use | Worked | Bad Reaction (explain) |
|-------------------------|--------------------|----------|--------|------------------------|
| Antidepressants | | | | |
| Imipramine | Tofranil | | | |
| Desipramine | Norpramin | | | |
| Amitriptyline | Elavil | | | |
| Nortriptyline | Pamelor | | | |
| Trazodone | Desyrel, Oleptro | | | |
| Nefazodone | Serzone | | | |
| Fluoxetine | Prozac | | | |
| Bupropion | Wellbutrin | | | |
| Sertraline | Zoloft | | | |
| Paroxetine | Paxil | | | |
| Venlafaxine | Effexor | | | |
| Esketamine | Ketanest, Spravato | | | |
| Desvenlafaxine | Pristiq | | | |
| Fluvoxamine | Luvox | | | |
| Mirtazapine | Remeron | | | |
| Citalopram | Celexa | | | |
| Escitalopram | Lexapro | | | |
| Duloxetine | Cymbalta | | | |
| Vilazodone | Viibryd | | | |
| Atomoxetine | Strattera | | | |
| Vortioxetine | Trintellix | | | |
| Levomilnacipram | Fetzima | | | |
| Milnacipram | Savella | | | |
| Phenelzine | Nardil | | | |
| Tranylcypromine | Parnate | | | |
| Selegiline | Emsam (patch) | | | |
| Mood Stabilizers | | | | |
| Lithium | Eskalith | | | |
| Olanzapine/Fluoxetine | Symbyax | | | |
| Carbamazepine | Tegretol | | | |
| Divalproex | Depakote | | | |
| Lamotrigine | Lamictal | | | |
| Oxcarbazepine | Trileptal | | | |
| Gabapentin | Neurontin | | | |
| Pregabalin | Lyrica | | | |
| Stimulants | | | | |
| Methylphenidate | Ritalin, Concerta | | | |
| Dexmethylphenidate | Focalin | | | |
| Dextromethylphenidate | Dexedrine | | | |
| Lisdexamphetamine | Vyvanse | | | |

| Generic Drug Name | Brand Name | Past Use | Worked | Bad Reaction (explain) |
|--|-------------------|----------|--------|------------------------|
| D-and L-amphetamine | Adderall | | | |
| Modafinil | Provigil, Sparlon | | | |
| Armodafonil | Nuvigil | | | |
| Antipsychotics | | | | |
| Chlorpromazine | Thorazine | | | |
| Clozapine | Clozaril | | | |
| Quetiapine | Seroquel | | | |
| Perphenazine | Trilafon | | | |
| Loxapine | Loxitane | | | |
| Fluphenazine | Prolixin | | | |
| Haloperidol | Haldol | | | |
| Pimozide | Orap | | | |
| Risperidone | Risperdal | | | |
| Paliperidone | Invega | | | |
| Olanzapine | Zyprexa | | | |
| Ziprasidone | Geodon | | | |
| Iloperidone | Fanapt | | | |
| Asenapine | Saphris | | | |
| Lurasidone | Latuda | | | |
| Aripiprazole | Abilify | | | |
| Brexipiprazole | Rexulti | | | |
| Cariprazine | Vraylar | | | |
| Anti-Anxiety Medications | | | | |
| Diazepam | Valium | | | |
| Chlordiazepoxide | Librium | | | |
| Clonazepam | Klonopin | | | |
| Lorazepam | Ativan | | | |
| Alprazolam | Xanax | | | |
| Buspirone | BuSpar | | | |
| Gabapentin | Neurontin | | | |
| Hydroxyzine | Atarax, Vistaril | | | |
| Propranolol | Inderal | | | |
| Atenolol | Tenormin | | | |
| Guafacine | Tenex, Intuniv | | | |
| Clonidine | Catapres, Kapvay | | | |
| Pregabalin | Lyrica | | | |
| Prazosin | Minipress | | | |
| Experimental Therapies | | | | |
| Medical Cannabis | | | | |
| Ketamine | Ketalar | | | |
| PsiLocybin (Under Medical Supervision) | | | | |

| Generic Drug Name | Brand Name | Past Use | Worked | Bad Reaction (explain |
|---|------------|----------|--------|-----------------------|
| MDMA (Under Medical Supervision) | | | | |
| Other: | | | | |
| Other: | | | | |
| Herbal, Supplements, Medical Foods | | | | |
| L-Methylfolate | Deplin | | | |
| St. John's Wort | | | | |
| SAM-E | | | | |
| Omega-3 EPA | | | | |
| 5-HTP | | | | |
| Electricity-Based Therapies | | | | |
| Electroconvulsive Therapy (ECT) | | | | |
| Transcranial Magnetic Stimulation (TMS) | | | | |
| Other: | | | | |

Hospitalizations and Surgeries:

| Where | When | Reason |
|-------|------|--------|
| | | |
| | | |
| | | |
| | | |

Family History: Do any of your relatives have the following: (mark the box to the left of each illness)

| | | | |
|--------------------------|-----------------------|--------------------------|---------------------|
| <input type="checkbox"/> | Alzheimer's | <input type="checkbox"/> | High Blood Pressure |
| <input type="checkbox"/> | Diabetes | <input type="checkbox"/> | Senile Dementia |
| <input type="checkbox"/> | Tuberculosis | <input type="checkbox"/> | Asthma |
| <input type="checkbox"/> | Heart Disease | <input type="checkbox"/> | Kidney Disease |
| <input type="checkbox"/> | Parkinson's | <input type="checkbox"/> | Stroke |
| <input type="checkbox"/> | Autoimmune Disorder | <input type="checkbox"/> | Other: _____ |
| <input type="checkbox"/> | Cancer (type: _____) | <input type="checkbox"/> | Mental Illness |

Gynecological History (Women Only)

If female, might you be pregnant? _____
 Birth Control Method: _____
 Provide number of:
 Pregnancies _____ Caesarean _____ Vaginal Deliveries _____ Miscarriage _____ Abortion _____

| Now | Past | WOMEN'S DISORDERS/HORMONAL IMBALANCES |
|-----|------|---------------------------------------|
| | | Fibrocystic Breasts |
| | | Endometriosis |
| | | Fibroids |
| | | Infertility |
| | | Painful Periods |
| | | Heavy Periods |
| | | PMS |
| | | Decreased libido |
| | | Trouble reaching orgasm |

Are you in menopause? yes no Age at Menopause: _____

Men's History (Men only)

Have you had your testosterone checked? yes no

Testosterone results normal low high

| Now | Past | Men's Disorders |
|-----|------|------------------------------------|
| | | Change in Libido |
| | | Impotence |
| | | Difficulty Obtaining an Erection |
| | | Difficulty Maintaining an Erection |

What did you eat for the last 2 days?

| Day 1 | Day 2 |
|--|--|
| Breakfast _____ _____ _____ _____ _____ | Breakfast _____ _____ _____ _____ _____ |
| Lunch _____ _____ _____ _____ _____ | Lunch _____ _____ _____ _____ _____ |
| Dinner _____ _____ _____ _____ _____ | Dinner _____ _____ _____ _____ _____ |
| Snacks _____ _____ _____ _____ _____ | Snacks _____ _____ _____ _____ _____ |
| Drinks _____ _____ _____ _____ | Drinks _____ _____ _____ _____ |

“Let food be thy medicine, and medicine be thy food” - Hippocrates

“He that takes medicine and neglects diet wastes the skills of the physician”. - Chinese Proverb

AUTHORIZATION TO RELEASE INFORMATION TO PRIMARY CARE PROVIDER

CLIENT NAME: _____

DATE OF BIRTH: _____

I do hereby authorize Dr. Caroline Williams to: Disclose to Exchange with Obtain from

My Primary Care Provider _____

Address: _____ Phone: _____ Fax: _____

Indicate the type of information to be disclosed by indicating Yes or No for EACH choice below:

- | | | |
|--|--|--|
| <input checked="" type="checkbox"/> No Mental Health Treatment | <input checked="" type="checkbox"/> No Alcohol/Drug Abuse Treatment | <input checked="" type="checkbox"/> No Progress Notes |
| <input checked="" type="checkbox"/> No Intake Narrative/ASI | <input checked="" type="checkbox"/> No Program Attendance/Compliance | <input checked="" type="checkbox"/> No Testing & Lab Results |
| <input checked="" type="checkbox"/> No Drug Screen Results | <input checked="" type="checkbox"/> No Treatment Plan | <input checked="" type="checkbox"/> No HIV Status |
| <input checked="" type="checkbox"/> No Medical Information | <input checked="" type="checkbox"/> No Progress in treatment/Prognosis | <input checked="" type="checkbox"/> No Emergency Medical information |
| <input checked="" type="checkbox"/> No Other specific information to be released | Please specify: _____ | |
| <input checked="" type="checkbox"/> No All records (please circle if Yes) | | |

This information to be released by means of: Photocopies/mail Verbal/telephone Fax

Information to be released is for services during the period of _____ to completion of treatment with Dr. Williams

The purpose of this disclosure is: Continuity of care Other (Please specify) _____

I understand that my records are protected by state and federal confidentiality laws and cannot be disclosed without my written consent unless otherwise permitted by law. I understand that I may revoke this authorization at any time except to the extent that action has already been taken. I have the right to revoke this consent, but revocation will not be effective until received in writing by the person in possession of my records. If you give written consent to re-disclose your information by the recipient, it may no longer be protected by federal or state laws. If not revoked earlier, this consent will expire as specified below, or if not specified, within one year from the date signed.

Date consent expires: upon completion of treatment with Dr. Williams or one year from the date of client or legal guardian's signature.

Signature of client or legal guardian Date Signature of Witness Date

In the case of Substance Abuse Records: This information has been disclosed to you from records protected by Federal Confidentiality Rule 42 CFR, Part 2. The Federal Rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal Rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse client.

NOTICE OF PRIVACY PRACTICES

Effective Date: April 14, 2003

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

PLEASE READ IT CAREFULLY.

Uses and Disclosures:

Treatment: Mental health providers do not disclose information to other health care professionals without your written consent.

Payment: Your health information may be used to seek payment from your health plan, from other sources of coverage such as an automobile insurer, or from credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, services provided, and the medical condition being treated. Should your account become delinquent, your information may be used to seek payment through a collection agency.

Health Care Operations: Your health information may be used as necessary to support the day-to-day activities and management of this mental health practice. For example, information on the services you receive may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

Law Enforcement: Your mental health information may be disclosed to law enforcement when a legitimate subpoena or court order is presented. Further, information regarding physical, sexual or emotional abuse of a child or an elderly person, and potentially imminent suicidal and/or homicidal behavior, may be released to law enforcement without your knowledge.

Public Health Reporting: Mental health professionals do not participate in public health reporting.

Licensing Boards: Revelation that another mental health provider has engaged in a sexual relationship with a client must be reported to the licensing board for that provider. The client involved may remain anonymous in such a report.

Additional Uses of Information: Mental health professionals in this office do not mail Appointment reminders. Your health information will not be used to provide you with information about treatments through the mail, and will not be used for fund raising activities.

Other uses and disclosures require your authorization: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Individual Rights: You have certain rights under the federal privacy standards. These include:

1. The right to request restrictions on the use and disclosure of your protected health information
2. The right to receive confidential communications concerning your medical condition and treatment
3. The right to inspect and copy your protected health information
4. The right to amend or submit corrections to your protected health information.
5. The right to receive an accounting of how and to whom your protected health information has been disclosed
6. The right to receive a printed copy of this notice

We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices.

We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy policies and practices. These changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Request to Inspect Protected Health information: As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the office manager or your mental health provider.

Complaints: If you would like to submit a comment or complaint about our privacy practices, you can do so by sending a letter outlining your concerns to:

Dr. Caroline B. Williams
2204 Brothers Rd, Ste. B
Santa Fe, NM 87505

If you believe that your privacy rights have been violated, you should call the matter to our attention by sending a letter describing the cause of your concern to the same address. You will not be penalized or otherwise retaliated against for filing a complaint.

Contact Person: The name and address of the person you can contact for further information concerning our privacy practice is:

Dr. Caroline B. Williams
2204 Brothers Rd, Ste. B
Santa Fe, NM 87505

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Use and Disclosure of Your Protected Health Information:

Your protected health information will be used by your treatment provider or disclosed to others for the purposes of treatment, obtaining payment, or supporting the day-to-day health care operations of the practice.

Notice of Privacy Practices:

You should review the Notice of Privacy Practices for a more complete description of how your protected health information may be used or disclosed. You may review the notice prior to signing this consent.

Requesting a Restriction on the Use or Disclosure of Your Information:

You may request a restriction on the use or disclosure of your protected health information. Your provider may or may not agree to restrict the use or disclosure of your protected health information. If your provider agrees to your request, the restriction will be binding on the practice. Use and disclosure of protected information in violation of an agreed upon restriction will be a violation of the federal privacy standards.

Revocation of Consent:

You may revoke this consent to the use and disclosure of your protected health information. You must revoke this consent in writing. Any use or disclosure that has already occurred prior to the date on which your revocation is received will not be affected.

Reservation of Right to Change Privacy Practices:

Your provider reserves the right to modify the privacy practice outlined in this notice.

I have received a copy of the privacy guidelines for private health information as they are applied to Dr. Williams' practice. I have reviewed this consent form and give my permission to Dr. Williams to use and disclose my health information in accordance with the guidelines in this form and the office's general privacy policies.

Printed Name

Date of Birth

Signature

Date of Signature

**CONSENT TO RECEIVE TEXT AND VOICE TELEPHONE CALL
REMINDERS**

In addition to providing courtesy appointment reminder e-mails to our patients, we are also able to provide appointment reminder phone calls and/or text messages. In order to authorize receiving calls and/or text messages, please fill out the information below and provide the phone number where you wish to receive these messages.

By providing your cell phone number below, you consent to receiving appointment reminder calls and/or text messages on your cell phone. If you would like us to utilize a different phone number, please provide that number below instead of your cell phone number.

I understand that once Dr. Caroline Williams sends a text or voice message, she no longer has control over who has access to this information.

Upon reviewing the above information, I still request that Dr. Williams send appointment reminders via text and/or voice messaging.

Patient Name: _____

Date of Birth: _____

Signature

Date

Preferred contact mode is:

- Cellular Phone Call
- Cellular Text Message
- E-mail
- All of the above

Cellular phone number to call and/or text: _____

E-mail Address: _____