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Advanced Practice
— MENTAL HEALTH AND WELLNESS —

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4325 Dick Pond Rd.
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Little River, SC 29566

Consent for Treatment, Notice of Privacy, & Policies Acknowledgement

I have read The Informed Consent for Assessment and Treatment and Office Policies and Notice of Privacy Practices, and I understand and accept the policies contained therein. Having read that information, I hereby agree to assessment and treatment. I acknowledge that this consent is truly voluntary and is valid until revoked. I hereby consent for my provider to release information to the billing agent/funding source and for the billing agent/funding source to release information to your provider. I understand that I am responsible for any fee not covered by insurance and agree to pay for sessions or co-pays at time of service. I authorize the release of any information relating to all claims and benefits submitted on my behalf or on behalf of my child or minor in my legal custody. I further acknowledge that my signature here authorizes the clinician or his/her billing specialist to submit claims for services rendered without obtaining my signature on every claim. I understand that I am responsible for paying the co- pay, coinsurance or deductible amount at the time of service. If the claim is denied, I agree to pay for the service. I authorize payment of medical benefits for assessment or psychotherapy to the providing clinician, for services rendered. I acknowledge that I have reviewed and understood the Consent for Treatment and Practice Policies. I voluntarily consent to evaluation and treatment, including telehealth services when applicable, and understand that results are not guaranteed and that I may withdraw consent at any time. I acknowledge receipt of the Notice of Privacy Practices and understand how my health information may be used and disclosed.

_____ _____

Patient Name

Patient Signature
(If signed by other than Patient, indicate relationship)

_____ _____

Date of Birth

Todays Date

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— MENTAL HEALTH AND WELLNESS —

Telehealth Services Consent & Acknowledgement

I understand that privacy and confidentiality laws apply to telehealth services, and that no information obtained through telehealth will be disclosed to researchers or other entities without my written consent, except as otherwise permitted or required by law.

1. I understand that telehealth services will be provided through videoconferencing technology and that, unlike an in-person visit, I will not be in the same physical location as my healthcare provider during the session.
2. I understand that telehealth services involve the use of electronic communication technology, which may include potential risks such as interruptions, technical difficulties, unauthorized access, or other security-related issues. I understand that either my healthcare provider or I may discontinue the telehealth session if the technology is not adequate for the situation.
3. I understand that telehealth may involve the electronic transmission of my personal health information to other healthcare professionals or consultants who may be located in different geographic areas, including outside the state.
4. I understand that telehealth services are not appropriate for emergencies or crisis situations. If I am experiencing a medical or mental health emergency, I should immediately call 911 or seek assistance from the nearest emergency room, hospital, or crisis service provider in my area.
5. I understand that I do not need to download any software or receive a link in advance for my appointment. My provider will send the telehealth link at my scheduled appointment date and time. By clicking the link, I will be connected directly to my provider.
6. I understand that all patients must have a completed Payment Authorization Form and a valid payment card on file in order to schedule and attend telehealth appointments. The form is available through the patient portal and must be updated as needed. Telehealth appointments cannot be conducted without a completed authorization form and valid payment method on file. If a payment method is declined, the office will make one attempt to contact me for updated payment information. Payment must be received by 10:00 AM on the day of the appointment or the appointment may be considered a no-show.

By signing below, I acknowledge that I have read and understand this Telehealth Consent and Acknowledgment form, including the risks and benefits of telehealth services, and I voluntarily consent to participate in telehealth treatment.

Patient Name: _____ **Patient Signature:** _____

Todays Date: _____ **Parent/Guardian (if applicable):** _____

Relationship to Patient: _____

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—MENTAL HEALTH AND WELLNESS—

ADULT (18+) MENTAL HEALTH INTAKE FORM

NAME _____ DATE OF BIRTH _____

PRIMARY CARE PHYSCIAN (IF APPLICABLE): _____

What are the problems with which you are seeking help?

1. _____
2. _____
3. _____

What are your treatment goals?

_____

Current symptoms checklist:

- Depressed mood
- Sleep disturbance
- Change in appetite
- Excessive guilt
- Forgetfulness
- Fatigue
- Decreased libido
- Racing thoughts
- Impulsivity
- Increased libido
- Decrease need for sleep
- Excessive energy
- Increased irritability
- Crying spells
- Excessive worry
- Anxiety attacks
- Avoidance
- Hallucinations
- Lack of Concentration

Suicide Risk Assessment

Have you **ever** had feelings or thoughts that you did not want to live? _____

If YES, please answer the following. If **NO**, please skip to the next section

Do you **currently** feel that you don't want to live? _____

How often have you had these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened to make you feel this way? _____

Have you ever thought about how you would kill yourself? YES NO

Have you ever tried to kill or harm yourself before? YES NO

Past Psychiatric History:

Outpatient treatment

Reason: _____

Dates Treated: _____ By Whom: _____

Psychiatric Hospitalizations

Reason: _____

Dates Hospitalized: _____ Where: _____

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—MENTAL HEALTH AND WELLNESS—

Family Psychiatric History:
Has anyone in your family been diagnosed with or treated for: (Please Circle)

Bipolar YES NO	Anger YES NO	PTSD YES NO
Depression YES NO	Suicide YES NO	Alcohol abuse YES NO
Anxiety YES NO	Schizophrenia YES NO	Substance abuse YES NO

If yes, who had each problem? Were they treated with psychiatric medication?

_____

Alcohol/Substance Use:
Have you ever been treated for alcohol or drug abuse? _____ If yes, what substance? _____ Where were you treated and when? _____
How many days per week do you drink alcohol? _____
What is the least number of drinks you drink in a day? _____

What is the most number of drinks you drink in a day? _____

Have you ever felt bad or guilty about your drinking or drug use? _____

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? _____

Do you think you may have a problem with alcohol or drug use? _____

Have you used any "street" drugs in the past 3 months? If yes, which ones? _____

_____

Have you ever abused prescription medication? If yes, which ones and for how long? _____

_____

Check if you have ever tried the following:

- ○ Methamphetamine
- ○ Cocaine
- ○ Stimulants (pills)
- ○ Heroin
- ○ LSD or Hallucinogens
- ○ Marijuana
- ○ Pain killers (not as prescribed)
- ○ Methadone
- ○ Tranquilizer/ sleeping pills
- ○ Alcohol
- ○ Ecstasy

If yes, how long and when did you last use?

_____

Tobacco History

How you ever smoked cigarettes YES NO Currently Smoking? YES NO

How many packs a day on average? _____ How many years? _____

How many years did you smoke? _____ When did you quit? _____

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— MENTAL HEALTH AND WELLNESS —

Your Exercise Level

Do you exercise regularly? _____ How many days a week do you get exercise? _____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically, or by neglect? If yes, please describe when, where, and by whom:

_____

_____

Relationship History and Current Family:

Are you currently

- Married
- Partnered
- Divorced
- Widowed
- Single

How long? _____

Are you sexually active? YES NO

How would you identify your sexual orientation?

- Straight/heterosexual
- Lesbian/gay/homosexual
- Bisexual
- Transexual
- Unsure/questioning
- Asexual
- Other
- Prefer not to answer

Describe your relationship with your spouse or significant other:

_____

_____

Have you had any prior marriages YES NO If so, how many? _____

Do you have children YES NO

List everyone who currently lives with you _____

Is there anything else you would like us to know?

_____

_____

_____

_____

_____

ADVANCED PRACTICE MENTAL HEALTH AND WELLNESS

NAME: _____ **DOB:** _____

CHECK BOX IF YOU HAVEN EVER TAKEN ANY OF THE MEDICATIONS LISTED BELOW

Antidepressants

- ☐ Marplan (isocarboxazid)
- ☐ Nardil (phenelzine)
- ☐ Parnate (tranylcypromine)
- ☐ Emsam patch (Selegiline)
- ☐ Tofranil (imipramine)
- ☐ Elavil (amitriptyline)
- ☐ Vivactil (protriptyline)
- ☐ Pamelor (nortriptyline)
- ☐ Anafranil (clomipramine)
- ☐ Norpramin (desipramine)
- ☐ Sinequan / Silenor (doxepin)
- ☐ Surmontil (trimipramine)
- ☐ Ludiomil (maprotiline)
- ☐ Prozac (fluoxetine)
- ☐ Zoloft (sertraline)
- ☐ Paxil (paroxetine)
- ☐ Luvox (fluvoxamine)
- ☐ Celexa (citalopram)
- ☐ Lexapro (escitalopram)
- ☐ Effexor XR (venlafaxine ER)
- ☐ Cymbalta (duloxetine DR)
- ☐ Pristiq (desvenlafaxine ER)
- ☐ Savella (milnacipran)
- ☐ Fetzima (levomilnacipran ER)
- ☐ Wellbutrin/Aplenzin/ Zyban (bupropion)
- ☐ Serzone (nefazodone)
- ☐ Remeron (mirtazapine)
- ☐ Symbyax (fluoxetine+olanzepine)
- ☐ Viibyrd (vilazodone)
- ☐ Trintellix / Brintellix (vortioxetine)
- ☐ Ketamine (IV/IM)
- ☐ Spravato (intranasal esketamine)
- ☐ Zulresso (brexanolone)

Sleep disorders

- ☐ Ambien (zolpidem)
- ☐ Belsomra (suvorexant)
- ☐ Dayvigo (lemborexant)
- ☐ Doral (quazepam)
- ☐ Hetlioz (tasimelteon)
- ☐ Lunesta (eszopiclone)
- ☐ Prazosin (Minipress)
- ☐ Restoril (temazepam)
- ☐ Rozerem (ramelteon)
- ☐ Sonata
- ☐ Trazodone
- ☐ Sunosi (solriamfetol)

Mood Disorders

- ☐ Haldol (haloperidol)
- ☐ Loxitane (loxapine)
- ☐ Navane (thiothixene)
- ☐ Prolixin (fluphenazine)
- ☐ Stelazine (trifluoperazine)
- ☐ Thorazine (chlorpromazine)
- ☐ Trilafon (perphenazine)
- ☐ Clozaril (clozapine)
- ☐ Fanapt (iloperidone)
- ☐ Geodon (ziprasidone)
- ☐ Invega (paliperidone)
- ☐ Latuda (lurasidone)
- ☐ Risperdal (risperidone)
- ☐ Saphris (asenapine)
- ☐ Seroquel (quetiapine)
- ☐ Zyprexa (olanzepine)
- ☐ Abilify (aripiprazole)
- ☐ Rexulti (brexpiprazole)
- ☐ Vraylar (cariprazine)
- ☐ Caplyta (lumateperone)
- ☐ Nuplazid (pimvanserin)
- ☐ Haldol Decanoate (haloperidol)
- ☐ Prolixin Decanoate (fluphenazine)
- ☐ Zyprexa Relprevv (olanzepine)
- ☐ Abilify Maintena (aripiprazole)
- ☐ Aristada (aripiprazole lauroxil)
- ☐ Risperdal Consta (risperidone)
- ☐ Invega Sustenna (paliperidone 1 mo)
- ☐ Invega Trinza (paliperidone 3 month)
- ☐ Perseris (subcutaneous risperidone)
- ☐ Nuedexta (dextromethoprhan&quinidine)

Sedatives

- ☐ Ativan (lorazepam)
- ☐ BuSpar (buspirone)
- ☐ Inderal (propranolol)
- ☐ Klonopin (clonazepam)
- ☐ Librium (chlordiazepoxide)
- ☐ Valium (diazepam)
- ☐ Vistaril / Atarax (hydroxyzine)
- ☐ Xanax(alprazolam)

Seizures

- ☐ Depakene (valproic acid)
- ☐ Depakote (divalproex)
- ☐ Dilantin (phenytoin)
- ☐ Keppra (levetiracetam)
- ☐Lamictal (lamotrigine)
- ☐Lithium / Lithobid
- ☐Neurontin (gabapentin)
- ☐Phenobarbital
- ☐Tegretol (carbamazepine)
- ☐Topamax (topiramate)
- ☐Trileptal (oxcarbazepine)
- ☐Zonegran (zonisamide)

Stimulants

- ☐ Adderall
- ☐ Evekeo
- ☐ Procentra (liquid)
- ☐ Zenzedi
- ☐ Adderall XR
- ☐ Adzenys
- ☐ Dexedrine Spansule
- ☐ Dyanavel XR (liquid)
- ☐ Mydayis
- ☐ Vyvanse
- ☐ Ritalin
- ☐ Focalin
- ☐ Adhansia
- ☐ Aptensio
- ☐ Concerta
- ☐ Cotempla XR-ODT
- ☐ Daytrana (patch)
- ☐ Focalin XR
- ☐ Jornay PM
- ☐ Metadate CD
- ☐ Metadate ER
- ☐ Ritalin LA
- ☐ Quillichew ER
- ☐ Quillivant XR (liquid)
- ☐ Provigil (modafinil)
- ☐ Nuvigil (armodafinil)
- ☐ Wakix (pitolisant)
- ☐ Xyrem (sodium oxybate)

Movement disorders

- ☐ Artane (trihexyphenidyl)
- ☐ Austedo (deutetrabenazine)
- ☐ Cogentin (benztropine)
- ☐ Gralise (gabapentin once daily)
- ☐ Horizant (gabapentin enacarbil)
- ☐ Ingrezza (valbenazine)
- ☐ Primidone
- ☐ Symmetrel / Osmolex (amantadine)
- ☐ Xenazine (tetrabenzene)
- ☐ Aricept (donepezil)
- ☐ Exelon patch (rivastigmine)
- ☐ Namenda [XR] (memantine)
- ☐ Namzaric (donepezil/memantine)
- ☐ Razadyne ER (galantamine)
- ☐ Apokyn (apomorphine)
- ☐ Azilect (rasagiline)
- ☐ Comtan (entacapone)
- ☐ Gocovri (amantadine ER)
- ☐ Mirapex [☐ER] (pramipexole)
- ☐ Neupro patch (rotigone)
- ☐ Northera (droxidopa)
- ☐ Nourianz (istradefylline)
- ☐ Requip [☐XL] (ropinirole)
- ☐ Rytary (carbidopa/levodopa ER)
- ☐ Sinemet [☐CR] (carbidopa/levodopa)
- ☐ Xadago (safinamide)

Weight loss

- ☐ Belviq [XR] (Lorcaserin)
- ☐ Chantix (varenicline)
- ☐ Contrave (bupropion/naltrexone)
- ☐ Phentermine (Adipex)
- ☐ Qsymia (phentermine/topamax)
- ☐ Saxenda / ☐Victoza (liraglutide)

Opioid/alcohol/ substance abuse

- ☐ Antabuse (disulfiram)
- ☐ Campral (acamprosate)
- ☐ Lyrica [☐CR] (pregabalin)
- ☐ Methadone
- ☐ Nucynta [ER] (tapentadol)
- ☐ Suboxone/subutex (buprenorphine)
- ☐ Vivitrol injection (naltrexone)

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

ID# DOB

Patient		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?	○	○	○	○	○
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?	○	○	○	○	○
3. How often do you have problems remembering appointments or obligations?	○	○	○	○	○
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?	○	○	○	○	○
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?	○	○	○	○	○
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?	○	○	○	○	○
7. How often do you make careless mistakes when you have to work on a boring or difficult project?	○	○	○	○	○
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?	○	○	○	○	○
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?	○	○	○	○	○
10. How often do you misplace or have difficulty finding things at home or at work?	○	○	○	○	○
11. How often are you distracted by activity or noise around you?	○	○	○	○	○
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?	○	○	○	○	○
13. How often do you feel restless or fidgety?	○	○	○	○	○
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?	○	○	○	○	○
15. How often do you find yourself talking too much when you are in social situations?	○	○	○	○	○
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?	○	○	○	○	○
17. How often do you have difficulty waiting your turn in situations when turn taking is required?	○	○	○	○	○
18. How often do you interrupt others when they are busy?	○	○	○	○	○

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NAME: _____ **DOB:** _____ **TODAYS DATE:** _____

GAD-7 ASSESMENT

Over the last 2 weeks, how often have you been bothered by any of the following problems?

		NOT AT ALL	SEVERAL DAYS	MORE THAN HALF OF 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 is 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

PHQ-9 ASSESSMENT

Over the last 2 weeks, how often have you been bothered by any of the following problems?

		NOT AT ALL	SEVERAL DAYS	MORE THAN HALF OF 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

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Mood Disorder Questionnaire (MDQ)

Patient Name: _____ **Date:** _____

1. 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 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 really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...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 more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned 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?	☐	☐
...spending money got you or your family into trouble?	☐	☐

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?

☐ Yes
☐ No

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

☐ No Problem
☐ Minor Problem
☐ Moderate Problem
☐ Serious Problem

Advanced Practice Mental Health and Wellness

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Georgetown
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Georgetown, SC 29440

Socastee
4325 Dick Pond Rd.
Myrtle Beach, SC 29588

Little River
4360 Big Barn Dr.
Little River, SC 29566

Payment Authorization Form

I, the undersigned patient (or responsible party), authorize Advanced Practice Mental Health and Wellness to securely keep my preferred payment method on file (credit card, debit card, or HSA/FSA card). I understand and agree to the following terms:

- **Authorization for Charges**

I authorize Advanced Practice Mental Health and Wellness to charge the payment method on file for any patient balances, including but not limited to co-pays, deductibles, co-insurance, outstanding account balances, and fees related to services provided. I authorize charges for any **late cancellation fees** and **no-show fees** in accordance with the practice's policies, without the need for additional written or verbal authorization. **Late Cancellation Fee:** $25.00 (applies when an appointment is canceled less than 24 hours before the scheduled time). **No-Show Fee:** $50.00 (applies when an appointment is missed without notice).

- **Timing of Charges**

Payment will be processed **the day before my scheduled appointment**. If payment is declined, I understand it is my responsibility to update my payment information before services can be provided.

- **Ongoing Authorization**

This authorization will remain in effect until I provide and updated card on file with a new form filled out I agree to maintain a valid payment method on file at all times while receiving services from Advanced Practice Mental Health and Wellness.

- **Acknowledgement**

I understand that it is my responsibility to review and understand the financial policies of Advanced Practice Mental Health and Wellness. I acknowledge that any fees charged are consistent with the practice's published policies.

Patient Name: _____ Date of Birth: _____

CARD NUMBER: _____

CARD EXPIRATION: _____CVV SECURITY CODE: _____

BILLING ZIP CODE: _____

Signature: _____ **Date:** _____

Thank you for helping us maintain efficient billing practices. If you have questions about this authorization, please contact our office staff prior to signing.