MICHAEL T. INGRAM, JR., M.D., M.S.

M.T.I. PSYCHIATRY, INC.

M.T.I. PSYCHIATRY, INC

NEW PATIENT PACKET

2023

8271 MELROSE AVENUE, SUITE 110, LOS ANGELES, CA 90046 PHONE: (949) 436 – 9099 FAX: (475) 313 - 1260
WEBSITE: WWW.MICHAELTINGRAM.COM EMAIL: MINGRAM@MTIPSYCHIATRY.COM

CONFIDENTIAL

MICHAEL T. INGRAM, JR., M.D., M.S.

M.T.I. PSYCHIATRY, INC.

PRACTICE POLICIES

Welcome! Agreement to the following terms and conditions is required for the patient ["you" or "your"] to receive psychiatric services from Dr. Michael T. Ingram, Jr., M.S., M.D. ["provider" or "me" or "my" or "I" or "we" or "our"]. If you do not agree, I will be glad to give you referrals to other providers.

CLINICAL SERVICES

You are providing consent to receive a comprehensive diagnostic assessment. At the end of the evaluation, we will mutually decide if we will continue treatment together.

If you are in a life threatening medical and/or psychiatric emergency or are a threat to public safety, you agree to call 911 immediately or go to the nearest emergency room. For non-life-threatening inquiries please feel free to reach me anytime between 9am and 6pm by phone, email, or luminello messaging. Please know I will do everything I can to respond as soon as possible. You can expect a response within 48 hours.

Note that I do not have admitting privileges, nor am I affiliated with or on staff at any hospital. Should I deem more intensive services are needed than I can provide, I will do my best to ensure safety and obtain the appropriate level of care, but I cannot provide that care directly and cannot guarantee the receipt or quality of care that others provide.

All communication and clinical treatment will be documented in the patient chart. Both the law and the standards of the profession require such. You are entitled to receive a copy of these records unless I believe that seeing them would be emotionally damaging. If this is the case, I will be happy to provide the records to an appropriate mental health professional of your choice or to prepare an appropriate summary instead. Because client/patient records are professional documents, they can be misinterpreted and can be upsetting. If you wish to see the records, it is best to review them with me so that we can discuss their contents.

IF YOU ARE SEEING ME FOR MEDICATION MANAGEMENT:

- You agree to contact your therapist first (if applicable) for any psychiatric emergency or crisis, unless it is related to medication. If the emergency or crisis is related to medication, you agree to contact me immediately. HOWEVER, if you are experiencing a life threatening medical and/or psychiatric emergency, you agree to dial 911 or go to the nearest emergency room.

PATIENT INITIALS: __________

- You agree to inform me if you are considering stopping therapy or have actually stopped.
- You agree to see me in person or via telemedicine video conferencing at LEAST once per month for the first three months. After the first three months, you agree to see me in person or via telemedicine video conferencing as frequently as clinically appropriate based on my clinical judgement.
- You understand that medication refills for scheduled I, II, III, IV, or V medications will not be provided unless you've attended a scheduled appointment within the previous two months for schedule I, II, or III medications or three months for schedule IV or V medications.
- You understand that no schedule I, II, III, IV, or V medication will be prescribed until you've been seen in-person at least once.

IF YOU ARE BEING PRESCRIBED A SCHEDULE I, II, OR III MEDICATION:

- You agree to see me in office or via telemedicine video conferencing AT LEAST once every two months.
- You understand that refills for schedule I, II, or III medications will not be provided unless you've attended a scheduled appointment within the previous two months.
- You agree to see me in office (i.e., in-person) AT LEAST once per year.

IF YOU ARE BEING PRESCRIBED A SCHEDULE IV or V MEDICATION:

- You agree to see me in person or via telemedicine video conferencing as frequently as clinically appropriate based on my clinical judgement.
- You understand that refills for schedule IV or V medications will not be provided unless you've attended a scheduled appointment within the previous three months.
- You agree to see me in office (i.e., in-person) AT LEAST once per year.

PATIENT INITIALS: __________

TELEMEDICINE & ELECTRONIC PRESCRIBING

If using Telepsychiatry services, electronic prescribing is available. In compliance with federal and state law, all patients prescribed scheduled/controlled medications must be seen IN-PERSON AT LEAST ONCE prior to being prescribed a controlled medication.

RYAN HAIGHT ONLINE PHARMACY CONSUMER PROTECTION ACT OF 2008

The Ryan Haight Online Pharmacy Consumer Protection Act of 2008 was created to regulate online internet prescriptions, is enforced by the DEA (Drug Enforcement Agency) and also imposes rules around the prescription of controlled substances through telepsychiatry.

The Act requires any practitioner issuing a prescription for a controlled substance to conduct an in-person medical evaluation (with certain specified exemptions) prior to prescribing controlled substances. Per the Act, the prescribing practitioner is required to have conducted one in-person medical evaluation with the patient and may prescribe via telemedicine thereafter. The occurrence or frequency of additional in-person visits is not mandated under the Ryan Haight Act.

The Act also describes special circumstances such as “covering practitioners” – “a practitioner who conducts a medical evaluation [by telemedicine] at the request of a practitioner who … has conducted at least 1 in-person medical evaluation of the patient or an evaluation of the patient through the practice of telemedicine within the previous 24 months" – and prescribing within a federal health care system (e.g. Indian Health System; Department of Veteran’s Affairs).

Additional in-person evaluations, beyond the minimum required by relevant facility, state, and federal policy, is up to clinical discretion. For example, if the practitioner is unable to obtain the data they need for clinical decision-making through telehealth, the practitioner may recommend that a patient be seen in-person.

For more information, visit the following links

- https://www.congress.gov/110/plaws/publ425/PLAW-110publ425.pdf
- https://telehealth.hhs.gov/providers/policy-changes-during-the-covid-19-public-health-emergency/prescribing-controlled-substances-via-telehealth

PATIENT INITIALS: __________

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DEFINITION OF CONTROLLED SUBSTANCE SCHEDULES

Drugs and other substances that are considered controlled substances under the Controlled Substances Act (CSA) are divided into five schedules. An updated and complete list of the schedules is published annually in Title 21 Code of Federal Regulations (C.F.R.) §§1308.11 through 1308.15. Substances are placed in their respective schedules based on whether they have a currently accepted medical use in treatment in the United States, their relative abuse potential, and likelihood of causing dependence when abused. Some examples of the drugs in each schedule are listed below.

SCHEDULE I CONTROLLED SUBSTANCES

Substances in this schedule have no currently accepted medical use in the United States, a lack of accepted safety for use under medical supervision, and a high potential for abuse.

Some examples of substances listed in Schedule I are: heroin, lysergic acid diethylamide (LSD), marijuana (cannabis), peyote, methaqualone, and 3,4-methylenedioxymethamphetamine ("Ecstasy").

SCHEDULE II/IIN CONTROLLED SUBSTANCES (2/2N)

Substances in this schedule have a high potential for abuse which may lead to severe psychological or physical dependence.

Examples of Schedule II narcotics include: hydromorphone (Dilaudid®), methadone (Dolophine®), meperidine (Demerol®), oxycodone (OxyContin®, Percocet®), and fentanyl (Sublimaze®, Duragesic®). Other Schedule II narcotics include: morphine, opium, codeine, and hydrocodone.

Examples of Schedule IIN stimulants include: amphetamine (Dexedrine®, Adderall®), methamphetamine (Desoxyn®), and methylphenidate (Ritalin®).

Other Schedule II substances include: amobarbital, glutethimide, and pentobarbital.

SCHEDULE III/IIIN CONTROLLED SUBSTANCES (3/3N)

Substances in this schedule have a potential for abuse less than substances in Schedules I or II and abuse may lead to moderate or low physical dependence or high psychological dependence.

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Examples of Schedule III narcotics include: products containing not more than 90 milligrams of codeine per dosage unit (Tylenol with Codeine®), and buprenorphine (Suboxone®).

Examples of Schedule IIIN non-narcotics include: benzphetamine (Didrex®), phendimetrazine, ketamine, and anabolic steroids such as Depo®-Testosterone.

SCHEDULE IV CONTROLLED SUBSTANCES

Substances in this schedule have a low potential for abuse relative to substances in Schedule III.

Examples of Schedule IV substances include: alprazolam (Xanax®), carisoprodol (Soma®), clonazepam (Klonopin®), clorazepate (Tranxene®), diazepam (Valium®), lorazepam (Ativan®), midazolam (Versed®), temazepam (Restoril®), and triazolam (Halcion®).

SCHEDULE V CONTROLLED SUBSTANCES

Substances in this schedule have a low potential for abuse relative to substances listed in Schedule IV and consist primarily of preparations containing limited quantities of certain narcotics.

Examples of Schedule V substances include: cough preparations containing not more than 200 milligrams of codeine per 100 milliliters or per 100 grams (Robitussin AC®, Phenergan with Codeine®), and ezogabine.

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FOLLOW-UP POLICIES

IN COMPLIANCE WITH STATE LAW, NO SCHEDULE I, II, III, IV, OR V MEDICATION WILL BE PRESCRIBED UNTIL YOU'VE BEEN SEEN IN-PERSON AT LEAST ONCE.

NO SERVICES WILL BE PROVIDED UNTIL PAYMENT IS MADE IN FULL. NO EXCEPTIONS.

IF YOU ARE SEEING ME FOR PSYCHOTHERAPY ONLY

- You agree to contact me for any emergency or crisis, unless it is medication related. If the emergency or crisis is related to medication, you agree to contact the provider who is prescribing the medication first. HOWEVER, if you are experiencing a life threatening medical and/or psychiatric emergency, you agree to dial 911 or go to the nearest emergency room.
- You agree to inform me if you are considering stopping therapy, or have actually stopped
- You agree to see me in person or via telemedicine video conferencing as you prefer. There is no follow up requirement if you are seeing me for psychotherapy ONLY.

I RESERVE THE RIGHT TO STOP OR DISCONTINUE PRESCRIBING ANY MEDICATION(S) FOR ANY OF THE FOLLOWING REASONS AT ANY TIME:

- The policies outlined above are violated
- Based on my professional and clinical judgement, there is a medical or psychiatric contraindication that necessitates stopping or discontinuing any medication(s)
- Continuing any medication(s) pose(s) a significant risk to your physical or mental health that is not outweighed by potential benefits.
- Based on my professional and clinical judgement, there is suspicion of abuse or diversion of medications prescribed for you.

I RESERVE THE RIGHT TO DISCONTINUE OR TERMINATE CARE FOR ANY OF THE FOLLOWING REASONS AT ANY TIME:

- The policies outlined above are violated
- Violation(s) of the Payment Policy Agreement (see below)

PATIENT INITIALS: __________

- Lack of adherence in treatment which, in my clinical judgement, poses a medical or psychiatric danger necessitating termination of care and/or referral to another provider(s)
- Inappropriate conduct, abuse, or harassment
- Appointments are repeatedly rescheduled, canceled, or you do not attend appointments.
- It has been over 12 months since you've been seen by Dr. Ingram.

NOTE: *If care is terminated by Dr. Ingram, you will be provided with enough psychotropic medication, if applicable, to last no more than thirty (30) days. It will be your responsibility to find a new provider.*

RISKS AND BENEFITS OF PSYCHOTHERAPY

Psychotherapy has both risks and benefits.

- Possible risks include the experience of uncomfortable feelings (such as sadness, guilt, anxiety, anger, frustration, loneliness, or helplessness) or the recall of unpleasant events.
- Potential benefits include a reduction in feelings of distress, better relationships, better problem-solving and coping skills, and resolution of specific problems.
- Given the nature of psychotherapy, it remains an inexact science and no guarantees can be made regarding the outcome.

CONFIDENTIALITY

There is no guarantee of confidentiality under the following conditions:

- If I suspect you are in imminent danger of harm to self or others, or a child or elderly person is being abused or neglected (as I am a mandated reporter).
- If a court orders a release of information
- If you initiate a malpractice lawsuit, or a billing dispute with a financial institution
- If you pay by credit card, my name will appear on your credit card statement
- If you do not pay your bill, your balance due statement (including diagnostic and procedural codes) may be sent to a collections agency or other responsible party
- Between me and my administrative staff
- With your written permission only: between colleagues with whom I consult professionally.

PATIENT INITIALS: __________

- If you use text messaging or email to contact Dr. Ingram or his Administrative Assistant which is NOT a HIPAA Compliant means of communication
- If you call Dr. Ingram or his Administrative Assistant by phone which is NOT a HIPAA Compliant means of communication

SCHEDULING APPOINTMENTS

Please be sure to schedule a follow up visit in advanced. Last minute appointment requests may not be fulfilled as appointment slots fill up quickly. In the event of an emergency or crisis, you are instructed to go to the nearest emergency room and/or call 911 immediately.

NO SURPRISE BILLING STATEMENT

DR. MICHAEL INGRAM PROVIDES A FEE-FOR-SERVICE MODEL OF CARE

Dr. Michael Ingram isn't in your health plan's network. This means Dr. Michael Ingram doesn't have an agreement with your plan. The purpose of this statement is to let you know about your protections from unexpected medical bills. Receiving care from Dr. Michael Ingram could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

UNDERSTANDING YOUR OPTIONS

You are always welcome to receive care from other providers who are in-network with your health plan. Please contact your insurance company for a list of providers in-network. For more information about your rights and protections, please visit https://www.cms.gov for more information about your rights under federal law.

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OPEN PAYMENTS DATABASE & ASSEMBLY BILL 1278

Pursuant to Assembly Bill (AB) 1278, physicians are required to provide a notice to their patients regarding the Open Payments database (Database), which is managed by the U.S. Centers for Medicare & Medicaid Services, or CMS.

The Open Payments database is a federal tool used to search payments made by drug and device companies to physicians and teaching hospitals. It can be found at https://openpaymentsdata.cms.gov .

For informational purposes only, a link to the federal Centers for Medicare and Medicaid Services (CMS) Open Payments web page is provided here (https://openpaymentsdata.cms.gov). The federal Physician Payments Sunshine Act requires that detailed information about payment and other payments of value worth over ten dollars ($10) from manufacturers of drugs, medical devices, and biologics to physicians and teaching hospitals be made available to the public.

STATEMENT ON DIAGNOSIS IN PSYCHIATRY

While a thorough diagnostic evaluation at the initial consultation visit provides Dr. Ingram with enough information to make one or more "provisional" diagnoses, it is important to remember that accurate diagnoses in psychiatric medicine develop over time (i.e., weeks to months) as Dr. Ingram gets to know his patients and their behavioral patterns. When appropriate, diagnoses will be given but should be viewed as provisional and subject to change. That is, diagnoses can evolve and change over time as new symptoms and patterns emerge. Dr. Ingram is primarily concerned with each individual's unique experience given that diagnoses do not adequately describe the complexity of a human being.

PATIENT INITIALS: __________

NOTICE TO PATIENTS

Medical doctors are licensed and regulated by the Medical Board of California. To check up on a license or to file a complaint, go to www.mbc.ca.gov or email licensecheck@mbc.ca.gov or call (800) 633-2322.

PATIENT INITIALS: __________

PAYMENT POLICY AGREEMENT

This Payment Policy Agreement is designed to help Dr. Ingram provide the most efficient and reasonable health care services. Therefore, it is necessary to have a Payment Policy Agreement stating Dr. Ingram's requirements for payment for services provided to patients.

DR. MICHAEL INGRAM PROVIDES A FEE-FOR-SERVICE MODEL OF CARE

You agree to pay for services and fees as outlined in this PAYMENT POLICY AGREEMENT section. You are responsible for full payment, whether your insurance company ends up paying partially, or not at all, for services rendered. I do not communicate with insurance companies directly.

YOU ARE FINANCIALLY RESPONSIBLE FOR ALL CHARGES, WHETHER OR NOT:

- Insurance pays for any services
- We decide to proceed with treatment
- Treatment is successful, for which there cannot be any guarantee

Dr. Ingram is considered an "Out-of-Network" Provider. Some insurance companies will pay for services from "Out-of-Network" Providers, but there is no guarantee that your insurance company will pay for services. You are responsible for paying the total amount billed for each session, regardless of whether your insurance company pays. Dr. Ingram does not accept Medicare or Medi-Cal as forms of payment (Non-Participating Provider).

Furthermore, Dr. Ingram is not responsible for any communication with insurance companies. This includes, but is not limited to, generating insurance claims, disputing reimbursements, or completing prior authorization forms for medications, laboratory studies, or other diagnostic studies recommended by Dr. Ingram. You will be able to generate an insurance claim for yourself through Luminello, Inc., the electronic medical record (EMR) system used by Dr. Ingram. If needed, Luminello has a user- guide to help you generate an insurance claim that you can submit to your insurance company.

There is no guarantee that your insurance company will reimburse you for the services provided by Dr. Ingram. You will be considered a self-pay patient during the entire course of treatment with Dr. Ingram.

PATIENT INITIALS: __________

Payment is due at the time of your scheduled appointment. No services will be provided until payment is received.

RATES

DESCRIPTION	LOCATION	DURATION	RATE
Initial Consultation Visit	Telemedicine or In-Office	90 Minutes	$1,200.00
Follow Up Visit	Telemedicine or In-Office	45 Minutes	$500.00
Follow Up Visit	Telemedicine or In-Office	25 Minutes	$350.00
Follow Up Visit	Telemedicine Only	15 Minutes	$275.00
Phone Calls, Conference Calls outside a scheduled visit	Telephone	--	$10.00 per minute

At-home (in-person) visits are available upon request. Rates are doubled for at-home visits.

ALL IN-OFFICE VISITS ARE 25 MINUTES OR 45 MINUTES

Unless other arrangements have been made, the rates above apply.

PHONE CALLS, TEXT MESSAGES, PAPER WORK, AND ADMINISTRATIVE WORK

All phone calls and/or paper work requested outside of your scheduled appointment will be charged at a rate of $10.00/min. This includes obtaining collateral information from previous and/or current healthcare/mental health providers, family members, friends, and coordination of care. No phone calls or administrative work will be completed without your consent. That is, you will be billed ONLY for services you provided consent for.

LUMINELLO MESSAGING

Messaging Dr. Ingram directly via Luminello messaging will remain free of charge. If you have questions that cannot be answered in a quick response, please schedule a follow up visit by phone or telemedicine using the online scheduling tool or by calling/texting Dr. Ingram's Administrative Assistant at 949-436-9099.

PROFILE INFORMATION AND CREDIT CARD/DEBIT CARD INFORMATION

Please be sure to keep your profile up to date. If you have a change of address, email, insurance, phone number, or emergency contact, please update this in your Luminello profile. An up-to-

PATIENT INITIALS: ________

date Credit Card or Debit Card is required at all times. Please keep this updated by using the "billing" tab within your portal.

The rates (prices) listed above will not change for the first 12 months of treatment, which begins on the day of your initial consultation visit and ends exactly 12 months after the day of your initial consultation visit. After the initial 12 months of treatment, rates (prices) for services may increase. You always have the option of discontinuing treatment with Dr. Ingram at any time and he will offer you referrals upon request.

NOTE: *If it has been over 12 months since you've been seen for a follow up visit, then another consultation visit will be required to continue receiving treatment from Dr. Ingram.*

ACCEPTED METHODS OF PAYMENT

- ✓ Cash
- ✓ Personal Check or Money Order
- ✓ Venmo
- ✓ Zelle
- ✓ Credit Card
- ✓ Debit Card

As you know, it is Dr. Ingram's policy to receive payment prior to your scheduled visit. No services will be provided until payment is received. If you choose to discontinue care before treatment is complete, your refund will be determined upon review of your case. If you have questions about your treatment plan or the choice of payment options, please do not hesitate to ask. We are here to help you receive the healthcare you deserve.

GENERATING A BILLING STATEMENT

You can generate your own insurance claim to submit to your insurance company for reimbursement by going to "Billing" and "Create Statement". If needed, we are happy to do this for you and send to you as a PDF.

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SUMMARY OF POTENTIAL FEES

WHAT ARE ALL THE POTENTIAL FEES YOU COULD INCUR DURING TREATMENT WITH DR. INGRAM?

1. **CANCELLATIONS/NO SHOWS:** Not showing up to a scheduled appointment AND/OR canceling an appointment within 48 hours of your scheduled follow up appointment will result in your credit card or debit card being charged for the full rate/fee of the visit. If you are running late, please notify us immediately. If you are not at your appointment within 10 minutes after your scheduled appointment time, then your appointment will be canceled, and you will be charged the cancellation/No Show Fee.
2. **SCHEDULED APPOINTMENTS:** Appointments are charged based on duration. Rates for appointments are listed above.
3. **ADMINISTRATIVE WORK:** All phone calls and/or paperwork requested outside of your scheduled appointment will be charged at a rate of $10.00/min. This includes obtaining collateral information from previous and/or current healthcare/mental health providers, family members, friends, and coordination of care. No phone calls or administrative work will be completed without your consent. That is, you will be billed ONLY for services you provided consent for.

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CREDIT CARD | DEBIT CARD INFORMATION

WHY DO YOU HAVE TO PROVIDE DR. INGRAM WITH YOUR CREDIT CARD OR DEBIT CARD INFORMATION?

Your Credit Card or Debit Card information is kept in your secure Luminello patient portal for the entire duration of treatment. Unless other arrangements have been made, your credit card or debit card will be charged for the initial consultation, each visit (see rates above), administrative work, and/or for cancellation/No Shows.

CHOOSE ONE:

☐ CREDIT CARD ☐ DEBIT CARD

CHOOSE ONE:

☐ VISA ☐ MASTERCARD ☐ AMERICAN EXPRESS ☐ DISCOVER ☐ OTHER:

NAME ON CARD:

CARD NUMBER: **CARD EXPIRATION DATE:**

CVV (THREE- OR FOUR-DIGIT NUMBER ON BACK/FRONT OF CARD):

BILLING ADDRESS (Number, Street, City, State, Zip, Country):

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PATIENT ATTESTATION

By signing your name in the space below,

- ✓ You have read the "Michael T Ingram Psychiatry Inc Practice Policies" and you agree to all the terms and conditions.
- ✓ You have read and understand the "Payment Policy Agreement" and you agree to its terms and conditions including all rates and fees. In the case that your insurance does not reimburse for services provided by Michael T. Ingram, Jr., M.S., M.D., you understand that you are responsible for payment of all services rendered.
- ✓ You affirm you are an authorized user of the credit card or debit card whose number, expiration date, CVV, and billing address are provided in this form, and you do authorize its use for all fees as outlined in all parts of this form.
- ✓ You acknowledge that you are consenting of your own free will and are not being coerced or pressured.
- ✓ You understand that you are giving up some consumer billing protections under federal law.
- ✓ You understand that you will pay in full for the services provided by Dr. Ingram
- ✓ You understand that you were given a written notice explaining that Dr. Ingram isn't in your health plan's network, the estimated cost of services, and what you may owe if you agree to be treated by Dr. Ingram.
- ✓ You fully and completely understand that some or all amounts you pay might not count toward your health plan's deductible or out-of-pocket limit.
- ✓ You understand that you can end this agreement by notifying Dr. Michael Ingram in writing before receiving services.
- ✓ You understand that you do not have to sign this form. But if you do not sign, Dr. Ingram will not treat you.
- ✓ You understand that you are always welcome to receive care from a provider or facility in your health plan's network.
- ✓ You understand that it is unethical to receive psychiatric services from two different psychiatrists at the same time and that doing so without informing Dr. Ingram will result in immediate termination of *care with Dr. Ingram.*

By signing your name in the space below, you agree to all the terms and conditions listed above.

PATIENT OR LEGAL GUARDIAN NAME (PRINT)

PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**

PATIENT INITIALS: __________

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RELEASE OF INFORMATION FORM

PATIENT FULL NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH
PATIENT HOME ADDRESS	PHONE

I GIVE DR MICHAEL INGRAM PERMISSION TO DISCUSS MY MEDICAL AND MENTAL HEALTH HISTORY WITH THE FOLLOWING INDIVIDUALS/INSTITUTIONS. IN ADDITION, I GIVE THE FOLLOWING INDIVIDUALS/INSTITUTIONS PERMISSION TO RELEASE MY MEDICAL AND/OR MENTAL HEALTH RECORDS TO DR MICHAEL T INGRAM. EXAMPLES INCLUDE PREVIOUS PSYCHIATRISTS, CURRENT THERAPIST, PRIMARY CARE PROVIDER, OTHER HEALTHCARE PROVIDERS, FAMILY MEMBERS, FRIENDS, ETC. (If none, write NONE):

By signing your name in the space provided, you are giving Dr. Michael T Ingram permission to contact the above-named individuals/institutions for the purpose of discussing and/or obtaining your mental health history and medical health history. This includes laboratory results, evaluation notes, progress notes, and other relevant health documents found in your medical and/or mental health records. You understand that this form is valid until you specifically state in writing that you no longer give Dr. Michael T. Ingram permission to do the above.

PATIENT OR LEGAL GUARDIAN NAME (PRINT)

PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**

PATIENT INITIALS: __________

MICHAEL T. INGRAM, JR., M.D., M.S.

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NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used, disclosed, and how you can get access to this information. Please review this document carefully.

PATIENT HEALTH INFORMATION (PHI)

Under federal law, your patient health information (PHI) is protected and confidential. Patient health information (PHI) includes information about your symptoms, test results, diagnosis, treatment, and related medical information. Your patient health information (PHI) also includes payment, billing and insurance information. We are committed to protect the privacy of your PHI.

HOW WE USE YOUR PATIENT HEALTH INFORMATION (PHI)

This Notice of Privacy Practices (Notice) describes how we may use within our practice or network and disclose (share outside of our practice or network) your PHI to carry out treatment, payment or health care operations, for administrative purposes, for evaluation of the quality of care, and so forth. We may also share your PHI for other purposes that are permitted or required by law. This Notice also describes your rights to access and control your PHI. Under some circumstances we may be required to use or disclose your PHI without your consent.

Treatment: We will use and disclose your PHI to provide you with medical treatment or services. We may also disclose your PHI to other health care providers who are participating in your treatment, to pharmacists who are filling your prescriptions, to laboratories performing tests, and to family members who are helping with your care, and so forth.

Payment: We will use and disclose your PHI for payment purposes. PHI may be shared with the following: billing companies, insurance companies (health plans), government agencies in order to assist with qualifications of benefits, or collection agencies.

Operation: We may ask you to complete a sign-in sheet or staff members may ask you the reason for your visit so we can better care for you. Despite safeguards, it is always possible in a doctor's office that you may learn information regarding other patients or they may inadvertently learn something about you. In all cases, we expect and request that our patients maintain strict confidentiality of PHI.

PATIENT INITIALS: __________

We may use and disclose your PHI to perform various routine functions (e.g. quality evaluations or records analysis, training students, other health care providers or ancillary staff such as billing personnel, to assist in resolving problems or complaints within the practice). We may use your PHI to contact you to provide information about referrals, for follow-up with lab results, to inquire about your health or for other reasons. We may share your PHI with Business Associates who assist us in performing routine operational functions, but we will always obtain assurances from them to protect your PHI the same as we do.

Special Situations that DO NOT require your permission: We may be required by law to report gunshot wounds, suspected abuse or neglect, and so on; we may be required to disclose vital statistics, diseases, and similar information to public health authorities; we may be required to disclose information for audits and similar activities, in response to a subpoena or court order, or as required by law enforcement officials. We may release information about you for worker's compensation or similar programs to protect your health or the health of others or for legitimate government needs, for approved medical research, or to certain entities in the case of death. Your PHI may also be shared if you are an inmate or under custody of the law which is necessary for your health or the health and safety of other individuals.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose PHI of individuals who are Armed Forces personnel for activities deemed necessary by appropriate military command authorities, for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or to foreign military authority if you are a member of that foreign military services.

In some situations, we may ask for your written authorization before using or disclosing any identifiable health information about you. If you sign an authorization, you can later revoke the authorization.

INDIVIDUAL RIGHTS

You have certain rights regarding your PHI, for example:

Unless you object, we may share your PHI with friends or family members, or other persons directly identified by you at the level they are involved in your care or payment of services. If you are not present or able to agree/object, the healthcare provider using professional judgment will determine if it is in your best interest to share the information. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person

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that is responsible for your care of your location, general condition or death. We may use or disclose your PHI to an authorized public or private entity to assist in disaster relief efforts.

You may request restrictions on certain uses and disclosures of your PHI. We are not required to accept all restrictions. If you pay in full for a treatment or service immediately, you can request that we not share this information with your medical insurance provider or our Business Associates. We will make every attempt to accommodate this request and, if we cannot, we will tell you prior to the treatment.

You may ask us to communicate with you confidentially by, for example, sending notices to a special address. In most cases, you have the right to get a copy of your PHI. There will be a charge for the copies.

If you believe information in your record is incorrect, or if important information is missing, you have the right to request that we amend the existing information by submitting a written request. You may request a list of instances where we have disclosed PHI about you for reasons other than treatment, payment, or operations. The first request in a 12 month period is free. There will be charges for additional reports.

You have the right to obtain a paper copy of this Notice from us, upon request. We will provide you a copy of this Notice on the first day we treat you. In an emergency situation we will give you this Notice as soon as possible. You have the right to receive notification of any breach of your protected health information.

OUR LEGAL DUTY

We are required by law to protect and maintain the privacy of your PHI, to provide this Notice about our legal duties and privacy practices regarding PHI, and to abide by the terms of the Notice currently in effect. We may update or change our privacy practices and policies at any time. Before we make a significant change in our policies, we will change our Notice and post the new Notice in the patient portal on Luminello (Electronic Medical Record System). You can also request a copy of our Notice at any time.

If you are concerned about your privacy rights, or if you disagree with a decision we made about your records, you may send a written complaint to the U.S. Department of Health and Human Services. You will not be penalized in any way for filing a complaint.

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MICHAEL T. INGRAM, JR., M.D., M.S.

M.T.I. PSYCHIATRY, INC.

Please sign your full name below to acknowledge that you have read and understand the NOTICE OF PRIVACY PRACTICES.

PATIENT OR LEGAL GUARDIAN NAME (PRINT)

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

PATIENT INITIALS: __________

MICHAEL T. INGRAM, JR., M.D., M.S.

M.T.I. PSYCHIATRY, INC.

TELEMEDICINE CONSENT FORM

INTRODUCTION

Telemedicine involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. Doxy.me is the software used by Dr. Michael T Ingram, Jr.

The information may be used for diagnosis, therapy, follow-up and/or education, and may include any of the following:

- Patient medical records
- Live two-way audio and video

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and medical record data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS

- Improved access to medical care by enabling a patient to visit with his/her psychiatrist [Dr. Michael T Ingram, Jr.] while at a remote location.
- More efficient medical evaluation and management.
- Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

- In rare cases, information transmitted may not be sufficient (e.g. poor resolution of video, images, or sound) to allow for appropriate medical decision making by the physician and consultant(s);
- Delays in medical evaluation and treatment could occur due to deficiencies or failures of the software, network connection, and/or equipment;

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- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
- In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

BY SIGNING THIS FORM, YOU ("THE PATIENT") UNDERSTAND THE FOLLOWING:

- You understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without your consent.
- You understand that you have the right to withhold or withdraw your consent to the use of telemedicine in the course of your care at any time, without affecting your right to future care or treatment.
- You understand that you have the right to inspect all information obtained and recorded in the course of a telemedicine interaction, and may receive copies of this information for a reasonable fee.
- You understand that a variety of alternative methods of medical care may be available to you, and that you may choose one or more of these at any time. Dr. Michael T. Ingram, Jr. has explained the alternatives to your satisfaction.
- You understand that telemedicine may involve electronic communication of your personal medical information.
- You understand that it is your duty to inform Dr. Michael T. Ingram, Jr. of electronic interactions regarding your care with other healthcare providers.
- You understand that you may expect the anticipated benefits from the use of telemedicine, but that no results can be guaranteed or assured.
- You understand that you must be physically located within California to be seen for initial consultation over Telemedicine. After initial evaluation, Telemedicine follow up may be received outside of California if needed.
- You have read and understand the information provided above regarding telemedicine, have discussed it with your physician or such assistants as may be designated, and all of your questions have been answered to your satisfaction. You hereby give informed consent for the use of telemedicine.

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MICHAEL T. INGRAM, JR., M.D., M.S.

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YOU ("THE PATIENT") HEREBY AUTHORIZE DR. MICHAEL T. INGRAM, JR. TO USE TELEMEDICINE THROUGHOUT YOUR DIAGNOSIS AND TREATMENT.

PATIENT OR LEGAL GUARDIAN NAME (PRINT)

PATIENT OR LEGAL GUARDIAN SIGNATURE **DATE**

PATIENT INITIALS: ___________

PATIENT CONSENT FOR TREATMENT

By signing my name below,

- ✓ **I, the patient, voluntarily consent to any and all health care treatment and diagnostic procedures provided by Michael T. Ingram, Jr., M.S., M.D.**
- ✓ **I, the patient, am aware that the practice of medicine, especially Psychiatry, is not an exact science and I further state that I understand that no guarantee has been or can be made as to the results of the treatments or examinations provided by Michael T. Ingram, Jr., M.S., M.D.**
- ✓ **I, the patient, agree to be contacted via email, phone, or Luminello EMR messaging system with information related to my visit, like: a patient portal invitation, medication and lab orders, requests to fill out forms, financial or payment information, pre-visit surveys, post-visit surveys, or appointment reminders.**
- ✓ **I, the patient, consent to the use and disclosure of my protected health information for purposes of obtaining payment for services rendered to me, treatment, and health care operations consistent with both the Notice of Privacy Practices and Payment Policy provided by Michael T. Ingram, Jr., M.S., M.D.**
- ✓ **I, the patient, have either received a copy of the Notice of Privacy Practice or I have been provided easy access to the Notice of Privacy Practice and I agree with its contents.**
- ✓ **I, the patient, have either received a copy of the Payment Policy Agreement or I have been provided easy access to the Payment Policy Agreement and I agree with its contents.**
- ✓ **I, the patient, have either received a copy of the Practice Policies or I have been provided easy access to the Practice Policies and I agree with its contents.**
- ✓ **I, the patient, give permission to obtain all my medication/prescription history when using an electronic system to process prescriptions for my medical treatment.**

PATIENT OR LEGAL GUARDIAN NAME (PRINT)

PATIENT OR LEGAL GUARDIAN SIGNATURE DATE

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MICHAEL T. INGRAM, JR., M.D., M.S.

M.T.I. PSYCHIATRY, INC.

SELF-ASSESSMENT QUESTIONNAIRE

TRAUMA SCREEN (PCL-5)

INSTRUCTIONS: Below is a list of problems that people sometimes have in response to a very stressful or traumatic experience. Please read each problem carefully and then circle one of the numbers to the right to indicate how much you have been bothered by that problem **in the past month.**

	0	1	2	3	4
In the past month, how much were you bothered by:	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
1. Repeated, disturbing, and unwanted memories of the stressful experience?	☐	☐	☐	☐	☐
2. Repeated, disturbing dreams of the stressful experience?	☐	☐	☐	☐	☐
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	☐	☐	☐	☐	☐
4. Feeling very upset when something reminded you of the stressful experience?	☐	☐	☐	☐	☐
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	☐	☐	☐	☐	☐
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	☐	☐	☐	☐	☐
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	☐	☐	☐	☐	☐
8. Trouble remembering important parts of the stressful experience?	☐	☐	☐	☐	☐

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	Not at all	A little bit	Moderately	Quite a bit	Extremely
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	☐	☐	☐	☐	☐
10. Blaming yourself or someone else for the stressful experience or what happened after it?	☐	☐	☐	☐	☐
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	☐	☐	☐	☐	☐
12. Loss of interest in activities that you used to enjoy?	☐	☐	☐	☐	☐
13. Feeling distant or cut off from other people?	☐	☐	☐	☐	☐
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	☐	☐	☐	☐	☐
15. Irritable behavior, angry outbursts, or acting aggressively?	☐	☐	☐	☐	☐
16. Taking too many risks or doing things that could cause you harm?	☐	☐	☐	☐	☐
17. Being "superalert" or watchful or on guard?	☐	☐	☐	☐	☐
18. Feeling jumpy or easily startled?	☐	☐	☐	☐	☐
19. Having difficulty concentrating?	☐	☐	☐	☐	☐
20. Trouble falling or staying asleep?	☐	☐	☐	☐	☐

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

	0	1	2	3
Over the last two weeks, how often you have been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed, or hopeless	☐	☐	☐	☐
3. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or overeating	☐	☐	☐	☐
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
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	☐	☐	☐	☐
9. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐
If you checked off any problems, how difficult have those problems made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

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GENERALIZED ANXIETY DISORDER-7 (GAD-7)

	0	1	2	3
Over the last 2 weeks, how often you have been bothered by any of the following problems?	Not at all	Several days	More than half the days	Nearly everyday
1. Feeling nervous, anxious or on edge	☐	☐	☐	☐
2. Not being able to stop or control worrying	☐	☐	☐	☐
3. Worrying too much about different things	☐	☐	☐	☐
4. Trouble relaxing	☐	☐	☐	☐
5. Being so restless that it is hard to sit still	☐	☐	☐	☐
6. Becoming easily annoyed or irritable	☐	☐	☐	☐
7. Feeling afraid as if something awful might happen	☐	☐	☐	☐
If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?	Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
	☐	☐	☐	☐

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MOOD DISORDER QUESTIONNAIRE (MDQ)

Please answer each question to the best of your ability.

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 were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that 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 in 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?	☐	☐

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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 problems	☐ Minor problem	☐ Moderate problem	☐ Serious problem

	YES	NO
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

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ADHD SELF-REPORT SCALE

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.

PART A	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?	☐	☐	☐	☐	☐

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PART B	Never	Rarely	Sometimes	Often	Very Often
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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YBOCS

PART I: OBSESSIONS: Obsessions are thoughts, ideas, images or urges that are disturbing or intrusive or unwanted. They often persist despite our wishes and efforts to resist them. Common obsessions are excessive fears of contamination; recurring doubts about danger, extreme concern with order, symmetry, or exactness; fear of losing important things; believing you're a bad person; fear that you will hurt someone you love or yourself.

1. How much of your time is occupied by obsessive thoughts?

0. ☐None
1. ☐ Less than 1 hr/day or occasional occurrence
2. ☐ One to three hrs/day or frequent
3. ☐ Greater than 3 and up to 8 hrs/day or very frequent occurrence
4. ☐ Greater than 8 hrs/day or nearly constant occurrence

2. How much do your obsessive thoughts interfere with your work, school, social, or other important role functioning? Is there anything that you don't do because of them?

0. ☐ None
1. ☐ Slight interference with social or other activities, but overall performance not impaired
2. ☐ Definite interference with social or occupational performance, but still manageable
3. ☐ Causes substantial impairment in social or occupational performance
4. ☐ Incapacitating

3. How much distress do your obsessive thoughts cause you?

0. ☐ None
1. ☐ Not too disturbing
2. ☐ Disturbing, but still manageable
3. ☐ Very disturbing
4. ☐ Near constant and disabling distress

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4. How much of an effort do you make to resist the obsessive thoughts? How often do you try to disregard or turn your attention away from these thoughts as they enter your mind?

0. ☐ Try to resist all the time
1. ☐ Try to resist most of the time
2. ☐ Make some effort to resist
3. ☐ Yield to all obsessions without attempting to control them, but with some reluctance
4. ☐ Completely and willingly yield to all obsessions

5. How much control do you have over your obsessive thoughts? How successful are you in stopping or diverting your obsessive thinking? Can you dismiss them?

0. ☐ Complete control
1. ☐ Usually able to stop or divert obsessions with some effort and concentration
2. ☐ Sometimes able to stop or divert obsessions
3. ☐ Rarely successful in stopping or dismissing obsessions, can only divert attention with difficulty
4. ☐ Obsessions are completely involuntary, rarely able to even momentarily alter obsessive thinking.

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PART II: COMPULSIONS: Compulsions are urges that people have to do something to reduce or relieve feelings of anxiety or discomfort. These urges can lead people to do repetitive, purposeful, intentional behaviors called rituals. Washing, checking, repeating, counting, straightening, hoarding and many other behaviors can be rituals. Some rituals can be purely mental. For example, thinking or saying things over and over under your breath or saying a word over and over until it sounds "just right" in your mind.

6. How much time do you spend performing compulsive behaviors? How much longer than most people does it take to complete routine activities because of your rituals? How frequently do you do rituals?

0. ☐ None
1. ☐ Less than 1 hr/day or occasional performance of compulsive behaviors
2. ☐ From 1 to 3 hrs/day, or frequent performance of compulsive behaviors
3. ☐ More than 3 and up to 8 hrs/day, or very frequent performance of compulsive behaviors
4. ☐ More than 8 hrs/day, or near constant performance of compulsive behaviors (too numerous to count)

7. How much do your compulsive behaviors interfere with your work, school, social, or other important role functioning? Is there anything that you don't do because of the compulsions?

0. ☐ None
1. ☐ Slight interference with social or other activities, but overall performance not impaired
2. ☐ Definite interference with social or occupational performance, but still manageable
3. ☐ Causes substantial impairment in social or occupational performance
4. ☐ Incapacitating

8. How would you feel if prevented from performing your compulsion(s)? How anxious would you become?

0. ☐ None
1. ☐ Only slightly anxious if compulsions prevented
2. ☐ Anxiety would mount but remain manageable if compulsions prevented
3. ☐ Prominent and very disturbing increase in anxiety if compulsions interrupted
4. ☐ Incapacitating anxiety from any intervention aimed at modifying activity

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9. How much of an effort do you make to resist the compulsions?

0. ☐ Always try to resist
1. ☐ Try to resist most of the time
2. ☐ Make some effort to resist
3. ☐ Yield to almost all compulsions without attempting to control them, but with some reluctance
4. ☐ Completely and willingly yield to all compulsions

10. How strong is the drive to perform the compulsive behavior? How much control do you have over the compulsions?

0. ☐ Complete control
1. ☐ Pressure to perform the behavior but usually able to exercise voluntary control over it
2. ☐ Strong pressure to perform behavior, can control it only with difficulty
3. ☐ Very strong drive to perform behavior, must be carried to completion, can only delay with difficulty
4. ☐ Drive to perform behavior experienced as completely involuntary and overpowering, rarely able to even momentarily delay activity.

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SELF-CARE ASSESSMENT

Self-care activities are the things you do to maintain good health and improve well-being. Many of these activities you do already as part of your normal routine. In this assessment you will think about how frequently, or how well, you are performing different self-care activities. This will help you learn about your self-care needs by spotting patterns and recognizing areas of your life that need more attention. **Some of these items may not apply to you.**

Adapted from*: Transforming the Pain: A Workbook on Vicarious Traumatization.*
Saakvitne, Pearlman & Staff of TSI/CAAP (Norton, 1996)

When completing this assessment, use the following rubric:

It never occurred to me	I never do this	I do this poorly/ I do this rarely	I do this alright/ I do this sometimes	I do this well/ I do this often	I would like to improve at this/ I would like to do this more frequently
1	2	3	4	5	◆

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PHYSICAL SELF-CARE	1	2	3	4	5	♦
Eat Healthy Foods	☐	☐	☐	☐	☐	☐
Drink plenty of water	☐	☐	☐	☐	☐	☐
Take care of personal hygiene	☐	☐	☐	☐	☐	☐
Exercise	☐	☐	☐	☐	☐	☐
Keep my living space clean and organized	☐	☐	☐	☐	☐	☐
Eat regularly (e.g., breakfast, lunch, dinner)	☐	☐	☐	☐	☐	☐
Participate in fun activities (e.g., walking, swimming, dancing, singing, sports)	☐	☐	☐	☐	☐	☐
Get enough sleep	☐	☐	☐	☐	☐	☐
Get regular medical care for prevention	☐	☐	☐	☐	☐	☐
Get regular dental checkups	☐	☐	☐	☐	☐	☐
Rest when sick	☐	☐	☐	☐	☐	☐
Eat foods I enjoy	☐	☐	☐	☐	☐	☐
Take time to be sexual (with a partner or myself)	☐	☐	☐	☐	☐	☐
Wear clothes I like	☐	☐	☐	☐	☐	☐
Buy myself things I want	☐	☐	☐	☐	☐	☐
Make time away from telephones and screens	☐	☐	☐	☐	☐	☐
Make time away from the internet and social media	☐	☐	☐	☐	☐	☐
Get massages	☐	☐	☐	☐	☐	☐
Take time off work, school, and other obligations	☐	☐	☐	☐	☐	☐
Go on vacations or daytrips	☐	☐	☐	☐	☐	☐
Overall Physical Self-Care						

PATIENT INITIALS: __________

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PSYCHOLOGICAL & EMOTIONAL SELF-CARE	1	2	3	4	5	♦
Take time off work, school, and other obligations	☐	☐	☐	☐	☐	☐
Participate in hobbies	☐	☐	☐	☐	☐	☐
Learn things unrelated to work or school	☐	☐	☐	☐	☐	☐
Express my feelings through talking, art, journaling, activist work	☐	☐	☐	☐	☐	☐
Recognize my own strengths and achievements	☐	☐	☐	☐	☐	☐
Go on vacations or daytrips	☐	☐	☐	☐	☐	☐
Do something comforting (e.g., re-read my favorite books, re-watch my favorite movies, take a bath)	☐	☐	☐	☐	☐	☐
Make time for self-reflection (notice my inner experience—listen to my thoughts, judgments, beliefs, attitudes, and feelings)	☐	☐	☐	☐	☐	☐
Write in a journal	☐	☐	☐	☐	☐	☐
Read material that is unrelated to work or school	☐	☐	☐	☐	☐	☐
Doing things I am not an expert at or things where I am not in charge	☐	☐	☐	☐	☐	☐
Let others know different aspects of me	☐	☐	☐	☐	☐	☐
Engage my intelligence in a new area, e.g. go to an art museum, history exhibit, sports event, auction, theater performance	☐	☐	☐	☐	☐	☐
Practice receiving from others or accepting compliments	☐	☐	☐	☐	☐	☐
Say "no" to extra responsibilities sometimes	☐	☐	☐	☐	☐	☐
Spend time with others whose company I enjoy	☐	☐	☐	☐	☐	☐
Stay in contact with important people in my life	☐	☐	☐	☐	☐	☐
Give myself affirmations, praise myself, Love myself	☐	☐	☐	☐	☐	☐
Allow myself to cry	☐	☐	☐	☐	☐	☐
Find things that make me laugh	☐	☐	☐	☐	☐	☐
Overall Psychological and Emotional Self-Care						

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SOCIAL & SPIRITUAL SELF-CARE	1	2	3	4	5	♦
Spend time with the people I love	☐	☐	☐	☐	☐	☐
Call or reach out to friends and family who are far away	☐	☐	☐	☐	☐	☐
Have stimulating conversations	☐	☐	☐	☐	☐	☐
Meet new people	☐	☐	☐	☐	☐	☐
Ask others for help, when needed	☐	☐	☐	☐	☐	☐
Keep in touch with old friends	☐	☐	☐	☐	☐	☐
Spend time in nature	☐	☐	☐	☐	☐	☐
Meditate or Pray	☐	☐	☐	☐	☐	☐
Recognize the things that give meaning to my life	☐	☐	☐	☐	☐	☐
Act in accordance with my morals and values	☐	☐	☐	☐	☐	☐
Participate in a cause that is important to me	☐	☐	☐	☐	☐	☐
Set aside time for thought and reflection	☐	☐	☐	☐	☐	☐
Read inspirational literature (talks, music, etc.)	☐	☐	☐	☐	☐	☐
Have experiences of awe or inspiration	☐	☐	☐	☐	☐	☐
Be open to not knowing	☐	☐	☐	☐	☐	☐
Try at times not to be in charge or the expert	☐	☐	☐	☐	☐	☐
Be aware of nonmaterial aspects of life	☐	☐	☐	☐	☐	☐
Find a spiritual connection or community	☐	☐	☐	☐	☐	☐
Cherish your optimism and hope	☐	☐	☐	☐	☐	☐
Overall Social and Spiritual Self-Care						

PATIENT INITIALS: __________

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PROFESSIONAL | WORK | SCHOOL SELF-CARE	1	2	3	4	5	♦
Take breaks during work/studying	☐	☐	☐	☐	☐	☐
Take time to chat with co-workers	☐	☐	☐	☐	☐	☐
Make quiet time to complete tasks	☐	☐	☐	☐	☐	☐
Say “no” to excessive new responsibilities	☐	☐	☐	☐	☐	☐
Set limits with my clients and colleagues	☐	☐	☐	☐	☐	☐
Take on projects that are interesting or rewarding	☐	☐	☐	☐	☐	☐
Get regular supervision or consultation	☐	☐	☐	☐	☐	☐
Negotiate for my needs (benefits, pay raise)	☐	☐	☐	☐	☐	☐
Have a peer support group	☐	☐	☐	☐	☐	☐
Balance my workload so that no one day or part of a day is “too much”	☐	☐	☐	☐	☐	☐
Learn new things related to my profession	☐	☐	☐	☐	☐	☐
Keep a comfortable workspace	☐	☐	☐	☐	☐	☐
Overall Professional/School Self-Care						

BALANCE	1	2	3	4	5	♦
Strive for balance within your work-life and workday	☐	☐	☐	☐	☐	☐
Strive for balance among work, family, relationships, play and rest	☐	☐	☐	☐	☐	☐
Overall Balance						

PATIENT INITIALS: ________

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INITIAL PSYCHIATRIC QUESTIONNAIRE

PATIENT DEMOGRAPHIC INFORMATION

FULL NAME (FIRST, MIDDLE, LAST)	DATE OF BIRTH	AGE (YEARS)
GENDER IDENTITY	PHONE NUMBER	EMAIL ADDRESS
HOME ADDRESS		
DRUG ALLERGIES (LIST DRUG AND REACTION)		
FOOD ALLERGIES (LIST FOOD AND REACTION)		
PREFERRED PHARMACY (NAME, ADDRESS, PHONE NUMBER)		
PRIMARY CARE PROVIDER (NAME AND CONTACT INFORMATION)		
CURRENT PSYCHOTHERAPIST (NAME AND CONTACT INFORMATION)		

PATIENT INITIALS: __________

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HISTORY OF PRESENT ILLNESS

Please explain the reason(s) for seeking mental health treatment. The more information you can provide, the better.

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PSYCHIATRIC REVIEW OF SYMPTOMS

Which of the following symptoms have you experienced in the past three (3) months? (Check all that apply)

☐Low mood
☐ Low motivation
☐ Insomnia
☐ Hypersexual
☐ Restlessness
☐ Low energy
☐ Lack of appetite
☐ Hypersomnia
☐ Trauma/Abuse
☐ Dissociation
☐ Weight loss
☐ Increased appetite
☐ Impulsivity
☐ Nightmares
☐ Lack of joy/interest in life
☐ Weight gain

☐ Physical pain
☐ Worrying/Anxiety
☐ Flashbacks
☐ Thoughts of hurting others
☐ Concentration problems
☐ Suicidal thoughts
☐ Panic Attacks
☐ Auditory hallucinations (hearing things that aren't there)
☐ Thoughts of harming yourself
☐ Forgetfulness
☐ Anger
☐ Intrusive Thoughts

☐ Visual hallucinations (seeing things that aren't there)
☐ Urge to harm yourself
☐ Worthlessness
☐ Irritability
☐ Compulsive hand washing, cleaning, counting
☐ Paranoia
☐ Urges to harm others
☐ Hopelessness
☐ Euphoria
☐ Low libido
☐ Rapid Mood swings
☐ Tics
☐ Other (specify):

PATIENT INITIALS: __________

MEDICAL REVIEW OF SYMPTOMS

Which of the following symptoms have you experienced in the past three (3) months? (Check all that apply)

☐ Fever
☐ Vomiting
☐ Palpitations
☐ Increased sweating
☐ Tremors
☐ Chills
☐ Diarrhea
☐ Racing heart beat
☐ Muscle weakness
☐ Head Injury
☐ Weight loss
☐ Increased appetite
☐ Dizziness
☐ Urinary problems
☐ Imbalance
☐ Weight gain
☐ Musculoskeletal pain
☐ Vertigo
☐ Sexual dysfunction
☐ Easy bruising
☐ Night sweats
☐ Constipation
☐ Lightheaded-ness
☐ Seizures
☐ Nosebleeds
☐ Vision changes
☐ Abdominal (Belly) pain
☐ Shortness of breath
☐ Changes in sense of smell
☐ Nerve pain/Neuropathy
☐ Headaches
☐ Bloody stools
☐ Cough
☐ Changes in taste
☐ Skin rashes/lesions
☐ Nausea
☐ Chest Pain on exertion
☐ Nasal Congestion
☐ Fatigue
☐ Muscle cramps
☐ Ringing in ears
☐ Sore throat
☐ Changes in hair
☐ Changes in nails
☐ Hair loss
☐ Hearing loss
☐ Eye Pain
☐ Difficulty swallowing
☐ Heartburn/Indigestion
☐ Bowel/Bladder incontinence
☐ OTHER (specify):

Has anyone else noticed a change in your behavior(s) in the past three (3) months?

☐ Yes ☐ No ☐ I don't know

SUBSTANCE USE HISTORY

☐ NONE

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DRUG	DATE/AGE OF FIRST USE	ROUTE OF USE	QUANTITY OF USE	FREQUENCY OF USE	DATE/AGE OF LAST USE
ALCOHOL					
TOBACCO					
NICOTINE PRODUCTS					
CAFFEINE					
CANNABIS/MARIJUANA					
METHAMPHETAMINE					
OPIOIDS | OPIATES | HEROIN | FENTANYL *(NOT PRESCRIBED TO YOU)*					
BENZODIAZEPINES | Xanax |Klonopin | etc. *(NOT PRESCRIBED TO YOU)*					
COCAINE					
LSD					
DRUG	DATE/AGE OF FIRST USE	ROUTE OF USE	QUANTITY OF USE	FREQUENCY OF USE	DATE/AGE OF LAST USE

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PSYLOCYBIN (MAGIC MUSHROOMS)					
MDMA/ECSTASY					
KETAMINE *(NOT PRESCRIBED TO YOU)*					
SPICE, SYNTHETIC MARIJUANA					
BATH SALTS, SYNTHETIC CATHINONES, PHENCYCLIDINE (PCP)					
PRESCRIPTION DRUGS *(NOT PRESCRIBED TO YOU)*					

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PAST MEDICAL HISTORY

Have you been treated for any medical problems? (Check all that apply)

☐ NONE
☐ Diabetes Mellitus Type I
☐ Diabetes Mellitus Type II
☐ Seizure Disorder/Epilepsy
☐ Chronic Obstructive Pulmonary Disease
☐ Bronchitis
☐ Asthma
☐ Obesity
☐ Hypertension (i.e. high blood pressure)
☐ Dyslipidemia (i.e., cholesterol problems)
☐ Iron Deficiency Anemia
☐ B12 Deficiency
☐ Cancer
☐ Parkinson Disease
☐ Stroke
☐ Irritable Bowel Syndrome
☐ Chronic Pain
☐ Arthritis
☐ Autoimmune Disease (e.g., Lupus, Rheumatoid)
☐ Coronary Artery Disease
☐ Congestive Heart Failure
☐ Cardiac Arrythmia (e.g., atrial fibrillation)
☐ HIV/AIDS
☐ Lyme Disease
☐ Hyperthyroidism
☐ Hypothyroidism
☐ Polycystic Ovarian Syndrome (PCOS)
☐ Prostate problems
☐ Traumatic Brain Injury/Concussions
☐ Dementia (e.g., Alzheimer, Lewy body, vascular)
☐ Inflammatory Bowel Disease (e.g., Crohn's, UC)
☐ Other (please specify)

When was the last time you completed blood work/Lab?

☐ < 1 month ago ☐ 3-6 months ago ☐ 6-12 months ago ☐ >12 months ago

How often do you see your primary care provider?

☐ Weekly ☐ Monthly ☐ Yearly

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CURRENT MEDICATIONS AND SUPPLEMENTS

Please list any medications or supplements you take. Include name, dose, and frequency

MEDICATION/SUPPLEMENT NAME	DOSAGE	FREQUENCY

PATIENT INITIALS: __________

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PREVIOUS MEDICATION TRIALS

Please check all medications you have tried in the past

ANTIDEPRESSANTS	BENZODIAZEPINES	SLEEP AIDS/HYPNOTICS
☐ Sertraline (Zoloft) ☐ Fluoxetine (Prozac) ☐ Paroxetine (Paxil) ☐ Fluvoxamine (Luvox) ☐ Citalopram (Celexa) ☐ Escitalopram (Lexapro) ☐ Duloxetine (Cymbalta) ☐ Venlafaxine (Effexor) ☐ Levomilnacipran (Fetzima) ☐ Mirtazapine (Remeron) ☐ Vilazodone (Viibryd) ☐ Vortioxetine (Trintellix) ☐ Bupropion (Wellbutrin)	☐ Clonazepam (Klonopin) ☐ Diazepam (Valium) ☐ Alprazolam (Xanax) ☐ Triazolam (Halcion) ☐ Temazepam (Restoril) ☐ Lorazepam (Ativan) ☐ Chlordiazepoxide (Librium)	☐ Doxepin (Silenor) ☐ Zolpidem (Ambien) ☐ Eszopiclone (Lunesta) ☐ Zaleplon (Sonata) ☐ Suvorexant (Belsomra) ☐ Melatonin ☐ Ramelteon (Rozerem) ☐ Diphenhydramine (Benadryl, Z-quil) ☐ Trazodone (Desyrel)
ANTIPSYCHOTICS	**PSYCHOSTIMULANTS**	**MOOD STABILIZERS**
☐ Quetiapine (Seroquel) ☐ Olanzapine (Zyprexa) ☐ Risperidone (Risperdal) ☐ Paliperidone (Invega) ☐ Lurasidone (Latuda) ☐ Ziprasidone (Geodon) ☐ Asenapine (Saphris) ☐ Haloperidol (Haldol) ☐ Chlorpromazine (Thorazine) ☐ Perphenazine ☐ Aripiprazole (Abilify) ☐ Brexpiprazole (Rexulti) ☐ Cariprazine (Vraylar)	☐ Dextroamphetamine (Zenzedi, Dexedrine Spansule) ☐ Dextroamphetamine-Amphetamine Mixed Salts (Adderall, Adderall XR) ☐ Lisdexamfetamine (Vyvanse) ☐ Methamphetamine (Desoxyn) ☐ Mydayis ☐ Modafinil (Provigil) ☐ Armodafinil (Nuvigil) ☐ Methylphenidate (Ritalin, Ritalin LA, Concerta) ☐ Dexmethylphenidate (Focalin, Focalin XR)	☐ Lithium ☐ Valproic Acid (Depakote) ☐ Topiramate (Topamax) ☐ Lamotrigine (Lamictal) ☐ Oxcarbazepine (Trileptal) ☐ Carbamazepine (Tegretol) **OTHER** ☐ Gabapentin (Neurontin) ☐ Clonidine ☐ Prazosin ☐ Pregabalin (Lyrica) ☐ Buprenorphine (Suboxone, Subutex) ☐ Naltrexone ☐ Varenicline (Chantix) ☐ Ketamine (infusions or intranasal spray

PATIENT INITIALS: __________

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PAST PSYCHIATRIC HISTORY

When was the first time you saw a mental health professional and what was the reason for seeking mental health treatment?

When was the first time you saw a psychiatrist?

When was the last time you saw a psychiatrist? (Please provide name of psychiatrist)

Have you ever been admitted to a psychiatric/Mental health hospital? (If so, please specify dates)

☐ **YES (specify):** ☐ **NO**

Have you ever participated in a residential drug rehabilitation program? (If so, please specify programs and dates)

☐ **YES (specify):** ☐ **NO**

Have you ever seen a therapist? (If so, please specify type of therapy if you know it)

PATIENT INITIALS: __________

☐ **YES (specify):** ☐ **NO**

Are you currently seeing a therapist? (If so, please provide name of therapist)

☐ **YES (specify):** ☐ **NO**

Have you ever attempted suicide? (If so, please specify dates and how you attempted)

☐ **YES (specify):** ☐ **NO**

Have you ever intentionally harmed yourself? (e.g., cutting, burning, hitting, biting)

☐ **YES (specify):** ☐ **NO**

Have you ever struggled with an eating disorder? (If so, please specify)

☐ **YES (specify):** ☐ **NO**

SOCIAL HISTORY

PATIENT INITIALS: __________

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MARITAL STATUS

☐ Married ☐ Single ☐ Divorced/Separated ☐ Widowed ☐ Partnered

Do you have children? If so, please specify number of children and their ages

☐ YES (# of children): ☐ NO

Where do you live?

Who do you live with?

Have you ever been arrested?

☐ YES (specify): ☐ NO

Have you ever intentionally hurt someone else? If so, please specify

☐ YES (specify): ☐ NO

Have you ever received a DUI (Driving under influence of drugs or alcohol)? If so, please specify

☐ YES (specify): ☐ NO

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Are you employed?

☐ **YES** ☐ **NO**

What do you do for work?

Who would you consider your support system?

Have you ever been victim of abuse?

☐ **YES (specify):** ☐ **NO** ☐ **I don't know**

☐ **Mental Abuse**

☐ **Physical Abuse**

☐ **Sexual Abuse**

☐ **Other Abuse**

What was the last grade in school you completed?

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In a few sentences, how would you describe your childhood?

FAMILY HISTORY

Has anyone in your immediate or extended family ever attempted or completed suicide? If so, please specify relative and method

☐ YES (specify): ☐ NO

Has anyone in your immediate or extended family ever been diagnosed with a mental illness? If so, please specify relative and condition

☐ YES (specify): ☐ NO

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RELATIVE	Alive? YES	Alive? NO	Age (years)	Mental Health Condition(s)
Father	☐	☐		
Mother	☐	☐		
Sibling 1	☐	☐		
Sibling 2	☐	☐		
Paternal Grandmother	☐	☐		
Paternal Grandfather	☐	☐		
Maternal Grandmother	☐	☐		
Maternal Grandfather	☐	☐		
Aunt 1	☐	☐		
Aunt 2	☐	☐		
Uncle 1	☐	☐		
Uncle 2	☐	☐		
Additional Comments				

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ADDITIONAL COMMENTS

Please provide any additional information you believe would be important for Dr. Ingram to know.

PATIENT ATTESTATION

By signing your name below you certify that the information provided in this form is true and accurate to the best of your knowledge and that you provided the answers to the questions even if someone else helped you fill out the form.

PATIENT NAME (PRINT) **LEGAL GUARDIAN NAME, IF APPLICABLE (PRINT)**

PATIENT/LEGAL GUARDIAN SIGNATURE **DATE**

PATIENT INITIALS: ___________