Kenneth E Goolsby MD & Associates PC

Psychiatry and Transcranial Magnetic Stimulation

Kenneth E. Goolsby, M.D.

Rob Findley, P.A./C.

Ann Marie Peck, FNP-C

April Smith, Practice Administrator

Gail Corpus, TMS Coordinator

Welcome to our office!

Treatment with our office is voluntary and can be terminated at any time without penalty. Our goal is to be as helpful to you as possible and to assist you in dealing with your medications. Please feel free to come to us with any questions during your time here as a patient.

As a new patient with our office, you have been scheduled with one of our providers. Your provider will complete the initial appointment during the first office visit, which will be approximately an hour long. Following your first appointment, you will be scheduled a follow up appointment that is 15 minutes long, unless otherwise specified by your provider. These appointments will be focused on your response to the prescribed medications, any symptoms you may be experiencing, and any side effects present. **This office does not handle counseling or therapy.** If you are interested in therapy/counseling services, please ask the front desk or your provider for a list of local offices we recommend. We can also provide a referral if necessary.

I understand that in all cases involving Kenneth E. Goolsby, MD & Associates, strict standards of confidentiality and professional ethics will be maintained, as well as my personal, financial, and private health information. Furthermore, I understand that no agreement can anticipate all events in medical treatment which may arise. In signing, I agree that me and my heirs will hold harmless Kenneth E. Goolsby, MD & Associates, its shareholders, officers, directors, employees, contractors, and agents for all resultant problems. This agreement supersedes and replaces all previous agreements. I have been given a copy of the *Notice of Privacy Practices.*

Signature of Patient, Parent, or Guardian Relation to Patient Date

_____

Printed Name Date of Birth

_____

Kenneth E Goolsby MD
& Associates PC

NAME_____ **DOB:** _____

ADDRESS_____

CITY: _____ **STATE:** _____ **ZIP:** _____**PHONE:** _____

I consent to appointment reminders via phone /text /email _____(initial)

Marital Status (circle one): Single / Married / Widowed / Divorced / Domestic Partnership / Separated

EMERGENCY CONTACT:
Name: _____ **Phone#**_____**Relationship:**_____

Parent/guardian Name (if applicable) _____ **Parent/Guardian Phone#** _____

By initialing here, _____I DO authorize the release of my protected health information to the following (appointment times, medication information, financial information.) I Authorize Consent to Release Medical Information to:

I. Name _____**Relationship**_____

Phone#_____ **Email**_____

By initialing here_____, I DO NOT authorize the release of release of my protected health information to anyone.

Primary Insurance
Insurance Carrier: _____**ID#**_____**Group#**_____

Secondary Insurance
Insurance Carrier: _____**ID#**_____**Group#**_____

Pharmacy Name: _____ **Address:** _____**Phone#** _____

By signing here, I clarify that all the information above is correct to the best of my knowledge and I, as the patient, am responsible for notifying the office of Kenneth E, Goolsby, MD& Associates of any changes that may occur during my time here as a patient.

Patient signature_____ **Date** _____

- **Consent to treat** I hereby authorize Kenneth E. Goolsby & Associates care to encompass the performance of all appropriate courses of treatment and any medications in which the judgement of my provider may be considered for my diagnosis. I am aware that the practice of medicine comes with the risks pertaining to unforeseen side effects and that no guarantees have been made regarding the result of treatment/medications prescribed.

- **Release of information:** I hereby authorize Kenneth E. Goolsby& Associates to release financial, medical and such other information that may be requested from an insurer or other party who may be liable for any part of the charges for my care. I authorize Kenneth E. Goolsby & Associates to contact my insurance carrier to verify my coverage at any time. I understand my personal, financial or medical information will not be released to anyone other than my insurance company without my written consent in the form of a HIPAA compliant release of information.

- **Insurance policy**: I hereby authorize payment benefits directly to Kenneth E. Goolsby& Associates for all covered services to be applied against the bill. I understand that I am responsible for all charges not covered under my insurance policy at the date(s) of service. I understand that I am responsible for providing Kenneth Goolsby& Associates with a copy of my current insurance cards as well as notifying Kenneth Goolsby & Associates of any changes in my insurance coverage. I understand that if my coverage Is terminated, I will be considered a self-pay patient and I am full responsible for the total amount of the services provided. I understand that a self-pay patient pays 275.00 for a new patient appointment and $100.00 for every follow up appointment. I understand that my insurance is a contract between me and my insurance company /my employer and the insurance company and I am ultimately responsible to be aware of the services, diagnosis, benefits, and if my plan has a maximum for allowed visits. I understand that if I exceed the annual number of visits on my insurance, there is no way for Kenneth E. Goolsby & Associates to know how many other providers/ offices I have seen within the year and I am responsible for knowing such information.

- **Medicare:** I understand that if I am a Medicare patient, I authorize and assign all payments of authorized Medicare benefits for medical services and/or procedures rendered to me, directly to Kenneth E. Goolsby& Associates. I hereby authorize Kenneth E. Goolsby & Associates to release medical information as necessary to obtain payment for the services I receive. I understand that I am financially responsible for all charges not covered by Medicare for which I have signed an Advanced Beneficiary Notice (ABN)

- **Workers' compensation:** I understand that if I am covered by workers' compensation, I am responsible for providing my adjusters name, contact number, fax number, billing address and approval to be seen for psychiatric purposes.

- **Financial Policy:** I understand that I am directly responsible for any balance on my account that is not covered by insurance. I am also aware that collection actions may be taken for any unpaid charges and fees not paid within 120 days of the service date and that any balance sent to collections is my responsibility, including any attorneys' fees and court cost incurred.

- **Payments:** I understand that payment for my copay, co- insurance and deductible is collected before my appointment otherwise my appointment may be rescheduled. I understand that, if paying with a check and that check is returned, I will be responsible for a $25.00 service fee and I will no longer be allowed to write checks for any of my payments in the future. I understand that any balance incurred will be due within 30 days of the service date, I agree to pay the $6.00-per month finance charge until my balance is resolved in full.

- Laboratory billing procedure: I have been notified that all laboratory procedures/tests (blood work, urine drug screening, sleep studies, etc.) are performed outside of the office and will not be included in the charges for Kenneth E. Goolsby & Associates. All lab tests performed by an outside laboratory are billed separately to either my insurance company or myself. I understand that I may receive a bill from the laboratory company and will direct any questions regarding billing, such as statements, or balance, to the lab directly.

- No show Policy: I understand that if I am more than 15 minutes late to my appointment, it may be rescheduled. I will contact the office if I am running late or need to change /cancel my appointment in a timely manner to avoid a no-show fee. If I do not call ahead and cancel my appointment, I understand I will be responsible for paying a $100.00 No- show fee before I am able to reschedule a new appointment. I understand that the reminder call/text are a courtesy, and if I do not receive one, I will still be responsible for the $100.00 no show fee.

- Less than 24 hours cancellation or reschedule: I Understand that if I cancel or reschedule without giving the office of Kenneth E. Goolsby & Associates 24-hour notice that I may be subjected to the $100.00 cancel or reschedule fee which must be paid before my next appointment can be scheduled.

- Appointments: I understand that if I leave my appointment before my provider can complete my entire visit, I may still be responsible for any charges billed by Kenneth E. Goolsby & Associates.

- Form completion fee: I understand that any forms that I need completed by my provider may be subject to a completion fee and it will not be released to me, my disability insurance, or my employer, until these fees are paid. I understand that disability paperwork is subject to a $50.00 service fee and medical records are subject to a fee starting at $15.00. I understand that a release of information is needed before any paperwork can be released.

- Privacy policy: I have received a copy of Kenneth E. Goolsby& Associates privacy policy and have been given the opportunity to have my questions answered in full.

- Residents: The practice is engaged in health care education. I can decline resident participation at any time during my treatment and I will notify the practice right away.

- Termination: I understand that abuse of the staff of Kenneth. Goolsby &Associates cannot and will not be tolerated. Physical or verbal abuse, threats, harassment, or excessive annoyance (as in more than 3 phone calls in a single day regarding the same question) can result in termination at the discretion of the practice administrator. I understand that if physical/verbal threat or harassment occur, the proper authorities will be notified and can be prosecuted to the full extent of the law.

Patient signature: _____ DATE:_____

Printed Patient Name: _____DOB:_____

Kenneth E. Goolsby Md & Associates realizes that emergencies can arise and affect timely payments. If extreme circumstances occur, please ask our front office for assistance in the management of your account with a payment plan.

Controlled Medication Treatment Agreement

The purpose of this agreement is to promote safe, effective use of controlled substance that may be prescribed by Kenneth E Goolsby MD & Associates and to comply with state and federal law. Controlledand non-controlled medications can improve symptoms and carry significant risks. By signing this agreement, I _____, agree to the following conditions and understand that failure to abide, these conditions will be considered a breach of contract and, by the sole discretion of my provider, may result in my termination from the practice. If termination does occur, I understand that my provider will stop prescribing all controlled medications and a drug dependence treatment program may be recommended.

- I understand that all medications prescribed to me are for my own use. I will not share, sell, or trade my medications.
- I agree to take my medication only as prescribed and to contact my provider before any changes are made. I understand that when taken otherwise, medications can result in overdose and death.
- I will not request or accept any psychiatric prescriptions for ADHD/ADD, anxiety, depression, sleep, or opioid/pain management medicines from any other office or physician while I am receiving such medication from Kenneth E. Goolsby & Associates.
- I understand that refills may not be made if I lose my prescription or run out early. I will use extreme caution when handling my medication.
- If I am experiencing side effects that are related to any of my prescribed medications, I will contact the office of Kenneth Goolsby & Associates.
- I am responsible for notifying my provider immediately if I need to visit another physician or emergency room for an issue where I may be prescribed a controlled substance.
- I agree to submit a urine drug screen at any given time if requested by my provider to detect the use of prescribed and non-prescribed medications and illicit substances. I may also be requested to bring my medication in its original bottles to be checked by my provider if requested by the provider.
- I will not drink alcohol, use illicit drugs (marijuana, cocaine, heroin, etc.) or take over the counter medications without asking my provider.
- I will not drive or operate heavy machinery if I feel impaired, in any way, from my medications, including over the counter medications.
- I am responsible for keeping track of the amount of medication I have remaining. If any medication is stolen, I will report to my local police department and obtain a stolen item report. Lost or stolen medication will not be replaced if they are controlled substances due to local, state, and federal laws.
- I understand that refills will only be made during the office hours of 8 am – 5pm Monday – Thursday. Certain medications can only be picked up in person. I understand that the refill requested on nights, holidays, or weekends (including Friday), will not be made until the next business day.
- I will tell my doctor all my past medical history including any history of alcoholism, prescription drug abuse, or illicit substance abuse.
- I will take appropriate steps to not become pregnant while I am prescribed psychiatric medications without my provider's knowledge. I understand that if I become pregnant, or if I am suspicious that I am pregnant, I will notify the staff immediately. Furthermore, I accept that any medications may cause harm to my embryo/fetus/baby, and I will not hold Kenneth. E. Goolsby and Associates, its shareholders, officers, directors, employees, contractors, and agents responsible for any injuries to the embryo/fetus/baby.
- By signing below, I certify that I have read the above information, I have received a copy of the patient/ provider contact, and my questions, if any, have been answered regarding my provider and mt psychotic treatment. I hereby give my consent to participate in psychiatric medication management services at this time.

Patient Signature_____ DATE:_____

Patient Printed Name: _____ DOB:_____

Financial Policy

We are committed to providing you with the best possible medical care, therefore we participate in a variety of insurance plans. We will file insurance as a courtesy; however, you are responsible for your charges. You are required to provide accurate, up-to-date health insurance information. Inaccurate health insurance information or changes to health insurance plan that is out of network will result in charges that are the sole responsibility of the patient.

If you have insurance that we do not participate with, or you don't not have insurance, payment in full is expected at the time of service. You will be a "Private Pay" patient in our office. We offer a prompt payment discount to "Private Pay" patients if the charges are paid at the time of service. You are financially responsible for any amount not covered by your health insurance plan.

Appointments are scheduled specifically for each patient. If you arrive more than 15 minutes late for your appointment, you may be asked to reschedule to another day. If you cannot keep your appointment, we ask you to cancel at least 24 hours prior to the appointment time. Appointments that are missed or not canceled 24 hours prior to the scheduled appointment time will be charged a missed appointment fee of $100.00. If you "no show" for an appointment three times we reserve the right to discharge you from the practice.

Lab charges from labs other than Kenneth E. Goolsby MD & Associates PC are independent of Kenneth E. Goolsby MD & Associates PC. Billing questions pertaining to other lab facilities are to be directed to that facility.

You are financially responsible for all charges incurred in your care and treatment. Balance due for any fees not collected at the time of service will be posted to your account. If you are carrying a past due balance or having financial hardship, please inquire with front desk staff to inquire about payment plan. You will be responsible for any fees associated with the collection of your outstanding balance. Failure to meet your financial obligations with this office could lead to dismissal from the practice.

An active payment method on file is required. At the time of registration, we will request your credit or debit card information. Your card information is stored in a secure, encrypted manner and only accessed and charged if there is an outstanding balance due. Kenneth E Goolsby MD & Associates will not provide medical care to Guarantors who refuse to sign and comply with our financial policy.

Patient Signature:_____ Date:_____

Visit Information

Reason for Visit/ Current Diagnosis: _____

Please Check any Symptoms you are Experiencing:

	Decreased Appetite		Explosive Temper		Trouble Falling Asleep/ Waking Up		Auditory Hallucination
	Increased Appetite		Violence		Sleeping too Much		Visual Hallucinations
	Low Energy		Aggression		Easily Irritated		Excessive Worrying
	High Energy		Self-Criticism		Withdrawn From Others		Inability to Hold a Job
	Distractibility		Legal Problems		Decreased Ability to Enjoy Things		Relationship Problems
	Impulsivity		Sexual Problems		Decreased Concentration		Alcohol/Drug Problems
	Nightmares		Tearfulness		Intrusive/Bothersome Thoughts		Legal Problems

Other Symptoms: _____

Any Risk Taking or Dangerous Behavior: _____

Medication Allergies: _____

List All Previous/Current Health Problems: _____

_____

List All **Current** Medications (include dosage and frequency): _____

_____

List All Prior Psychiatric History **(counseling, therapy, etc.)**: _____

_____

List All Prior Psychiatric Hospital Admissions (include dates and reason behind admission): _____

_____

List All Substance Abuse History: _____

_____

List Family Members Who Have Experienced Mental Health Struggles (i.e. Depression, Anxiety, Bipolar, Schizophrenia, Suicide, etc.): _____

_____

Are you on Disability? If so, please specify: _____

_____

List your current Employment Status and Location: _____

_____

	Medication	Max Daily Dosage	Date Started/Ended	Side Effects		Medication	Max Daily Dosage	Date Started/Ended	Side Effects
	Anafranil (clomipramine)					Paxil (paroxetine)			
	Asendin (amoxapine)					Pristiq (desvenlafaxine)			
	Celexa (citalopram hydrobromide)					Prozac (fluoxetine)			
	Cymbalta (duloxetine)					Remeron (mirtazapine)			
	Doxepin					Serzone (nefazodone)			
	Effexor (venlafaxine)					Surmontil (trimipramine)			
	Endep (amitriptyline)					Tofranil (imipramine)			
	Lexapro (escitalopram)					Viibryd			
	Nardil (phentezine)					Vivacil (protriptyline)			
	Norpramin (desipramine)					Wellbutrin (bupropion)			
	Pamelor (nortriptyline)					Zoloft (sertraline)			

Anti-Anxiety

	Ativan (lorazepam)					Tanxene (clorazepate)			
	Klonopin (clonazepam)					Librium (chloriazepoxide)			
	Valium (diazepam)					Centrax (prazepam)			
	Xanax (alprazolam)					Sorax (oxazepram)			
	Buspar (buspirone)					Vistaril			

ADHD

	Adderall (dextroamphetamine)					Strattera (atomoxetine)			
	Concerta (methylphenidate)					Focalin (dexmethylphenidate)			
	Ritalin (methylphenidate)					Cylert (pemoline)			
	Vyvanse (lisdexamfetamine)					Intuniv (guantacine)			
	Qelbree								

Insomnia

	Ambien (zolpidem)					Desyrel (trazodone)			
	Restoril (lemazepam)					Lunesta (eszopictone)			
	Sonata (zaleplon)					Halcion (traziam)			
	Rozerem					Dalmane (flurazepam)			

Mood Stabilizers/Anti-Psychotic

	Clozaril (clozapine)					Saphris (asenapine)			
	Compazine (rochlorperazine)					Serentil (mesoridazine)			
	Fanapt (iloperidone)					Seroquel (quetiapine)			
	Haldol (haloperidol)					Stelazine (trifluoperazine)			
	Invega (paliperidone)					Symbyax			
	Loxapine (loxitane)					Thorazine (chlorpromazine)			
	Melaril (thioridazine HCl)					Trilafon (perphenazine)			
	Moban (molindone)					Zyprexa (olanzapine)			
	Navane (thiothixene)					Latuda (lurasidone)			
	Prolixin (fluphenazine)					Abilify (aripiprazole)			
	Vraylar (cariprazine)					Depakote (divalproex Na)			
	Risperdal (risperidone)					Lithobid (lithium carbonate)			
	Lamictal (lamotrigine)					Geodon (ziprasidone)			
	Tegretol (carbamazepine)					Cibalith (lithium citrate)			
	Trileptal (oxcarbazepine)					Depakene (valproic acid)			

Kenneth E Goolsby MD & Associates PC

Psychiatry and Transcranial Magnetic Stimulation

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

Today's Date: ___/___/_____

Name: _____ DOB:___/___/_____

Over the last 2 weeks, how often have you been bothered by any of the following?	Not at all	Several days	More than half the days	Nearly every day
1. Little pleasure or interest in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling/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 certain 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 and restless that you have been moving around a lot	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3
For Office Coding	____	____	____	____
			= Total Score	_____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not at all difficult Somewhat difficult Very difficult Extremely difficult