Pelorus
Elder & Behavioral Health

_____
Patient Last Name

Office Information and Treatment Agreement

Welcome to our group practice, specializing primarily (but not exclusively) in Geriatric Psychiatry. We thought it would be helpful to spell out some details, to avoid any confusion. Our goal is to help you (or your loved one) feel better, while realizing that no honest person can predict the future or guarantee an outcome. To work together successfully, we need some guidelines:

1. **SCOPE OF PRACTICE/SERVICES:**
   Pelorus Elder & Behavioral Health is a group Psychiatric practice, with services provided by Psychiatrists, Nurse Practitioners, and Physician Assistants. Our Medical Director is Dr. Matthew Barnas. Our team assists patients with issues like memory loss, depression, anxiety, insomnia, weight loss, ADD, paranoia, delusions, hallucinations, impulsivity, and dementia with behavioral disturbances. We have experience treating individuals in hospital-based, residential, and office-based settings. We also offer TMS (Transcranial Magnetic Stimulation), a non-medication treatment for Depression not improving with medications, as well as SPRAVATO™ (esketamine) a new nasal spray for Depression not responding to other medications. Please note: **Should you be interested exclusively in psychotherapy only (no medication treatment), we would be happy to refer you out to an appropriate practice.**

   For more information about our team of clinicians, please visit our website:
   http://pelorusmemory.com/about/

2. **CANCELLATION AND NO-SHOW POLICY:**
   You (or your loved one) will receive the best benefit from treatment if you come to your appointments regularly. If you must cancel an appointment, this Agreement represents your promise that you will do so **at least 24 hours in advance of your scheduled time**. If you do not cancel 24 hours in advance, Pelorus Elder & Behavioral Health will need to charge you for a missed session, because your clinician will have reserved that treatment time for you, and will be unable to use that time to see any other patient. A missed appointment cannot be billed to your insurance carrier, which means **that you will be responsible for paying in full a $100 cancellation fee for the missed appointment**.

   Pelorus Elder & Behavioral Health recognizes that emergencies or other unplanned events do arise that cannot be helped (flat tires, illness, family emergencies), so **this Agreement allows you to cancel one (1) appointment less than 24 hours in advance within any 6 month period, without any charge to you.** If you cancel more than that, you understand and agree that Pelorus Elder & Behavioral Health can bill you $100 for each missed appointment.

   We try very hard to accommodate our patients and to see them in a timely manner; however, there is often a waiting list for individuals seeking treatment due to a lack of available session times. Therefore, if you miss 3 appointments where you fail to give 24 hours cancellation notice within any 12 month period, you may be dismissed from Pelorus Elder & Behavioral Health.

3. COMMUNICATION:

You may contact our office during regular business hours, Monday through Friday from 9:00 AM to 5:00 PM at 973-295-6335. We will be happy to help you with appointments, with insurance questions, or with clinical questions. Our clinicians make all reasonable efforts to respond to calls promptly.

We always prioritize "Safety First", therefore:

******If you have an emergency or crisis, and are unable to reach your clinician: please do not hesitate to call 911, or call or go to your local hospital's emergency room for immediate help - such as Overlook Hospital's Crisis Center (908-522-3586) or Morristown Hospital's Crisis Center (973-971-5402) or RWJ Somerset Hospital's Crisis Center (800-300-0628).** The ER staff will contact us, while you are safely under the hospital's care and supervision.********

During business hours, if you are routed to our secure voicemail, it means our team is occupied assisting other patients, and *you should kindly leave us a detailed message in order for us to follow up with you as efficiently as possible*. Non-urgent calls are usually returned within the same day, but at the latest, by the following business day.

When leaving us a message, please select the **appropriate option** from our voicemail system as follows:

- Refill requests, press **3**
- Appointments and questions for your clinician, press **0**
- Emergencies, press **5**
- TMS, press **1**

We ask that you please utilize the above voicemail options and leave your messages in the correct inboxes. Note that refill requests and routine appointment scheduling are *not* considered emergencies. If you leave your message in the *wrong voicemail* (such as a "refill request" in the Emergency voicemail), **it may cause a delay in our ability to respond.**

The office is **not** staffed on weekends or holidays.

If you are calling with a very serious, emergency situation, press "**5**" and leave your message there. This emergency line is monitored 24 hours/day, 7 days/week. Your message will go directly to our clinician that is on-duty covering *emergency* calls. (Again, this option is not for refills or routine appointments.

4. EMAIL:

Be aware that email is not a confidential means of communication. We also cannot guarantee that email messages will be received or responded to in a timely fashion. As such, **email is not an appropriate way to communicate very urgent or confidential information**. Dr. Barnas and our medical providers do not email with patients or family, although our administrative office team will email with patients for non-urgent issues like medication refills and appointment scheduling (see below).

5. MEDICATION REFILL REQUESTS:

Please keep track of your medication supply. Kindly **email your medication refill requests** to our staff with "Refill" in the subject line, to: office@pelorusmemory.com

In your email, please include:

- the patient's name and birthday
- name, dosage, strength, and the instructions for the medication(s) which need refilling,
- the name and phone number of your pharmacy

The office is staffed Monday through Friday, 9am – 5pm. Medications will be **refilled within two (2) business days**, so please give us enough advance notice. (If you do not use email, you may call our office at 973-295-6335, and leave the refill info in mailbox "**3**". Email is preferred, if possible).

Routine medication refills **will not be phoned in by on-call coverage, off-hours, weekends, or holidays.

6. INSURANCE, BILLING, AND PAYMENTS:

This Agreement requires that you pay for each session you have at Pelorus Elder and Behavioral Health. If you have health insurance, your Psychiatric treatment may be covered in whole or in part. Where applicable, we will bill the insurance company for you, but you are required to pay your co-payment and any deductible involved. As a courtesy, we will check with your insurance carrier, and will make reasonable attempts to determine what you will need to pay at each session; however, we cannot guarantee that the information provided to us is correct, and you are ultimately responsible for determining your insurance coverage and for paying the treatments provided to you which are not covered by your insurance plan.

Some insurance policies may require a "Prior Authorization" before covering the costs of treatment. Or, your plan may involve a minimum "Deductible" payment every year. If your policy requires it, we will endeavor to obtain a "Prior Authorization" for your psychiatric treatment. If you have any remaining "Deductible" on your policy at the time of our service, it would need to be paid by you, before your insurance policy would cover the cost of your treatment – exactly the same as an auto insurance policy "deductible".

When patients with a policy "deductible" are seen early in the year (ie January or February), they usually have yet to pay their deductible for that new year - therefore they receive a higher-than-normal bill. The reason for the higher bill is because your policy's deductible has to be paid. Please call your insurance company to clarify if your policy requires a "prior authorization" or has a "deductible" remaining. **Every patient has a different policy with different details, so you must communicate directly with your insurers, to understand the particulars related to your own specific insurance policy.** If your insurance denies coverage because of such, you are responsible for payment.

By signing this Agreement you agree that you will pay any outstanding amounts due and owing to Pelorus Elder & Behavioral Health. In circumstances of financial hardship, please contact our office to discuss the situation.

7. SECOND OPINION:

If at any time you desire a second opinion (with an outside, non-Pelorus provider), please feel free to discuss this with us. We are eager to help you, and will not be offended by such a request.

8. MEDICATIONS:

Medications may be recommended to help improve the symptoms which led you (or your loved one) to seek a consultation. If it is agreed that medications are indicated, your treating clinician will discuss with you the various medication options that are available to treat your current condition. Information will be presented to you in language that you can understand.

Treatment with medications of any kind always involves potential risks and benefits. You will learn the potential benefits of the medication, possible side effects and risks, its dosage and frequency, possible drug interactions, and any withdrawal effects you may experience if you stop taking the medication abruptly.

By the end of the discussion you will have all the information you need to make an informed decision as to which medication is right for you (or your loved one). If you decide that the benefits of treatment outweigh the risks, medications will be prescribed. **If you have questions about the medications, your treating Pelorus medical provider will be happy to answer them.**

9. CONFIDENTIALITY:

Confidentiality is a cornerstone of mental health treatment and is protected by the law. We can only release information about you to others with your written permission. Some basic information about diagnosis and treatment may be required as a condition of your insurance coverage.

Exceptions to confidentiality where disclosure is required by law:

- if there is threat of serious bodily harm to others, we are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization
- if there is threat to harm yourself, we are required to seek hospitalization for the patient, or to contact family members or others who can help provide protection
- if there is an indication of abuse to a child, an elderly person, or a disabled person, even if it is about a party other than yourself, we must file a report with the appropriate state agency
- if you are involved in judicial proceedings, you have the right to seek to prevent us from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require our testimony
- if due to mental illness, you are unable to meet your basic needs, such as clothing, food, and shelter, we may have to disclose information in order to access services to provide for your basic needs
- These situations have rarely arisen in our clinical practice, but should such a situation occur, we will make every effort to fully discuss it with you before taking any action.

10. TREATMENT CONSENT:

By signing below, you certify that you have read this five (5) page document and understand the terms stated in this Office Policy and Treatment Consent Form. You understand that you have the right to choose between treatment vs. non-treatment, and that you can always inquire about the risks and benefits of treatment options. You understand that outcomes are not guaranteed. You agree that Pelorus Elder & Behavioral Health will bill you for missed appointments that were not cancelled in advance, per policy number two, on page one. You indicate that you understand the nature of our offered services, the office and payment policies, insurance reimbursement, confidentiality issues, and our contact information, and that you agree to abide by the terms stated above during our professional relationship.

Signed_____ Date_____

Patient
(or Power-of-Attorney)

Pelorus
Elder & Behavioral Health

Authorization to Release Health Information Pursuant to HIPAA

Patient Name_____ **Birth Date**_____

Authorization: By signing this form, I authorize:

- Any other providers involved in my medical care to release my records to Pelorus Elder & Behavioral Health.
- Pelorus Elder & Behavioral Health to release my records to the following people, without requiring a signed release from them:

Primary Care Physician: _____

Neurologist / Other Doctors: _____

Therapist: _____

Family / Other (POA, Spouse, Parent, Children, etc): _____

_____

I, or my authorized representative, request and authorize that health care information regarding my care and treatment be released as described below:

Complete medical record (unless otherwise noted here): _____

_____

I *specifically authorize* the release of the following types of highly confidential information: AIDS or HIV, Mental Health Information, Treatment Recommendations, Drug and Alcohol information, and Sexually Transmitted Diseases. (Unless otherwise noted immediately above)

I understand that, unless action already has been taken in reliance on this authorization, I may revoke this authorization at any time by making a written request to Pelorus Elder & Behavioral Health.

I understand that signing this authorization is voluntary and that Pelorus Elder & Behavioral Health, may not condition treatment, payment, enrollment, or eligibility for benefits on my signing this authorization, unless my treatment is related to research and the purpose of this authorization is to enable the protected health information described above to be used for such research.

I understand that information disclosed based on this authorization may be subject to re-disclosure by the recipient, and no longer protected by federal or state privacy regulations.

I have received a copy of this authorization.

Purpose of Release: Records are being released for **continuity of my medical care**, and/or for the reasons specified here: _____

Signature of Patient: _____
(or Authorized Representative, i.e. Power of Attorney)

Date: _____

Name of Authorized Representative (if applicable) _____

Authority of Representative (ie Power of Attorney): _____
(if applicable)

Signature of Witness: _____

Pelorus
Elder & Behavioral Health

PATIENT DEMOGRAPHIC INFORMATION

Date_____ Referred by:_____

Patient: _____
Last Name First Name Middle Initial

Cell Ph:_____Home Ph: _____Email:_____
(indicate preferred method of contact)

Sex: ☐ M ☐ F Age_____Date of Birth_____ ☐ Single ☐ Married ☐ Widowed ☐ Separated ☐ Divorced

Street Address _____ City_____State_____Zip_____Social Security #_____

Primary Care Doctor:_____ Doctor's Phone:_____

Doc's Fax:_____Doc's Address:_____

Neurologist:_____ Neurologist's Phone:_____

Neurologist Fax:_____ Neurol's Address:_____

☐Retired ☐ Working ☐ Student ☐ On Disability Employer/School (if applies)_____

Spouse's Name (or Guardian/Next of Kin)_____

Who is responsible for this account? (ie Self, "Power of Attorney", etc) _____

Relationship to patient: (if other than "Self") _____

Do you have Medical Insurance? ☐Yes ☐ No If yes:

Name of **Primary** Insurance (ie Medicare, Cigna, etc) _____

Name of **Secondary** Insurance (if any, ie AARP, etc) _____

In case of emergency, who should be notified?_____Phone #_____

Preferred Pharmacy_____ Phone #_____

Pharmacy Address _____

ASSIGNMENT AND RELEASE

I, the undersigned, have insurance coverage with:

_____
Name of Insurance Company

And assign directly to Pelorus Elder & Behavioral Health all medical benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance. I hereby authorize the doctor to release all information necessary to secure the payment of benefits. I authorize the use of this signature on all my insurance submissions.

_____ _____
Signature of Insured/Guardian **Date**

MEDICARE AUTHORIZATION

I request that payment of authorized Medicare benefits be made either to me or on my behalf to Pelorus Elder & Behavioral Health for any services furnished me by that physician. I authorize any holder of medical information about me to release to the Health Care Financing Administration and its agents any information needed to determine these benefits or the benefits payable for related services. I understand my signature requests that payment be made and authorizes release of medical information necessary to pay the claim. If "other health insurance" is indicated in item 9 of the HCFA-1500 form, or elsewhere on other approved claim forms or electronically submitted claims, my signature authorizes releasing of the information to the insurer or agency shown. In Medicare assigned cases, the physician or supplier agrees to accept the charge determination of the Medicare carrier as the full charge, and the patient is responsible for only the deductible, coinsurance, and non-covered services. Coinsurance and deductible are based upon the charge determination of the Medicare Carrier.

_____ _____
Signature of Insured/Guardian **Date**

**In the event of late cancellation or no-show for a scheduled appointment, you may be charged a fee per Pelorus policy*

Pelorus
Elder & Behavioral Health

NEW PATIENT INTAKE QUESTIONNAIRE

Patient Name:_____ **Date:** _____

Patient Date of Birth: _____

Who referred you to Pelorus Elder & Behavioral Health, or how did you find out about this practice?

_____

Reason for seeking evaluation/treatment (ie Diagnosis, Symptoms, Recent History)?

_____

_____

_____

_____

Stressors/Precipitants contributing to current situation/symptoms?

_____

_____

Past Psychiatric History?

Previous psychiatrists? _____

Previous Psych. Diagnoses? _____

Past Psychiatric Meds? _____

_____

Past Inpatient psychiatric hospitalization, or "IOP" / "Partial Hospital" treatment?

_____

Any violent, self-injurious, or suicidal behaviors? _____

_____

Past treatment with ECT ("Shock Treatments"), TMS, or Ketamine? _____

_____

Substance Abuse History (i.e. Nicotine, alcohol, painkillers, illegal drugs, etc.)?

Do you smoke?_____If so, how many per day? _____

Have you ever smoked?_____For how long?_____How many per day? _____

Do you use or have you used any illegal drugs?_____If so, please describe. _____

_____

Have you misused, abused, or become addicted to any painkillers? _____

Do you consume alcohol?_____If so, please describe the frequency and amount:

_____

Past Medical History:

	Yes	No		Yes	No
Vision Loss	☐	☐	Seizures with high fever as child or baby	☐	☐
Glaucoma	☐	☐	Head trauma w/loss of consciousness	☐	☐
Loss of hearing	☐	☐	Back pain	☐	☐
Recurrent Vertigo	☐	☐	Hematological disorder (Sickle cell, Hemophilia)	☐	☐
Hypertension (High Blood Pressure)	☐	☐	Bleeding Tendency	☐	☐
Dyslipidemia (High Cholesterol)	☐	☐	Diabetes	☐	☐
History of M.I. ("Heart attack")	☐	☐	Thyroid disease	☐	☐
COPD / Emphysema	☐	☐	Immunologic disorder (Rheumatoid Arthritis, Lupus, etc)	☐	☐
Gastrointestinal disease	☐	☐	Chronic allergies/hay fever	☐	☐
Liver disease	☐	☐	Depression	☐	☐
Chronic skin condition	☐	☐	Psychiatric illness other than Depression	☐	☐
Osteoarthritis / Degenerative Joint Disease	☐	☐	Kidney disease, Prostate, or other urological disorder	☐	☐
Chronic sleep disorder	☐	☐	Tuberculosis	☐	☐
Stroke (CVA)	☐	☐	HIV or AIDS	☐	☐
Alzheimer's or other cognitive Disorder	☐	☐	Encephalitis or Meningitis	☐	☐
Parkinson's or other movement disorder	☐	☐	Polio	☐	☐
Essential tremor	☐	☐	Infections (Lyme, Tuberculosis…)	☐	☐
Fainting or blackouts	☐	☐	Gynecological problems	☐	☐
Seizures/Epilepsy	☐	☐	Any history of cancer	☐	☐

Please list any other medical illnesses not already described, or clarify any noted above:

_____

_____

_____

Current Medications (Including Psychiatric Meds):
(Please list all medications, doses, and frequency/schedule for each)

_____

_____

_____

_____

_____

_____

Allergies (to medications or food):

❒No Known Drug Allergies _____

Personal/Social history:

Location born and raised? _____

Education / Degree? _____

Occupation? _____

For how long?_____If unemployed or retired, how long? _____

Marital Status?_____Living situation? (alone, etc) _____

Children? How many? _____

Any history of being the victim of abuse? _____

Any history of any legal problems, including DUI's? _____

Any Family History of neurological or psychiatric illness?_____

_____

Review of Systems:

(Please indicate any relevant symptoms below, or check "N/A" if no symptoms apply):

	Other:	N/A
CONSTITUTIONAL: ❒fever ❒fatigue ❒night sweats ❒weight loss		
EYES: ❒glasses ❒blindness ❒double vision ❒visual field deficit ❒drooping eyelid		
EAR NOSE THROAT: ❒hearing loss ❒tinnitus ❒infection ❒trouble swallowing ❒snoring		
CARDIOVASCULAR: ❒shortness of breath ❒chest pain ❒edema ❒palpitations ❒heart murmur		
PULMONARY: ❒cough ❒wheezing ❒shortness of breath ❒coughing up blood		
GASTROINTESTINAL: ❒constipation ❒vomiting ❒diarrhea ❒rectal bleeding ❒nausea ❒abdominal pain		
SKIN: ❒rash ❒itchiness ❒ulcers ❒lesions		
MUSCULOSKELETAL: ❒back pain ❒joint pain or stiffness ❒joint swelling ❒muscle cramps or weakness		
NEUROLOGICAL: ❒memory loss ❒headache ❒tremor ❒dizziness ❒paralysis or weakness (ie hemiplegia after a stroke)		
HEMATOLOGICAL/LYMPHATIC: ❒bleeding tendency ❒tendency to bruise easily ❒history of blood clots		
ENDOCRINE: ❒increased urination ❒increased appetite ❒intolerance to heat or cold ❒weight loss ❒weight gain		
ALLERGIC/IMMUNO: ❒swollen lymph nodes ❒reactions to food or medications		
PSYCHIATRIC: ❒depression ❒anxiety ❒panic attacks ❒insomnia ❒hallucinations ❒delusions		
UROLOGICAL: ❒incontinence ❒nocturnal frequency ❒burning on urination ❒dialysis ❒bloody urine		
INFECTIOUS DISEASE: ❒fever ❒night sweats ❒known disease		
OBGYN (women only): ❒pregnant ❒painful menses ❒abnormal menses ❒vaginal discharge ❒breast mass		

Clarify any positive answers above, or any health symptoms not already mentioned:

_____

_____

_____

Cognitive and Behavioral Symptoms Questionnaire

***ONLY* ANSWER THE FOLLOWING FOUR (4) PAGES OF QUESTIONS IF THE REASON FOR EVALUATION IS RELATED TO A COGNITIVE ISSUE.** ❒ No Responses for pages 5-8

Is there a history of prior diagnosis with a cognitive disorder (ie: ❒Alzheimer's Disease ❒Vascular Dementia ❒Frontotemporal Dementia ❒Pick's Disease ❒Parkinson's Dementia

_____

Is there a history of having a ❒Stroke or ❒TIA's (mini-strokes)?

_____

Is there a history of recent worsening of ❒Urinary Incontinence ❒Walking/Gait problems ❒Confusion/agitation?

_____

COGNITIVE SYMPTOMS

Is there a history of memory problems that are progressively getting worse?

Describe: _____

_____

Is there forgetfulness for: ❒recent details ❒conversations ❒events? Any pattern of: ❒misplacing items or ❒getting lost in familiar neighborhoods? Describe:

_____

_____

_____

Is there: ❒a change in language ability? (ie ❒ "word finding difficulty" ❒change in ability to articulate thoughts or express self coherently). Describe:

_____

_____

_____

Is there any ❒Difficulty with time relationships? (❒thinking that events from the past are happening in the present confusing the past and present.) Describe:

_____

_____

_____

BEHAVIORAL SYMPTOMS

Is there any ❒ "apathy"? (ie ❒lack of interest ❒less affection in personal relationships ❒loss of enthusiasm ❒decreased initiative/motivation to do things ❒social withdrawal). Describe:

_____

_____

Is there a ❒change in personality or social comportment? (Including: ❒tactlessness ❒impulsivity ❒new or more obsessive interests ❒inappropriate or disinhibited behaviors ❒hypersexuality). Describe:

_____

_____

Have there been any ❒ "hallucinations"? (❒hearing someone talking when no one is there or ❒seeing things that are not there). Describe.

_____

_____

Have there been any ❒"delusions" – thoughts that are not based in reality, but the patient cannot be convinced otherwise? (ie ❒Paranoid --- that someone is stealing their things, or wants to harm/kill them, or that a spouse is unfaithful. ❒Somatic – that something is wrong with their body, such as an illness [when they're not sick]. ❒Misidentification – that someone is "an imposter", or feeling their home is "not their home". ❒Bizarre – regarding aliens or other strange topics. ❒Grandiose). Describe.

_____

_____

_____

Has there been any❒ "sundowning"? (❒worsened agitation in the late afternoon or night-time ❒more disorganized behavior than in the daytime ❒associated hallucinations or delusions). Describe:

_____

_____

_____

Has there been any ❒reversal of sleep cycle? (Awake all night, sleeping all day).

_____

_____

Has there been any ❒physical aggression? (including being ❒ "resistive to care," if requiring assistance with toileting, dressing, etc)?

_____

_____

_____

Have there been any purposeless behaviors, including: ❒wandering, ❒pacing, ❒rummaging, ❒picking, or ❒others?

_____

_____

Any other issues, behaviors, or symptoms not already described?

_____

_____

_____

ACTIVITIES OF DAILY LIVING

Is there ❒difficulty with performing tasks that were previously handled acceptably? (Difficulty with: ❒tasks related to their career ❒managing the bills and finances ❒medications ❒performing work duties ❒driving the car ❒car accidents ❒using the stove [burnt pots] ❒getting dressed ❒personal hygiene). Describe.

_____

Does the patient manage the finances?_____ If not, who, and since when?

Does the patient drive a car? (If not, when did they stop)_____

If driving, any issues (car accidents, getting lost)? _____

Does the patient manage their own medications?_____If not, who, and since when?

Who else is present in the patient's residence (spouse, aide, etc)?

Any other family members nearby or involved in helping the patient (children, siblings, etc)?