TERRY E. PASSMAN, M.D., L.L.C.
208 N. Greeno Road, Suite D-2
Fairhope, AL 36532
Phone: 251-928-4750
FAX: 251-990-2560

Dear Sir or Ma'am,

Thank you for choosing Dr. Terry Passman. We look forward to helping you achieve your treatment goals.

In order to make your experience here as pleasant as possible we request your assistance with the following tasks:

1. Arrive 15 minutes prior to any scheduled appointment to allow adequate time for your provider to review your pre-visit evaluation.

2. Dr. Terry Passman **does not** accept any insurance. Medicare patients sign a private contract: Provider Opt-out Contract of Medicare, and may not submit for reimbursement.

3. For your convenience, our office accepts cash, personal checks, and Visa, Master Card, Discover, American Express, with a 3.5% transaction fee. All payments are due at the time of your visit.

4. To assure that we always have up to date information, please inform the front desk of any changes in your address or phone number.

5. Sessions are generally scheduled Monday through Thursday, 8:00AM - Noon. The office does not provide 24 hours, 7 days a week emergency services. Coverage is only available when Dr. Passman is in the office. Anyone whose condition requires more extensive monitoring, should contact a practice that offers extended services.

6. The office has a 48-business hour cancellation and reschedule policy. The scheduled appointment time is a reservation for a psychiatry session with Dr. Terry Passman at a specific time. If the appointment is missed, the patient will still be charged a session fee.

If there is anything we can do to make your time with us more enjoyable please let us know.

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Patient Intake Information

*Date:*________________

Patient Name: ___________________________________ Nickname: _____________________
Street Address:____ P.O. Box or Apt # _________
City: ________________________________ State: ____________________ Zip:_____________
Cell Phone: ___________________________ Home Phone: ______________________________
Cell Phone Company (appointment notification): ____
E-mail: _______________________________________

Date of Birth:___________________________ Age: _____________ Sex: F _____ M _____
Social Security Number: ___________________________
Marital Status: Single___ Married___ Separated ___ Divorced___ Partner ___ Widow(er) ____

Employer: ______________________________________ Occupation: ________________________
Employer Address:________________________________ Work Phone: _______________________

Spouse's Name: ________________________________ Spouse's Date of Birth: ______________
Spouse's Employer: ___________________________ Spouse's Phone: ____________________

Primary Care Physician: ___________________________ Phone: ____________________
□ You may communicate with my primary care physician □ Do not speak to my primary care physician concerning my care

Pharmacy: ______________________________________ Phone: ____________________

Name of Referring Party: __________________________ Phone: ____________________

In Case of an Emergency, please notify:
Name: _________________________________ Relationship to Patient: _______________
Street Address:____ Apt # _______
City: _________________________________ State: ______________ Zip:______________
Phone: _____________________________ E-mail: _________________________________

Please list below the individuals whom you authorize our office to communicate with regarding your care:

Name: _______________________________ _______________ _________________________
(Relationship) (Phone number)
Name: _______________________________ _______________ _________________________
(Relationship) (Phone number)
Name: _______________________________ _______________ _________________________
(Relationship) (Phone number)

Patient Record Disclosures
In general, the HIPPA privacy rule gives individuals the right to request restrictions on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communication or that a communication of PHI is made by alternative means, such as sending correspondence to the individual's office instead of the individual's home. Notify the office of any changes or restrictions.

Signature: ________________________________Date: ________________
(Patient or Responsible Party)

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48 Business Hours Cancellation Notice & Credit Card Information

This page **MUST** be completed before an appointment can be given. It is not optional. Please read carefully and if you have any questions regarding this policy, please ask any of the office staff.

I understand that I must give notice of ***48***-business hours to cancel or reschedule an appointment. If I miss my appointment, and it is unexcused by my healthcare provider, Terry Passman, M.D., LLC, will use this credit card for payment of the missed appointment charge. This will apply to ***all*** missed appointments, including the initial evaluation or any follow-up appointments. I realize that the charge for a missed appointment will be the cost of an appointment.

I understand that the credit card transaction fee of 3.5% will be added to the receipt.

This card will be used for the payment of missed appointments or checks returned for insufficient funds, and the card may be used for payment of appointments.

By signing this form, I acknowledge, as well as give my permission and consent, that my card information will be used in my absence to pay for the situations outlined above. Should these charges be disputed I will be in fact severing my relationship with Terry Passman, M.D., LLC.

Print Patient's Name: ____________________________________

Patient's Signature: ____________________________________

Credit Card Number: ______________________________________

Expiration date: ____________________ Code *(on back of card):* __________________

Zip Code: _____________________

Name on Credit Card: ____

Current Phone Number: ____

____ ____________________________________
(Cardholder's signature) (Patient's signature if different)

_________________ ____________________
(Date) (Date)

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Patient Acknowledgement of Responsibilities

I, _________________________________, a potential new patient of Dr. Terry Passman, acknowledge, understand, and agree that I will be billed for services in my behalf and I will be held responsible for a missed appointment charge if I do not keep or cancel my appointment in a timely manner. This charge can apply to an initial evaluation or a follow-up appointment. Terry E. Passman, M.D., L.L.C. does not accept insurance and Medicare recipients will sign an opt-out agreement.

RESPECT: You are responsible for treating your provider, the staff at this office, and others with respect and dignity.

SAFETY: You are responsible for your personal safety, including avoiding any actions that could harm yourself or others. This includes being responsible for telling your provider if you feel that you might harm yourself or any other person so that your provider can take actions to keep you safe.

FOLLOWING THERAPEUTIC ADVICE: In order for treatment to be effective, you have the responsibility to follow the advice given by your provider. This may include taking medication as prescribed, completing homework assignments between sessions, or trying new behaviors as suggested by your provider. If you do not understand your provider's advice, you have a responsibility to ask questions about it so that you can understand. If you do not agree with your provider's advice, you have the responsibility to inform you provider of this so that you can understand your care and your role in it. You must also inform your provider whenever treatment does not seem to be working for you. Terry E. Passman, M.D., L.L.C. does not provide 24 hours/7 days a week emergency services.

TIMELY NOTIFICATION: You are responsible for notifying the receptionist of any change in your address or telephone number so that your provider can contact you if needed. 48 business hours are required for an appointment cancellation or reschedule, and a session fee will be charged to the patient/responsible party if not rescheduled in the timely manner or for a missed appointment.

ACKNOWLEDGEMENT OF RESPONSIBILITY & AGREEMENT TO PAY: I understand that I am financially responsible to you for all professional services rendered. I understand that payment for these charges is due at the time of service. Failure to pay my portion in full at the time of service may result in a $10 billing fee being added to my account. I, the undersigned, accept the fee charged as a legal and lawful debt and agree to pay said fee, including any/all collection fees, 33.3%, attorney fees and/or court costs if such be necessary. I waive now and forever my right of exemption under the laws of the constitution of the State of Alabama and any other state.

MEDICARE PRIVATE PRIVATE CONTRACT ACKNOWLEDGEMENT OF RESPONSIBILITY & AGREEMENT TO PAY:
I understand that if I am a Medicare beneficiary patient, I will sign a private contract with Terry E. Passman, M.D., LLC: Provider Opt-out Contract of Medicare, and may not submit claims for reimbursement.

EXPRESS PRIOR CONSENT TO CONTACT PATIENT BY CELL PHONE AND E-MAIL: You agree, in order for us to communicate, service your account, or to collect the monies you may owe, Terry Passman, M.D., LLC and/or our agents may contact you by telephone at any telephone number associated with your account, including wireless telephone numbers, which could result in charges to you. We may also contact you by sending text messages or emails, using any email address you provide to use. Methods of contact may include using pre-recorded/artificial voice messages and/or use of automatic dialing devices, as applicable.

My signature below indicates that I have read and understand my rights and responsibilities. I understand that it is my sole responsibility to request clarification or additional information concerning my rights and responsibilities.

____ _______________________
(Signature of client or legal guardian) (Date)

Print name: ___________________________________

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Family & Medical History

The following information is important to your doctor and so that we may provide the highest quality of care.
Your answers are confidential to the fullest extent allowed by law.

Patient Name: ___________________________

Children:

Name: ____________________________ Age:____ Name: _____________________________ Age:____
Name: ____________________________ Age:____ Name: _____________________________ Age:____

If you have been married, how old were you when first married? _____ How many times have you been married? ____
Length of time married? ______

Please list anyone else living in your home: ____

What is the primary reason you are seeking help at this time?

____
____
____

List any allergies or adverse reactions to medications, or write 'none':

____

Medical problems you are having now or in the recent past:

____
____
____

Please list any medications you are now taking, including the name of the provider prescribing them:
(Include over the counter & birth control medication)

MEDICATION	STRENGTH	DIRECTIONS	PRESCRIBING PHYSICIAN

Please list any past surgeries: ____
____

Please list any past medical hospitalizations including those for psychiatric difficulties, or alcohol or drug rehabilitation:
____
____
____

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Family & Medical History

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Please list family members and their relationship to you, who have had mental, emotional, relationship, substance, or alcohol abuse problems, and if they were hospitalized. Explain problems in space provided.

Family Member (Relationship to you)	**Type of Illness** (Such as substance/alcohol abuse, mental, nervous, or emotional problems)	Were they hospitalized for this problem ?

Have you had a past drug problem? Yes____ No____ *Please check any drugs you now use or used in the past year:*

□ "Crack'', cocaine □ Sniffing chemicals □ "Speed", amphetamines □ Heroin, methadone
□ "Acid", LSD □ Marijuana □ "Downers", depressants □ Any others? ____________

Do you smoke cigarettes? Yes____ No____ How many per day?________

At what age did you first try alcohol? _____ How much do you drink in a typical weekend? ______ Weekday?_______
Have you ever been convicted of a DUI? Yes__ No___ Have you ever thought you should cut back on drinking?_____

Please check any of the following you endured as a child or adult:

□ Verbal abuse, criticism □ Sexual abuse □ Emotional abuse □ Rape
□ Physical abuse □ Losses, deaths, separation □ Abortions □ Infidelity

How far did you go in school? ___________________ What kinds of grades did you get?_________________
Were you in Special Education classes? ___________ Do you have a learning disability?_________________
Did you repeat any grades? _____________________ Any conduct or behavior problems?________________

Are you currently on probation? _________ Have you ever been arrested?__________ How long ago?___________
If you have been arrested, what was the charge?____
Have you ever gotten into trouble because of your temper or violence? _______________________________________

Do you consider your spiritual life to be important to you? _________ Are you involved in organized religion?________
Whom do you feel you can talk to, is "on your side" in life? ____

What are three major things you would like to change by coming to Dr. Terry Passman, M.D.?
1. ____
2. ____
3.____

On your first visit, what would you like to accomplish and what are your expectations? ____________________________
____

Do you have any special paperwork for the doctor to fill out? Yes _______ No ______

Please explain: ____

Is there anything else you would like for your doctor/therapist to know? (*Use back of sheet if necessary*)

Symptom Checklist

If you are having any of the following symptoms or problems, check the box of that symptom.
Circle the number that most describes the severity of that symptom.

1= Mild 2= Moderate 3= Severe 4= Extreme

	Symptom	Severity
	Tremors, trembling, or shakiness	0 1 2 3 4
	Repetitive thoughts	0 1 2 3 4
	Repetitive behaviors	0 1 2 3 4
	Behaviors you can’t stop	0 1 2 3 4
	Constant worry	0 1 2 3 4
	Irritability	0 1 2 3 4
	Tension	0 1 2 3 4
	Feeling in a dreamlike state	0 1 2 3 4
	Fearful feelings	0 1 2 3 4
	Fear of losing control	0 1 2 3 4
	Restlessness/Agitation/Nervousness	0 1 2 3 4
	Panic attacks	0 1 2 3 4
	Can’t pay attention, distractibility	0 1 2 3 4
	Trouble concentrating	0 1 2 3 4
	Sleeping too much	0 1 2 3 4
	Insomnia/trouble sleeping	0 1 2 3 4
	Increase/Decrease in sex drive	0 1 2 3 4
	Trouble making decisions	0 1 2 3 4
	Sad/depressed/down in the dumps	0 1 2 3 4
	Lack of/loss of interest in things	0 1 2 3 4
	Helpless feelings	0 1 2 3 4
	Increase or decrease in appetite	0 1 2 3 4
	Increase or decrease in weight	0 1 2 3 4
	Frequent crying or weeping, crying spells	0 1 2 3 4
	Feeling life is not worth living	0 1 2 3 4
	Frequent thoughts of death or suicide	0 1 2 3 4
	Worthless feelings	0 1 2 3 4
	Excessive feelings of guilt	0 1 2 3 4
	Hopeless feelings	0 1 2 3 4
	Memory problems	0 1 2 3 4
	Fear of doing something uncontrollable	0 1 2 3 4
	Fear of dying	0 1 2 3 4
	Seeing or hearing things that are not real	0 1 2 3 4
	Fear of going crazy	0 1 2 3 4
	Thoughts of hurting animals	0 1 2 3 4
	Thoughts of hurting people	0 1 2 3 4
	Fire starting	0 1 2 3 4
	Violent behavior	0 1 2 3 4
	Problems with the past	0 1 2 3 4
	Frequent negative thinking	0 1 2 3 4
	Racing thoughts	0 1 2 3 4

	Other symptoms or problems (check all that apply)
	Fainting or feeling faint
	Seizures
	Fever
	Skin rash/skin problems
	Headache
	Sweating
	Dizziness/lightheadedness
	Fatigue/lack of energy
	Weakness
	Chills
	Eye problems
	Chest pain/chest discomfort
	Heart pounding
	Diarrhea
	Constipation
	Heartburn
	Other digestive problems
	Food intolerance
	Upper respiratory problems
	Wheezing
	Shortness of breath
	Pain when breathing
	Nosebleeds
	Urinary problems
	Muscular problems
	Hormonal problems
	Problems with alcohol
	Problems with drugs
	Relationship problems
	Financial problems
	Job problems
	Legal problems
	Domestic violence
Other:	

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CONFIDENTIAL

Directions: Please read carefully, initial the bottom of this page and sign and date the next page.

TREATMENT CONSENT:

Terry Passman, M.D., L.L.C. is an outpatient practice and only provides coverage during the time the office is open. Anyone whose condition requires 24-hour, 7 days a per week psychiatric monitoring, back-up, or admission to a psychiatric hospital should find another practice that offers these services.

This treatment consent covers all procedures that are not of a nature to require a special consent, and it provides protection for the procedures performed by the professional staff of Terry Passman, MD, LLC. This document states that the client has consented to treatment by Terry Passman, M.D., including, but not limited to psychotherapy and counseling. This allows the professional staff at Terry Passman, M.D., LLC to provide services to you.

This provides evidence that no guarantee is made by any professional at Terry Passman, M.D., LLC concerning the outcome of treatment. There is no guarantee that treatment will be successful. If you have any questions concerning this or any other matters, it is your responsibility to ask your therapist. By signing this form, you acknowledge that you understand your consent to treatment as explained in this form.

I as the patient/legal guardian/caregiver do hereby voluntarily consent to care and treatment by doctors and/or licensed staff at Terry Passman, M.D., LLC. I am aware that the practice of medicine, psychiatry, clinical psychology, and clinical social work is not an exact science and I acknowledge that no guarantees have been made as to the result of evaluation and treatment. I am aware that I am an active participant in the counseling process and that I share responsibility for treatment. My responsibilities in treatment including informing the therapist of any information that may be relevant to the problems or conditions being treatment, assisting in setting goals for treatment, following therapeutic advice to the best of my ability, and ending treatment in a responsible way.

If I am consenting to treatment for another person, I certify that I am legally responsible for that person and am entitled to consent to treatment for them.

CLIENT RIGHTS AND RESPONSIBILITIES:

Confidentiality: Everything you say to your therapist is confidential, which means that it is private and cannot be shared with anyone outside this office without your permission. Your therapist cannot release any information about you without a signed consent for release of information, except in emergencies or when there is a court order requiring the information be released. Please note that information released about dangerous behaviors, including serious thoughts of hurting yourself or another person, as well as information about child abuse, is not confidential and will be reported by your therapist to the appropriate authorities to keep you and other people safe. Also, if you were referred to counseling by a Court order, information about your treatment is **not** confidential and can be released to the Court without your consent.

Informed Consent: You have the right to an explanation of your condition and treatment in language that you can understand. You have the right to consent or agree to treatment, and you also have the right to refuse treatment. You have the right to consent to the release of records if you want someone else to be informed about your treatment, and you have the right to refuse release of records if you do not want someone else to know about your treatment. If you do not consent to treatment or if you do not consent to release of information, this does not affect your other rights as listed on this sheet.

Input into Treatment: You have the right to provide input into the policies of Terry Passman, M.D., LLC and into your treatment. You have the right to share in the treatment planning process, determining what options you choose for your treatment. You have the right to file complaints and compliments related to your treatment. You may also have the right to file grievances and appeals related to this treatment.

Promptness: Your counseling session will start promptly at the time scheduled therapist is delayed by a previous emergency.

Respect and Non-Discrimination: You have the right to be treated with respect and dignity by all staff at Terry Passman, M.D., LLC. You have the right to be treated equally regardless of your race, ethnic origin, religion, creed, gender, age, disability status, sexual orientation, or source of payment.

Other Information and Options: You have the right to information concerning your provider. You also have the right to know about your treatment options, regardless of their costs or if they are covered by your insurance. You have the right to know what clinical guidelines or standards are used in providing your treatment. You have the right to know about your rights and responsibilities in treatment. You have other rights and responsibilities as provided by Alabama Law.

Initials:____________________

HIPPA NOTICE OF PRIVACY PRACTICES
Terry Passman, M.D., LLC

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.
This notice of Privacy Practices describes how we may use and disclose your Personal Health Information (PHI) to carry out treatment, payment, or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your P.H.I. "P.H.I" is information about you, including demographic information, that may identify you and that relates to your past, present, or future physical or mental health or condition and related health care services.
Uses and Disclosures of P.H.I. Your P.H.I. may be used and disclosed by your physician, our office staff and others outside our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practices, and any other use required by law.
Treatment We will use and disclose your P.H.I. to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your P.H.I. as necessary, to a home health agency that provides care to you. For example, your P.H.I. may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.
Payment Your P.H.I. will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant P.H.I. be disclosed to the health plan to obtain approval for the hospital admission.
Healthcare Operations We may use or disclose, as needed, your P.H.I. in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing and condition or arranging for other business activities. For example, we may disclose your P.H.I. to medical school students that see patients at out office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready to see you. We may use or disclose your P.H.I., as necessary, to contact you to remind you of your appointment.
We may use or disclose your P.H.I. in the following situations without your authorization. These situations include: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse or neglect, food and drug administration requirements, legal proceedings, law enforcement, coroners, funeral directors, organ donation, research, criminal activity, military activity and national security, workers compensation, inmates, required uses and disclosures, under the law, we must make disclosures to you and when required by the Secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500. Other permitted and required uses and disclosures will be made with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physicians' practice has taken an action in reliance on the use or disclosure indication in the authorization.

Your Rights Following is a statement of your rights with respect to your P.H.I.

You have the right to inspect and copy your P.H.I. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and P.H.I. that is subject to law that prohibits access to P.H.I..

You have the right to request a restriction of your P.H.I. This means you may ask us not to use or disclose part of your P.H.I. for the purposes of treatment, payment or healthcare operations. You may also request that any part of your P.H.I. not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.
Your physician is not required to agree to a restriction that you may request. If the physician believes it is in the best interest to permit use and disclose your P.H.I., your P.H.I. will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us. Upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your P.H.I. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your P.H.I. We reserve the right to change the terms of this notice and inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints You may complain to us or the Secretary of Health and Human Services if you believe your rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint. *We will not retaliate against you for filling a complaint.*

This notice was published and becomes effective on/or before April 14, 2003.
We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone at our Main Phone Number.
Signature below is only acknowledgement that you have received this Notice of our Privacy Practices.

Print Name: ____________________ Signature: ______________________ Date: ______________