



Office Phone: 843.945.1452 | Fax: 843.945.1489  
Email: info@apmhofsc.com | Website: apmhofsc.com

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|-------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------|
| <b>Myrtle Beach</b><br>630 Chestnut Rd.<br>Myrtle Beach, SC 29572 | <b>Loris</b><br>3997 Meeting St.<br>Loris, SC 29569             | <b>Florence</b><br>2141 Hoffmeyer Rd.<br>Florence, SC 29501        |
| <b>Georgetown</b><br>1837 N Fraser St.<br>Georgetown, SC 29440    | <b>Socastee</b><br>4325 Dick Pond Rd.<br>Myrtle Beach, SC 29588 | <b>Little River</b><br>4360 Big Barn Dr.<br>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.

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Patient Name

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

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Date of Birth

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Today's Date



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## **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:** \_\_\_\_\_

**ADULT (18+) MENTAL HEALTH INTAKE FORM**

NAME \_\_\_\_\_ DATE OF BIRTH \_\_\_\_\_

PRIMARY CARE PHYSICIAN (IF APPLICABLE): \_\_\_\_\_

What are the problems with which you are seeking help?

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

What are your treatment goals?

\_\_\_\_\_

Current symptoms checklist:

- |                                             |                                                  |                                                 |
|---------------------------------------------|--------------------------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Depressed mood     | <input type="checkbox"/> Racing thoughts         | <input type="checkbox"/> Increased irritability |
| <input type="checkbox"/> Sleep disturbance  | <input type="checkbox"/> Impulsivity             | <input type="checkbox"/> Crying spells          |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Increased libido        | <input type="checkbox"/> Excessive worry        |
| <input type="checkbox"/> Excessive guilt    | <input type="checkbox"/> Decrease need for sleep | <input type="checkbox"/> Anxiety attacks        |
| <input type="checkbox"/> Forgetfulness      | <input type="checkbox"/> Excessive energy        | <input type="checkbox"/> Avoidance              |
| <input type="checkbox"/> Fatigue            |                                                  | <input type="checkbox"/> Hallucinations         |
| <input type="checkbox"/> Decreased libido   |                                                  | <input type="checkbox"/> 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: \_\_\_\_\_

**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? \_\_\_\_\_

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

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**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? \_\_\_\_\_

# Advanced Practice

— 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:

---

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## Relationship History and Current Family:

Are you currently

- |                                 |                                |                              |
|---------------------------------|--------------------------------|------------------------------|
| <input type="radio"/> Married   | <input type="radio"/> Divorced | <input type="radio"/> Single |
| <input type="radio"/> Partnered | <input type="radio"/> Widowed  |                              |

How long? \_\_\_\_\_

Are you sexually active?      YES      NO

How would you identify your sexual orientation?

- |                                              |                                            |
|----------------------------------------------|--------------------------------------------|
| <input type="radio"/> Straight/heterosexual  |                                            |
| <input type="radio"/> Lesbian/gay/homosexual |                                            |
| <input type="radio"/> Bisexual               | <input type="radio"/> Asexual              |
| <input type="radio"/> Transsexual            | <input type="radio"/> Other                |
| <input type="radio"/> Unsure/questioning     | <input type="radio"/> Prefer not to answer |

Describe your relationship with your spouse or significant other:

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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?

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## 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)
- ☐ Vilbyrd (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 (dextromethophran&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)
- ☐ Zonagan (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)
- ☐ Northra (droxidopa)
- ☐ Nourianz (istradefylline)
- ☐ Requip [□XL] (ropinirole)
- ☐ Ryтары (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?                                            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 2.                                                                                                                                                                                                                                                                                                                                                                                 | How often do you have difficulty getting things in order when you have to do a task that requires organization?                                                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 3.                                                                                                                                                                                                                                                                                                                                                                                 | How often do you have problems remembering appointments or obligations?                                                                                         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 4.                                                                                                                                                                                                                                                                                                                                                                                 | When you have a task that requires a lot of thought, how often do you avoid or delay getting started?                                                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 5.                                                                                                                                                                                                                                                                                                                                                                                 | How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?                                                            | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 6.                                                                                                                                                                                                                                                                                                                                                                                 | How often do you feel overly active and compelled to do things, like you were driven by a motor?                                                                | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 7.                                                                                                                                                                                                                                                                                                                                                                                 | How often do you make careless mistakes when you have to work on a boring or difficult project?                                                                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 8.                                                                                                                                                                                                                                                                                                                                                                                 | How often do you have difficulty keeping your attention when you are doing boring or repetitive work?                                                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 9.                                                                                                                                                                                                                                                                                                                                                                                 | How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?                                          | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 10.                                                                                                                                                                                                                                                                                                                                                                                | How often do you misplace or have difficulty finding things at home or at work?                                                                                 | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 11.                                                                                                                                                                                                                                                                                                                                                                                | How often are you distracted by activity or noise around you?                                                                                                   | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 12.                                                                                                                                                                                                                                                                                                                                                                                | How often do you leave your seat in meetings or other situations in which you are expected to remain seated?                                                    | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 13.                                                                                                                                                                                                                                                                                                                                                                                | How often do you feel restless or fidgety?                                                                                                                      | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 14.                                                                                                                                                                                                                                                                                                                                                                                | How often do you have difficulty unwinding and relaxing when you have time to yourself?                                                                         | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 15.                                                                                                                                                                                                                                                                                                                                                                                | How often do you find yourself talking too much when you are in social situations?                                                                              | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 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? | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 17.                                                                                                                                                                                                                                                                                                                                                                                | How often do you have difficulty waiting your turn in situations when turn taking is required?                                                                  | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |
| 18.                                                                                                                                                                                                                                                                                                                                                                                | How often do you interrupt others when they are busy?                                                                                                           | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> | <input type="radio"/> |

NAME: \_\_\_\_\_ DOB: \_\_\_\_\_ TODAYS DATE: \_\_\_\_\_

### GAD-7 ASSESSMENT

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

|                                                      | NOT<br>AT ALL | SEVERAL<br>DAYS | MORE<br>THAN HALF<br>OF DAYS | NEARLY<br>EVERY<br>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<br>AT ALL | SEVERAL<br>DAYS | MORE<br>THAN HALF<br>OF DAYS | NEARLY<br>EVERY<br>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                      |

**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?       | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were so irritable that you shouted at people or started fights or arguments?                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you felt much more self-confident than usual?                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you got much less sleep than usual and found you didn't really miss it?                                             | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were much more talkative or spoke much faster than usual?                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| ...thoughts raced through your head or you couldn't slow your mind down?                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were so easily distracted by things around you that you had trouble concentrating or staying on track?          | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you had much more energy than usual?                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were much more active or did many more things than usual?                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?   | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you were much more interested in sex than usual?                                                                    | <input type="checkbox"/> | <input type="checkbox"/> |
| ...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? | <input type="checkbox"/> | <input type="checkbox"/> |
| ...spending money got you or your family into trouble?                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |

**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



Office Phone: 843.945.1452 | Fax: 843.945.1489  
Email: info@apmhfsc.com | Website: apmhfsc.com

|                                                                   |                                                                 |                                                                    |
|-------------------------------------------------------------------|-----------------------------------------------------------------|--------------------------------------------------------------------|
| <b>Myrtle Beach</b><br>630 Chestnut Rd.<br>Myrtle Beach, SC 29572 | <b>Loris</b><br>3997 Meeting St.<br>Loris, SC 29569             | <b>Florence</b><br>2141 Hoffmeyer Rd.<br>Florence, SC 29501        |
| <b>Georgetown</b><br>1837 N Fraser St.<br>Georgetown, SC 29440    | <b>Socastee</b><br>4325 Dick Pond Rd.<br>Myrtle Beach, SC 29588 | <b>Little River</b><br>4360 Big Barn Dr.<br>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.*