WELL BEING SYSTEMS, PLLC
Healthcare Provider – Patient Services Agreement

Patient Name: _____ Date of Birth: _____

Welcome, we are pleased you have chosen us for your healthcare needs. Please read the following document carefully as it contains important information about our professional services and practice policies.

MEDICATION SERVICES
Your treatment may include taking medication. There are wide varieties of medications available for sleep or sleepiness problems, as well as for mental health problems such as depression or other mood disorders like bipolar disorder, anxiety, post-traumatic stress disorder, psychotic disorders and others. Prescribing of medication must take into account your personal medical history, other medications that you take, allergies to medicines or other products, and your treatment goals. When we recommend a medication prescription for you, we will inform you of significant benefits and risks, answer any of your questions to the best of our ability and advise you about appropriate regular monitoring of your use of medication, including any necessary periodic laboratory tests.

_____ Initial Here

CONTACTING ME
Due to our work schedule, we are not immediately available by telephone. Telephones are answered by office staff or our answering service. Every effort will be made to return your call promptly, either by your provider or by the office staff, during business hours. After hours emergencies will be returned by the on-call provider. If you are unable to reach us during normal business hours, and feel you cannot wait for a return call, contact 911 or go to the nearest emergency room.

_____ Initial Here

LEGAL LIMITS ON CONFIDENTIALITY PROTECTIONS
The law protects the privacy of all communications between a patient and a healthcare provider. In most situations, we can only release information about your treatment to others if you sign a written Authorization form that meets certain legal requirements imposed by the Health Information Portability and Accountability Act (HIPAA). There are other situations that require only written, advance consent. However, there are some situations in which we are permitted or required to disclose information without either your consent or Authorization. These situations are primarily related to being a danger to yourself or to others, and child or elder abuse or neglect. If such situations arise, we will make every effort to discuss them with you before taking any action and we will limit our disclosure to what is necessary. For details on the limits of your confidentiality required by law, please refer to our office form entitled, "Notice of Healthcare Providers Polices and Practices to Protect the Privacy of your Health Information," especially Section II ("Uses and Disclosures Requiring Authorization") and Section III ("Uses and Disclosures with Neither Consent nor Authorization"). Your signature on this Agreement provides consent for those activities. While this written summary of exceptions of confidentiality should prove helpful in informing you about potential problems, it is important that we discuss any questions or concerns that you may have now or in the future. The laws governing confidentiality can be quite complex and we do not give legal advice. In situations where specific advice is required, formal legal advice may be needed.

_____ Initial Here

MINORS & PARENTS
Patients under 18 years of age who are not emancipated, and their parent(s), should be aware that the law may allow parents to examine their child's treatment records. Because privacy in therapy is often crucial to successful progress, it is sometimes our policy to request an agreement from parents that they

consent to give up or suspend their access to their child's records. If they agree, during treatment we will provide them only with general information about the progress of the child's treatment, unless the child agrees otherwise. Before giving parents any information that the child expects to be confidential, we will discuss the matter with the child, if possible, and do our best to handle any objections. Important exceptions to this confidentiality procedure involve any issue or potential issues regarding matters of the child's safety. We will ensure that parents are rapidly informed about any safety concerns that come to our attention. This may be done by promptly scheduling a joint session to be attended by both child and parent(s) so that the child can inform their parents of the safety issue himself or herself in the context of the support offered in a therapy session. Alternatively, if the child is not able to agree to a joint meeting for any reason or if the safety concern is urgent, we may telephone one or both parents to quickly discuss the relevant safety concern. Parents should feel free to clarify this policy or request modification to it at any time they become aware of a safety concern for their child.

_____ Initial Here

PROFESSIONAL RECORDS

You should be aware that, pursuant to the Health Information Portability and Accountability Act (HIPAA), we keep Protected Health Information (PHI) about you in two sets of professional records. Please refer to the "Notice of Healthcare Provider's Policies and Practices to Protect the Privacy of Your Health Information," for more information regarding the above.

_____ Initial Here

PATIENT RIGHTS

HIPAA provides you with several new or expanded rights with regard to your Clinical Record and disclosures of Protect Health Information (PHI). These rights include requesting that we amend your record; requesting restrictions on what information from your Clinical Record is disclosed to others; requesting an accounting of most disclosures of PHI disclosures are sent; having any complaints you make about our policies and procedures recorded in your records; and the right to a paper copy of this Agreement, the attached Notice form and our privacy policies and procedures. We are happy to discuss any of these rights with you.

_____ Initial Here

CONSENT FOR TREATMENT AND CONSULTATION

I authorize and request that Well Being Systems' providers carry out behavioral health treatments and/or diagnostic procedures, that now or during the course of my care are advisable. I understand that the purpose of these procedures will be explained to me upon my request and are subject to my agreement. I also understand that while the course of treatment is designed to be helpful, it may at times be difficult and uncomfortable.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGMENT THAT YOU HAVE MAY RECEIVE ADDITIONAL HIPAA INFORMATION DESCRIBED ABOVE, UPON REQUEST.

_____

Patient (Authorized Parent/Guardian) Print Name

_____ _____

Patient (Authorized Parent/Guardian) Signature Date

WELL BEING SYSTEMS, PLLC
Financial Agreement

The purpose of this form is to inform you of our financial policy and obtain related consents. Patients are responsible for payment of services provided to them, unless another person has accepted financial responsibility for their account. Parents/Guardians are automatically financially responsible for payment for services provided to minors or legal dependents. If someone else will be financially responsible, they must also accept and sign a Financial Agreement. The financial guarantor is authorized to obtain non-clinical, appointment and billing-related information. Fees are subject to change. To obtain a current fee schedule or if you have questions regarding this agreement, please contact the office.

- Payment for services is due at the time services are rendered, including any balances, estimated amounts for co-pays, deductibles, co-insurance amounts, self-pay or other professional services.
- Balances must be paid promptly. Delinquent account balances older than 90 days may accrue finance charges or be subject to further collection action. Accounts forwarded to an outside agency will be subject to a 25% surcharge.
- It is your responsibility to know your insurance benefits and to obtain any required authorization or referral. You are responsible for fully disclosing accurate and complete insurance information, including insurance changes, in advance of your scheduled appointment. If services are denied by your insurance, or if the service is unpaid by insurance after 90 days, you will be billed the full fee for the services. You will be considered Self-Pay if you have no insurance, have out-of-network insurance, or have not provided verifiable insurance information.
- The office must be notified at least 24 hours in advance to cancel or change your appointment. Missed appointments or late cancellations will be charged the FULL FEE for the scheduled service. If you have had a fever, cough, or symptoms of any illness within 10 days of or on the day of your office visit, please contact the office to reschedule free of charge.
- You agree to maintain an active Card Authorization on file that will be charged for services automatically if other payment has not been provided. Your card on file may be charged with or without advance notification at the discretion of the office for services, including:
    - Missed appointments or late cancellations, billed at the full rate of the scheduled appointment
    - Estimated or actual amounts for co-pays, deductibles, and co-insurances amounts
    - Self-pay services or other professional services not billable to insurance
    - Fees incurred or any other account balance resulting from professional services rendered
- You understand that you must contact the office if you do not agree with the way a charge was processed. If your card was charged incorrectly, you will be refunded via the same payment method. Charge-backs may result in finance charges and your account may be referred to collections. You authorize our office to disclose information about your attendance and/or cancellation to your credit card company if you dispute a charge.
- You understand that we cannot guarantee the security and confidentiality of unencrypted email transmissions due to common risk factors. Other methods of electronic communication are available and encouraged – such as: secure texting, or messaging through Patient Fusion or Updox.

Initials: _____

Patient Name: _____ Date of Birth: _____

Financial Guarantor: _____ Relationship to Patient: _____
(responsible party)

Guarantor/Billing Contact information (if different from Patient):

Mailing Address: _____

Phone: _____ Email: _____

BY SIGNING THIS FINANCIAL AGREEMENT, I HAVE READ AND ACCEPT THE TERMS.

_____ _____ _____
Patient or Parent/Legal Guardian Signature Printed Name Date

_____ _____ _____
Other Financial Guarantor signature, if different Printed Name Date

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Card Authorization Agreement

** For HSA cards – please provide a secondary source of payment to be used if HSA card fails*

HSA = Health Savings Account (provided by your insurance plan/employer)

Cardholder Name (as printed on card): _____ HSA card? Y [ ] N [ ]

Card #: _____ Expiration: _____ Security code: _____

Billing Address (if different from above): _____

Cardholder Name (as printed on card): _____

Card #: _____ Expiration: _____ Security code: _____

Billing Address (if different from above): _____

By signing below, you understand the terms outlined in the financial agreement and authorize the office to charge your card on file. You attest that you are authorized to use the card provided above and consent to the disclosure of billing-related matters to the cardholder or credit card company as necessary to verify the accuracy of the charges.

_____ _____ _____
Patient or Financial Guarantor Signature Printed Name Date

WELL BEING SYSTEMS, PLLC
PATIENT – CLIENT INFORMATION

LEGAL Name _____ Date of Birth _____
(must match insurance card)

PREFERRED Name (**OPTIONAL**) _____

Address _____ City _____ State _____ Zip _____

Mailing Address _____ City _____ State _____ Zip _____
(If different)

Phone: Cell _____ Home/Other _____
Are Text messages OK? YES _____ NO _____

Email: _____
(Appt. reminders are sent via text, email and voice – unless otherwise requested)

Primary Insurance: _____ Insurance ID# _____

Relationship status: ____ Single ____ Married ____ Partnered ____ Divorced ____ Widowed

Name of Spouse/Partner (parents/guardian for minor) _____

Children & Ages (siblings for minor) _____

I GIVE PERMISSION FOR DR. BURSTEIN / P.A. MICHAEL SANDRIDGE TO RELEASE AND/OR RECEIVE MEDICAL OR FINANCIAL INFORMATION, WHICH MAY INCLUDE PROTECTED HEALTH INFORMATION, TO THE FOLLOWING PEOPLE, NOT INCLUDING HEALTH CARE PROVIDERS: (**OPTIONAL**)

NAME _____ RELATIONSHIP _____ Patient Initials _____

NAME _____ RELATIONSHIP _____ Patient Initials _____

Separate authorization form needed to release/receive information to/from healthcare providers. This form will be given upon request.

Name of referring physician _____

In case of emergency notify: _____ Relationship _____ Phone _____

REFERRED BY – IF OTHER THAN YOUR DOCTOR _____

Please explain why you are seeking help at this time:

_____
_____
_____

Please explain how your problems are affecting your work and relationships, plus your general functioning:

_____
_____
_____

Patient Name _____ Date of Birth _____

On a 1 to 10 scale, with 1 = no distress and 10 = extreme distress, please rate your distress level now: _____

Please check any health problems you have or have had:

_____lung	_____heart	_____head injury
_____liver	_____high blood pressure	_____cancer
_____kidney	_____diabetes	_____arthritis
_____stomach/intestinal	_____seizures	_____other pain

Drug Allergies (Please list the medication and type of reaction):

_____

_____

Please list all medications, supplements, or over-the-counter medicines if taken regularly: (can attach separate list)

_____

_____

_____

Preferred Pharmacy:

Pharmacy Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

Please rate your normal level of physical activity: _____

0 = Not Very Active (Little or no regular exercise)
1 = Fairly Active (Some exercise, or you work in a job that requires a lot of physical activity)
2 = Very Active (Near daily or daily exercise)

Height _____ Weight _____

Please rate your level of difficulty with these problems: 0 = none, 1 = mild, 2 = moderate, 3 = severe

___ Physical health	___ In-law problems	___ Using drugs	___ Anxiety symptoms
___ Chronic Pain	___ Job or school performance	___ Panic Attacks	___ *sweating*
___ Low mood	___ Friendships	___ Phobias	___ *short of breath*
___ Mood swings	___ Financial problems		___ *stomach upset*
___ Energy/motivation level	___ Obsessions (unwanted thoughts)		___ *dizziness*
___ Memory	___ Nightmares		___ *choking*
___ Concentration	___ Thoughts of hurting someone		___ *racing heart*
___ Sleep	___ Compulsions (unwanted actions)		___ *weakness*
___ Sexual functioning	___ Flashbacks		___ *dry mouth*
___ Suicidal thoughts	___ Paranoid thoughts		___ *feeling trapped*
___ Spirituality/religion	___ Domestic violence (verbal)		___ *panic*
___ Marriage/relationship	___ Domestic violence (physical)		
___ Family conflicts	___ Drinking alcohol		

Patient Name _____ Date of Birth _____

SUBSTANCE USE	Average amount Past 2 months	Most ever used
Coffee	_____	_____
Cigarettes	_____	_____
Alcohol	_____	_____
Recreational Drugs	_____	_____

For the following, please circle YES or NO – If YES, please give details:

Have you had counseling or psychotherapy in the past? YES – NO _____
Have you ever taken medication for your emotional or mental health? YES – NO _____
Have you ever been hospitalized for psychiatric problems? YES – NO _____
Have you ever been arrested? YES – NO _____
Is there any mental/emotional trouble, alcoholism or drug use, or suicide in your family? YES – NO
_____
Have you ever had any experiences that you would consider traumatic or abusive? YES – NO
_____
Have you ever tried to kill yourself or hurt yourself in any way? YES – NO _____
Is there currently any danger that you might hurt yourself or someone else? YES – NO _____

Please describe your education:
_____

Please describe the family you grew up in, including your parents and names/ages of your siblings:
_____
_____
_____
_____

Please describe your marital or domestic partnership history. Include first names of current and past spouses, and your age at the time:
_____
_____
_____
_____

Please describe your support system (family you are close to, friends you talk with, etc.):
_____
_____
_____

What is your current job and how do you like it?
_____
_____
_____

MOOD QUESTIONNAIRE

Patient Name: _____ Date Completed: _____

Has there ever been a period of time when you were not your usual self and….	**YES**	**NO**
You felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
You were so irritable that you shouted at people or started fights or arguments?		
You felt much more self-confident than usual?		
You got much less sleep than usual and found you didn't miss it?		
You were much more talkative or spoke much faster than usual?		
Thoughts raced through your head or you couldn't slow down your mind?		
You were so easily distracted by things around you that you had trouble concentrating or staying on track?		
You had much more energy than usual?		
You were much more active or did many things more than usual?		
You were much more social or outgoing than usual, for example, you called friends in the middle of the night?		
You were much more interested in sex than usual?		
You did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
You spent money that got you or your family into trouble?		

If you checked YES to more than one of the above, have several of these happened during the same period of time? ____ YES ____ NO

How much of a problem did any of these cause you – like being able to work; having family, money or legal troubles, getting into arguments or fights?

____ No Problem ____ Minor Problem ____ Moderate Problem ____ Serious Problem

SLEEP QUESTIONNAIRE
PLEASE COMPLETE IF YOU HAVE A SLEEP PROBLEM

Patient Name _____ Date Completed _____

What is the main problem with your sleep? _____
Are you a shift worker? _____ If so, what hours do you work? _____
On average, how many hours of sleep do you get in 24 hours? _____
All at once or with naps? _____ Is this enough? _____ Or too much? _____

INSOMNIA – POOR SLEEP QUALITY	YES	NO
Do you have problems getting to sleep?		
Do you have problems staying asleep?		
Do you tend to sleep at the wrong time (extreme night owl or morning lark)? If so, what is your best window of time for sleeping?		
Do your legs or arms itch, burn, tingle or just feel "fidgety" when you are trying to sleep?		
EXCESSIVE SLEEP OR SLEEPINESS	YES	NO
Are you often too sleepy when you need to be awake?		
SLEEP BEHAVIORS and OTHER PROBLEMS	YES	NO
Do you snore? Loudly enough to disturb others? Stop Breathing?		
Do your legs or arms twitch or jerk during sleep?		
Does your whole body twitch or jerk during sleep?		
If either, do these twitches or jerks seem to interfere with your sleep?		
Do you sleepwalk or act out dreams?		
Do you fall out of bed or have unusual movements during sleep?		
Have you ever injured yourself or someone else while asleep?		
Do you have nightmares?		

On your usual schedule in recent weeks or months, how likely are you to doze off or fall asleep in the following situations, in contrast to just feeling tired? Even if you have not done some of these activities recently, try to answer according to how you think they might affect you.

Choose the most appropriate number for each situation:

0 = would never doze 1 = slight chance of dozing 2 = moderate chance 3 = high chance of dozing

Sitting & reading	
Watching TV	
Sitting in a public place, like a waiting room	
Riding in a car for 1 hour	
Lying down to rest	
Sitting & talking	
Sitting after lunch without alcohol	
Driving a car while stopped in traffic	
Total Score	

The Epworth Sleepiness Scale
(John, M.W. (1993) Chest 103:30-36)

Other situations in which you fall asleep when you don't mean to? _____

ANXIETY SCALE (GAD-7)

Patient Name: _____ Date Completed: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
Feeling nervous, anxious, or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worrying too much about different things	0	1	2	3
Having trouble relaxing	0	1	2	3
Being so restless that it's hard to sit still	0	1	2	3
Becoming easily annoyed or irritable	0	1	2	3
Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	0 +	+	+	
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?

Not difficult at all ____

Somewhat difficult ____

Very difficult ____

Extremely difficult ____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

TRAUMA QUESTIONNAIRE

Patient Name: _____ Date Completed: _____

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

____ YES ____ NO

If NO, screen total = 0. Please stop here.

If YES, please answer the questions below.

In the past month, have you…	YES	NO
had nightmares about the event(s) or thought about the event(s) when you did not want to?		
tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?		
been constantly on guard, watchful, or easily startled?		
felt numb or detached from people, activities, or your surroundings?		
felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?		

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Patient Name: _____ Date Completed: _____

Over the last 2 weeks, how often have you been bothered by the following problems? *(Use a "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than ½ 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	0 +	+	+	
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?

Not difficult at all ___ Somewhat difficult ___ Very difficult ___ Extremely difficult ___