

PHQ-9 QUESTIONNAIRE

(PG.1 OF 1)



Over the last 2 weeks, how often have you been bothered by any of the following problems?
(Use "✓" to indicate your answer)

	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Feeling down, depressed, or hopeless	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Trouble falling or staying asleep, or sleeping too much	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling tired or having little energy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Poor appetite or overeating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
7. Trouble concentrating on things, such as reading the newspaper or watching television	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
9. Thoughts that you would be better off dead or of hurting yourself in some way	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

FOR OFFICE CODING 0 + _____ + _____ + _____
=Total Score: _____

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

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

DSM IV - ADULT ADHD CHECKLIST SELF REPORT VERSION

(PG.1 OF 1)



NAME:

DATE:

SEX:

Check the box that best describes you.

Inattention

Not at All Just a Little Often Very Often

1.	fails to give close attention to details or makes careless mistakes in schoolwork, work, or other activities				
2.	has difficulty sustaining attention in tasks or play activities				
3.	does not seem to listen when spoken to directly				
4.	does not follow through on instructions and fails to finish schoolwork, chores, or duties in the workplace (not due to oppositional behavior or failure to understand instructions)				
5.	has difficulty organizing tasks and activities				
6.	avoids, dislikes, or is reluctant to engage in tasks that require sustained mental effort (e.g., schoolwork or homework)				
7.	loses things necessary for tasks or activities (e.g., toys, school assignments, pencils, books, or tools)				
8.	is easily distracted by extraneous stimuli				
9.	is forgetful in daily activities				

Hyperactivity

10.	fidgets with hands or feet or squirms in seat				
11.	leaves seat in classroom or in situations in which remaining seated is expected				
12.	runs about or climbs excessively in situations in which it is inappropriate (in adolescents may be feelings of restlessness)				
13.	has difficulty playing or engaging in leisure activities quietly				
14.	is "on the go" or often acts as if "driven by a motor"				
15.	talks excessively				

Impulsivity

16.	blurts out answers before questions have been completed				
17.	has difficulty awaiting turn				
18.	interrupts or intrudes on others (e.g., butts into conversations or games)				

At what age did these symptoms first appear? Or when did you notice them? _____

Do these symptoms impair the child's functioning in two or more settings? (Yes, No, DK) _____

Where is their impairment? Home? School? Work? (list all) _____

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BRANCH PSYCHIATRY & ASSOCIATES.
GENERAL & CHILD/ADOLESCENT PSYCHIATRY
1806 TOWN PLAZA CT WINTER SPRINGS, FL 32708
PH: 407-542-4946 FAX: 407-695-3674

GENERAL INFORMATION

Date: _____

Patient Name: _____ Date of Birth: _____

Sex: _____ Email: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Cell: _____ Secondary Number: _____

PARENT/GUARDIAN NAME (IF PATIENT IS A MINOR)

Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell # _____ Work: _____

Name of nearest relative not living at home: _____

Cell: _____ Relationship: _____

Pharmacy Information: _____ Ph: _____

Address: _____ City: _____ State: _____ Zip: _____

AUTHORIZATION FOR TREATMENT

I hereby authorize Myrtho Mompont-Branch, M.D. to administer treatment.

I understand that information of the nature and purpose of treatment common side effects and alternative treatment modalities Will be provided to me, and that consent can be revoked orally or in writing prior to or during the treatment period.

Appointment cancellations require 24-hour advance notice. I understand that I will be charged the total copayment (up to \$150.00) for a missed appointment without prior cancellation.

Signature of Patient/ Representative: _____ Date: _____

Relationship to patient: _____

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Patient Name: _____ DOB: _____ Date: _____

PRIMARY INSURANCE INFORMATION

Name of Policyholder: _____ DOB: _____ Sex: _____

Relationship to Patient: _____ Insurance Policy # _____

Insurance Company: _____ Phone # _____

Group # _____ Is this through employer? _____ Employer: _____

ASSIGNMENT OF INSURANCE BENEFITS: I authorize payment of benefits to Myrtho Mompont-Branch M.D., otherwise payable to the patient or guarantor. I also assign all rights to insurance coverage relative to this treatment, interpretation and/or examination.	
AUTHORIZATION FOR RELEASE OF CONFIDENTIAL INFORMATION: I give permission for Myrtho Mompont-Branch, M.D. to disclose any medical, psychiatric, alcohol and/or drug abuse information contained in my record to my insurance company for the purpose of review and authorization.	
_____	_____
Signature of Patient or Patient's Representative	Date
_____	_____
Print name and Relationship to Patient	Date

**BRANCH PSYCHIATRY & ASSOCIATES.
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1806 TOWN PLAZA CT WINTER SPRINGS, FL 32708
PH: 407-542-4946 FAX: 407-695-3674**

Date: _____

FINANCIAL POLICY

(Please **initial** to acknowledge understanding of the following)

_____ Co-Pays, deductibles, and coinsurances are collected at the time of visit.

_____ Appointment cancellations require 24 HR advance notice. A fee of \$150.00 will be charged for No-Show confirmed appointments as well as for cancellation calls received the same day of the appointment.

_____ There is a charge of \$1.00 per page for copying medical records, including lab results.

_____ There is a charge for requested letters:

- FMLA: \$35
- Short Letters: \$25
- Long Letters: \$45
- Summaries of treatment: \$50
- 504 plan (short) for school children: \$10

_____ There is a \$2.00 fee for payments not paid at the time of the visit.

Notice: We do not accept checks. Form of payment is accepted by cash or card.



The office of:
Dr. Myrtho Mompont Branch - MD
1806 Town Plaza Court
Winter Springs, FL 32708
PH: 407-542-4946 FAX: 407-695-3674

**CREDIT CARD AUTHORIZATION FORM/ FINANCIAL POLICY
RECURRING PAYMENTS FOR SERVICES RENDERED**

Per our office policy, we require to retain credit card information on file to collect for all services rendered including missed appointments, known as a "No Show". The Credit Card on file will pay for Patients copay payments, front end deductibles requirement based on their insurance verification of benefits, known as "VOB, coinsurance payments and/or self pay payments not covered by the patient's insurance provider.

I, _____, authorize the office
(PRINT NAME)

Dr. Myrtho Mompont Branch - MD, "Branch Psychiatry & Associates", to deduct for any and/or all services as stated above and/or within this Credit Card Authorization Form/ Financial Policy.

Patient services , *OTHER THAN MYSELF*, Which I am in agreement for the credit card on file to be processed for their completed services:

(PRINT PATIENT'S NAME, RECIPIENT OF PAYMENT RENDERED BY CARD HOLDER)

CREDIT CARD SELECTED: CHECK ONE

VISA___ MASTERCARD___ DISCOVER___
AMERICAN EXPRESS CARDS ARE NOT ACCEPTED

Credit Card # _____

Card Holder Name: _____

CVV_____ Exp. Date_____ Zip Code_____

Mailing Address: _____

A credit card authorization may be rescinded as long as all services are paid in full and no other recurring appointments will be scheduled.

I authorize the use to my credit card and agree to the guidelines contained within this form:

Card Holder Signature Date

TELEHEALTH CONSENT FORM

By signing this form, you agree to the following points:

1. I authorize Branch Psychiatry & Associates to use appropriate telecommunication technologies for the purposes of evaluating and diagnosing my medical condition and any health complaints.
2. I understand that technical issues may arise before or during telehealth sessions and, on occasion, my appointments may not start or end at agreed-upon times.
3. I accept that medical professionals will attempt to contact me using video conferencing software. However, I also understand that other communication channels, such as telephone calls, may be used in case of internet connectivity or other issues.
4. I understand that my insurance plan may not encompass telehealth services. In cases where my insurance plan does not cover any expenses which have been incurred, I will be personally liable to cover these expenses.
5. I understand that I can't be driving during telehealth sessions for my own safety and will park in a safe location if I'm in a vehicle.

I AGREE TO THE TERMS AND CONDITIONS LISTED ABOVE.

Signature of Patient or Patient's Representative

Date

Print name and Relationship to Patient

Date

Notice of Privacy Practices Patient Acknowledgement

Patient Name: _____

Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights, and the practice's legal duties with respect to my information.

I understand that this practice reserves the right to change the terms of this Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice. I understand I can obtain this practice's current Notice of Privacy Practices on request.

Signature: _____ Date: _____

Relationship to patient (if signed by a personal representative of patient):

Authorization for Release Use and Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____ Phone # _____
 Street Address: _____ City/state/zip: _____

I Authorize the Release Use and Disclosure of Protected Health Information about the Above Individual as Described Below

Myrtho Mompont Branch, M.D. Child, Adolescent & Adult Psychiatry
 1806 Town Plaza Court, Winter Springs, FL 32708
 Phone: 407-542-4946
 Fax: 407-695-3674

This information may be Released to or obtained from:

Name of Facility/Individual: _____

Street Address: _____ City/State/ Zip: _____

Phone # _____ Fax# _____

The Purpose of this disclosure

<input type="checkbox"/> Changing Physician	<input type="checkbox"/> Legal Investigation	<input type="checkbox"/> Other (please specify)
<input type="checkbox"/> Mental Health Treatment	<input type="checkbox"/> Inspection/copying of records	
<input type="checkbox"/> Academic Performance	<input type="checkbox"/> Personal	

The Type of information to be disclosed is as Follows

<input type="checkbox"/> Complete Record	<input type="checkbox"/> Abstract Of Medical record	<input type="checkbox"/> Educational Evaluation/records	<input type="checkbox"/> Other (explain below)
<input type="checkbox"/> Intake/Discharge summaries	<input type="checkbox"/> Medical History & Physical	<input type="checkbox"/> Letter/ summary of treatment	
<input type="checkbox"/> Mental Health Evaluations	<input type="checkbox"/> Test Results	<input type="checkbox"/> Verbal Communication	
<input type="checkbox"/> Progress notes	<input type="checkbox"/> X-ray and Imaging Reports	<input type="checkbox"/> Laboratory Results (RECENT)	

I Understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency Virus (HIV). It may also include information about behavioral or mental Health services and treatment for alcohol and/or substance abuse. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under terms of this authorization.

I understand that I may revoke this authorization in writing at any time. I understand that the revocation will not apply to information that has already been released in response to this authorization. This authorization expires within six (6) months, unless otherwise specified. Other specified expiration date:

Signature of patient or patient's representative: _____ **Date:** _____

Print Name of patient/ representative: _____ **Relationship:** _____

•Minor _____ •Dependent _____ •Other _____