Welcome

Thank you for scheduling an appointment with our clinic. The purpose of this letter is to explain what you can expect from us during your first session. We also want to provide information about our practice and explain important issues that often arise during treatment. Please review this letter carefully.

The first session usually lasts 45-60 minutes. The focus will be on determining the specific nature of your problem, and outlining an initial treatment plan. This is primarily an information-gathering meeting and will not involve much "talk therapy." At the conclusion of this session, you will be given specific recommendations in order to begin your treatment.

We will be reserving this time specifically for you. If you are going to be late, please call our office. Also, **please call our office 48 hours prior to your appointment and confirm your attendance**. **If we do not hear from you, we will assume you have canceled your appointment.** If it would make you feel more comfortable to be accompanied by a friend or relative, please feel free to invite them.

Prior to your appointment, please review and complete the enclosed SELF-ASSESSMENT FORM. This will save time and allow for more discussion during the session. After completing the form, please bring the original with you to the session.

Insurance plans have become more numerous and complex. It is in your best interest to contact your insurance company prior to the initial session. We would recommend asking the following questions:

1. Are mental health services covered?
2. Is there a mental health deductible in addition to a medical deductible?
3. Is there a co-payment or other percentage that you are responsible for?
4. Are our providers signed up with your plan?

As a service to you, our office will file your insurance claim. Co-payments and unmet deductibles will be due at the time of service. If you are unaware of your mental health benefit and we are unable to obtain the information from your insurance company, you will be asked to pay the entire fee at the time of service. Our office will reimburse you for the amount we collect from your insurance company.

A 24-hour notice is required for all cancellations or you may be billed for the session. If your insurance company requires treatment plans to be completed, this will be done in the follow-up visit with you. It is your responsibility to keep track of your authorized visits and bring the treatment plan to the office to be completed.

We hope this letter is helpful to you. If you have further questions, please feel free to contact our office. We look forward to our meeting. Remember to confirm your attendance 48 hours prior to your appointment.

Sincerely,

Norman Psychiatry

Policy and Procedures

Office Hours:

Office hours are Monday-Thursday from 8:00 am to 5:00 pm, excluding holidays. We do not answer the phones from 8:00 am to 9:00 am. We are closed for lunch between 12:00-1:00 pm. If you have an urgent problem requiring attention after-hours, you may contact the psychiatrist on call. This number changes on a monthly basis, so call our office at (405) 579-4111 and the phone number for the on-call psychiatrist will always be updated on our voicemail. Prescription refills are NOT considered an emergency.

Telephone Calls:

Our telephone is answered during 9:00am – 12:00pm and from 1:00pm to 5:00 pm. You may leave a message on our answering machine after hours and your call will be returned the next business day. Calls received on weekends will be returned on Monday. After-hour telephone consultations with your provider will be reserved for emergency situations only. Providers answer phone messages by the end of the business day, after they are done seeing patients. Any voicemails left after 3:30 pm will be answered the next business day.

Prescriptions and Refills:

Allow at least 3 days to process prescription renewals and/or pick-up requests. Sometimes requests are filled sooner than this. You are responsible for knowing when your medication will run out and accounting for the time it takes for our providers to authorize your request. Have your pharmacy fax a request to (405)579-4223. Prescriptions require a scheduled follow-up appointment before we will refill. Count your pills and make sure you have enough to last until your next visit. No refills will be authorized if there is a history of missed appointments.

No controlled prescriptions will be replaced if lost, stolen, misplaced, or overused. No prescriptions will be refilled on Fridays, Saturdays, Sundays, or Holidays. Prescription phone in/pick up hours: Monday-Thursday 9:00-5:00 pm. Prescriptions will not be filled for unauthorized walk-in patients. New symptoms require an appointment. Providers will not diagnose via phone. Medications are for the prescribed individual's use only. It is illegal to share or sell your medication. You must pick-up your prescription in person, unless pre-authorized by our staff. Please note: we will not refill SUBOXONE early under any circumstances.

A signed "Controlled-Substance Policy" is required for narcotic/controlled medications. Our practice takes the controlled substance policy very seriously. When physician-patient relationship is strained due to perceived drug-seeking behavior, providers may continue services but cease in prescribing any controlled substances. In other cases, a patient may be terminated from this office and given direction to locate another medical office for continued care. Patient termination is at the discretion of the provider. Common reasons for termination include, but are not limited to, chronic noncompliance with recommended treatment, drug-seeking behavior, and abusive behavior towards staff, physicians, visitors, or other patients.

Controlled Substance(s) Policy

Due to recent guidelines by standard health maintenance agencies, we reserve the right to conduct an initial urine drug test and every sixty days thereafter for patients prescribed a controlled substance for sleep, anxiety, or any other conditions.

I have read and agree to all of the policies and procedures listed above:

Signature_____date:_____

Patient Information

Please provide the information in the spaces provided. This and all other information relating to your association with Norman Psychiatry is regarded as strictly confidential and will not be shared without your signed consent.

Date:_____Referred by:_____

Patient Name:_____

Street Address:_____City:_____State:_____Zip:_____

Sex:_____ Birthdate:_____ Marital Status:_____

Social Security #:_____ Email Address: _____

Employer:_____Employer Phone:_____

Home Phone:_____Work phone:_____ Cell phone:_____

Primary Insured or Responsible Party

If Insurance does not pay your bill, who is financially responsible for the balance?

Name:_____Street Address:_____

City:_____State:_____Zip:_____Phone:_____

Social Security Number:_____DOB:_____

Insurance Information

#1 Insurance Company:_____Policy #:_____

Policy Holder's Name:_____DOB:_____SS#:_____

Mail Claims to:_____Ph#:_____

#2 Insurance Company:_____Policy #:_____

Policy Holder's Name:_____DOB:_____SS#:_____

Mail Claims to:_____Ph#:_____

Authorizations and Agreements

Payment Policy and Cancellation Agreement: I understand that the office files my primary insurance as a courtesy, but the bill is MY responsibility. I am aware that notice of cancellation must be given 24 hours in advance so that I will not be charged.

Release of Information and Assignment of Benefits Agreement: I authorize Norman Psychiatry to release any information acquired in the course of my treatment to my insurance company and assign the insurance payment due to me to Norman Psychiatry.

Patient's Signature:_____Date:_____

Patient Record of Disclosure

In general, the HIPPA Privacy Rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications on PHI be made by alternative means, such as sending correspondence to your office instead of your home.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER

(Check all that apply):

____Home Telephone:_____
____OK to leave a message with detailed information
____Leave message with call-back number only

_____Cell Phone:_____
_____OK to leave a message with detailed information
_____Leave message with call-back number only

_____OK to receive email appointment reminders
_____OK to receive SMS text message appointment reminders
_____OK to receive voice appointment reminders and messaging

_____ _____
Patient Signature Date

_____ _____
Print Name Birthdate

_____ _____
Parent or Guardian Date
(If patient is under 18 years old)

_____ _____
Print Name Relationship to Patient

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use or disclosure of, and requests for PHI to the minimum necessary to accomplish the intended purpose. The provisions do not apply to the uses or disclosures made pursuant to an authorization requested by the individual.

NOTE: Uses and disclosures for TPO may be permitted without prior consent in an emergency.

ACKNOWLEDGMENT OF NOTICE OF PRIVACY PRACTICES: A complete description of how my medical information will be used and disclosed by Norman Psychiatry is in the "Notice of Privacy Practices." A copy of the "Notice of Privacy Practices" is posted in the clinical site and is available if you would like a copy.

I have accepted a copy of "Notice of Privacy Practices" _____yes _____no

Reason for the refusal, if No:_____

Informed Consent, Confidentiality, Description of Services

Description of Services: It is my understanding that Joseph M. Ripperger, M.D. is a licensed Psychiatrist, qualified in Oklahoma to practice medicine and provide psychotherapy. Counseling and psychotherapy involve discussing in detail my concerns, giving background information, and talking about areas that may cause me emotional pain, all for the purpose of trying to develop new and more effective methods of coping with problem areas in my or my child's life. I understand that I am free to withdraw from therapeutic contact at any time if I so desire and will only be responsible to pay for the completed sessions.

Confidentiality: All services provided and all information obtained is kept confidential and cannot be released without your written permission. You need to know, however, that there are special situations under which confidential information could be revealed, such as:

1. A "duty to warn" ethic allows a psychiatrist to break confidentiality when danger exists to the patient or others.
2. Under special circumstances, the court may subpoena patient records and may order a psychiatrist to give testimony during a court hearing.
3. Third party payers, such as insurance companies, have a right to review patient's records prior to payment.
4. Delinquent accounts may be turned over to a Collections Agency.
5. Based on clinical judgment, consultation with another professional with respect to your treatment may be sought.
6. Actual or suspected abuse to children or the elderly must be reported to authorities.

Your signature indicates that you have read and understood the above information concerning your confidentiality and that you have read and understood the description of possible services, and consent is given to provide services to you and/or your child (or children), _____, who is (are) not of legal age.

_____ _____ _____

Signature Date Relationship, if patient is a minor

_____ _____

Witness Date

Advance Benificiary Notice (ABN)

Patient Name:_____

Medicare/Private Insurance will not pay for all of your health care costs. They only pay for covered items and services when Medicare/Private Insurance rules are met. Some of the item(s) or service(s) they do not cover are described below. The fact that Medicare/Private Insurance will not pay for a particular item or service does not mean that you should not receive it. There may be good reason your doctor recommended it.

MEDICARE/PRIVATE INSURANCE DOES NOT PAY FOR THESE SERVICES:

- **Prior Authorizations**
- **Letters/Forms Completed**
- **Patient Assistance for Medication**
- **Phone Sessions**

I understand I will be responsible for payment of these services.

_____ _____

Signature of patient or legal guardian Date

Note: Your health information will be kept confidential. Any information that we collect on this form will be kept confidential in our office.

Tips For Future Visits

1. It is expected that you will arrive 30 minutes early for your initial evaluation. Please arrive 10 minutes early for all appointments thereafter to avoid last-minute rushes.

2. **To avoid being charged, give a 24 hour notice for cancellations.** Otherwise, your provider will likely charge you the full price of the visit. You will be responsible for the balance, and it must be paid off before services will be rendered again. Missed appointment charges are not covered by your insurance.

3. The physician on call is available 24 hours per day for emergencies. Do not use this service if it is not an emergency. Prescription refills will not be considered an urgent matter.

4. Count your pills before your visit. Get a written prescription to ensure you have enough medicine to last until your next visit.

5. Know your charge and write checks beforehand to make the best use of your session time.

6. Do not change appointment times unless absolutely unavoidable.

7. For routine matters, call during office hours only.

8. Know your insurance benefits. Call your insurance company before receiving services. Find out your exact copayment and/or deductible amount. Remember that if our provider is out-of-network, you will be responsible for the full charge.

9. Unless prior arrangements are made, payment is required at the time of service.

10. Please visit our website for additional information and services we provide: www.normanpsychiatry.com

Financial Policy and Missed Appointment Policy

Please read over our financial and missed appointment policy. If you have questions, feel free to ask our staff.

Financial Policy Information: Fees vary depending on what provider you are seeing and for what service.

Initial evaluation with Psychiatrist: $300
Suboxone Initial Evaluation - $330
Medication Appointments: $90-135 (more if therapy is added)

Initial evaluation with Nurse Practitioner: $230-260
Medication Appointments: $90-110 (more if therapy is added)

Initial evaluation with Counselor: $150
Therapy appointments: $135

Insurance Patients. If you have health insurance, our office is happy to call your insurance company and verify your insurance benefits. They will also file your insurance for you. If your insurance covers a portion of your therapy, we will wait for 90 days for them to pay their portion. However, you will be responsible for your deductible and co-pays. That portion of your care will be due at the time of your appointment.

You will be responsible for all charges not covered by your insurance company. Any outstanding balance that has not been paid off in 90 days will be charged to your credit card on file. If for some reason this is not possible, you will be billed what you owe. If this is not paid within 30 days from that date, your account will be turned over to a collection agency.

Self-Pay Patients. Patients without insurance or with high deductibles are responsible for the cost of their care. Payment is expected at the time the service is rendered.

Methods of Payment. We accept cash, checks, and major credit cards.

Missed Appointment Policy. A full twenty-four hours is required for the cancellation of an appointment. Appointments canceled with less than 24 hour notice will be charged the full fee at rates shown above. Appointments missed due to inclement weather will not be charged. Your charge will be applied to your credit card on file.

Legal Proceedings. If you become involved in legal proceedings that require your provider's participation, you will be expected to pay for all of his/her professional time, including preparation and transportation time and costs, even if he/she is called to testify by another party. Because of the difficulties of legal involvement, we charge $300.00 per hour with a 3 hour minimum for any legal participation required.

I have read and agree to the above conditions.

_____ _____

Name Date

Credit Card Guarantee for Personal Balance

The credit card guarantee ensures that your account stays up-to-date and current. Your card will be kept on file and only used when payment has not been made by mail or in person. You can make co-pays, pay for special services, or pay your bill with your credit card on file, if you so choose. We will charge the amount due if payment has not been made in a timely manner. No show and/or cancellations made without 24 hour notice will be charged to your credit card on file.

( ) UNINSURED/SELF-PAY PATIENTS

I understand that since I do not have insurance that I am personally responsible for payment. I understand that payment is due at the time of service.

( ) INSURANCE ASSIGNMENT

I understand that as a courtesy to me, Norman Psychiatry will bill my health insurance carrier, but that my bill is MY responsibility. I understand that this office will wait up to 90 days for payment from my insurance provider. I understand that any amount owed after 90 days, which has not been paid by my insurance provider, will be placed on my designated credit card below. Any insurance payments made on these claims thereafter will be placed on my account as a credit or will be refunded to me, if I so choose.

I understand that if my insurance does not cover the cost of mental health treatment, if my deductible is high, or there are other limitations in my coverage, that I will be responsible for my bill at the time of service.

I agree to the above terms and authorize you to charge any payment not paid by the date due.

_____ _____

SIGNATURE DATE

CREDIT CARD: Visa MasterCard Discover AMEX

CARD HOLDER'S NAME:_____

CARD HOLDER'S BILLING ADDRESS:_____

_____

CARD #:_____

EXP. DATE:_____ THREE DIGIT CID NUMBER:_____

NORMAN PSYCHIATRY RELEASE OF INFORMATION

STANDARD AUTHORIZATION TO USE OR SHARE PROTECTED HEALTH INFORMATION (PHI)

I. INDIVIDUAL INFORMATION (PATIENT INFORMATION)

Name_____ Date of Birth _____

Address _____ Telephone Number _____

II. SCOPE & PURPOSE FOR SHARING INFORMATION

I understand protected health information is information that identifies me. The purpose of this authorization is to allow Norman Psychiatry, to share my protected health information.

III. AUTHORIZATION & INFORMATION TO BE SHARED

I authorize Norman Psychiatry, as set forth below, to share my protected health information for reasons in addition to those already permitted by law.

A. Persons/Organizations Authorized to Receive My Information: (Please do not include other physicians or your employer in this list)

(Name and Phone) Relationship

_____

_____

_____

B. Information to be shared (Check one or more boxes below)"

☐ Medical ☐ Scheduling and/or knowledge of appointments ☐ Refills ☐ Financial or Billing Information

☐ Labs ☐ All ☐ Other _____

IV. EXPIRATION & REVOCATION

A. This Authorization will expire 1 year after date signed

B. Right to Revoke:

I understand I may change this authorization at any time. I understand I cannot restrict information that may have already been shared based on this authorization.

V. ACKNOWLEDGEMENTS & SIGNATURES

A. Acknowledgements

1. I understand this authorization is voluntary and will not affect my eligibility for benefits, treatment, enrollment, or payment of claims.

2. I understand if the person/organization authorized to receive my protected health information is not a health plan or healthcare provider, privacy regulations may no longer protect the information.

3. I acknowledge information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

4. Acknowledgement of Notice of Privacy Practice: A complete description of how my medical information will be used and disclosed by Norman Psychiatry is in the "Notice of Privacy Practice", which I should read before signing this agreement. A copy has been offered to me and is posted in the clinical site.

Signing of this document must be signed by the individual or the individual's legal representative.

_____ _____

Signature (Patient or Legal Representative) Date

_____

Printed Patient or Legal Representative Name

SELF-ASSESSMENT FORM

Please Fill Out Completely and Do Not Skip Sections

Date:_____Name:_____

Street:_____

City:_____State:_____Zip:_____

Age:_____Date of Birth:_____Place of Birth:_____

With whom do you live (relationship, if any)?_____

Religion:_____ Gender Identity: _____ Sexual Orientation: _____

Education (Highest level completed)_____Degree, if any:_____

Occupation:_____

Marital History:

If you have been married, how many times?_____If you have been divorced, how many times?_____

Current Marital Status:

Never married:_____Married:____Living cooperatively:____Separated:_____Divorced:___Widowed:___

Emergency Contact:

Name of Person to call in an emergency:_____

Relationship:_____ Name of person filling out form, if not patient:_____

Home Phone:_____Work Phone:_____Cell Phone:_____

Medical Care:

Who is your Primary Care Physician?_____Phone:_____

Are you currently doing therapy with anyone else? If so, who? _____

Female patients of child bearing age:

Are you currently pregnant or plan to become pregnant? Yes_____ No _____

Some Psychiatric medications can have harmful effects to a fetus, do you agree that you will notify us immediately if you decide to try to get pregnant or find out you are pregnant during your treatment? Yes_____ No_____

Are you currently seeing any other medical providers, if so, please list them below:

Please State the Principal reason you are requesting a consultation or treatment:

Please describe your illness from the time of your first symptom to the present. Provide as many dates, names, and addresses of psychiatrists, psychologists, and/or social workers you have seen. Also, please provide the kind of treatment you received:

Please briefly describe any expectations you or your family members may have regarding treatment:

Suicide and/or Hospitalizations:

Have you ever thought about suicide? Yes___No___
If "yes," when was the last time?_____
Have you ever attempted suicide? Yes____No_____
Do you have thoughts about suicide now? Yes_____No____
Have you ever been hospitalized for a psychiatric reason? Yes____No____ How many times?_____

When was the last time and where?_____How long?_____

What were the circumstances?_____

Recent stressful life events:

(Check any of the following that have occurred in the last year)		Comments
Married		
Engaged		
Separated		
Divorced		
Breakup of important relationship		
Child left home		
Death of spouse or other loved one		
Bad health (behavior) of family member		
Personal Injury, illness		
Changes at school, work		
Retired, lost job		
Changed residences		
Legal difficulties, multiple traffic tickets		
Owe money		
Traumatic experiences		

Alcohol Use:

Do you drink alcohol? Yes____No____

If yes, how many drinks do you consume in an average day?_____Week?_____

In the past 12 months, have you had 3 or more alcoholic drinks within a 3-hour period on 3 or more occasions?

Yes_____No____ Was there ever a time when you felt you were or someone told you that you were drinking too much?

Yes_____No_____If "yes," under what circumstances?_____

Drug Use:

Check any drugs you have taken. List the circumstances and pattern of use, or any consequences to the use. Also, state the amount you used at its heaviest, and the last time you used.

None		
Marijuana		
Amphetamine/Speed		
Heroin/Opiates		
PCP		
LSD/Hallucinogens		
Cocaine/Crack		
Barbituates/sedatives/downers/benzos		
Purchased substances via the Internet		
Other		

Past History: Use NA if non applicable

Check if during childhood you...		Comments
Were afraid to go to school		
Had difficulty with reading, writing, or math		
Were truant		
Failed or repeated a grade		
Wet bed after age 5		
Had tics		
Had stutter/stammer		
Nightmares, disturbed sleep, fear of the dark		
Ran away from home		
Were cruel to animals		
Frequently lied to family or others		
Set fires		
Moved Frequently		
Worried excessively about your appearance		
Were exposed to incest		

Family History: Use NA if non applicable

Please list all psychiatric illnesses (include depression, bipolar, anxiety, substance abuse, suicide attempts,etc). Indicate their relationship to you and age at death if deceased

Relationship	Age	Age at death	Psychiatric Illness

Health History:

Weight

What is your current weight in pounds?_____Height?_____

Has your weight increased or decreased by more than 10 pounds in the last year: Yes____No____

If yes, please explain:_____

Do you have any history of an eating disorder? Yes____No_____

Do you have episodes of excessive overeating, in which you eat significantly more than what most people would eat in a similar period of time and then feel distressed about your episodes of excessive overeating? Yes____No____

Advanced Directives

Do you have any advanced directives? Yes_____ No_____

If yes, please explain:_____

Implantable Devices

Do have any implantable devices? Yes _____ No _____

If yes, please explain: _____

Sleep

Have you been diagnosed with a sleep disorder? Yes_____ No_____

Have you ever had a sleep study? Yes_____ No_____

If yes, where and when: _____

Do you:

Have difficulty sleeping? Yes _____No_____

Have difficulty staying asleep? Yes_____No_____

Experience daytime sleepiness? Yes_____No_____

Snore? Yes____No____

Wake up short of breath? Yes_____No____

Wake up with a headache? Yes____No_____

Has anyone ever told you that you stop breathing? Yes____No____

Jerk or have restless legs in your sleep? Yes____No____

Smoking

Do you smoke? Yes____No____ Vape? Yes____ No____ If yes, do you want to quit? Yes____No____

Caffeine

Do you drink caffeinated coffee, tea, or colas? Yes____No____

Do you believe you are sensitive to caffeine? Yes____No____

Sexual Functioning

Active? Yes____No____

Satisfied with your libido or your level of desire? Yes____No____

Satisfied with functioning? Yes___No___

Physical Activity

Activity	Type/Intensity (low-moderate-high)	# Days Per week	Duration (minutes)
Stretching/Yoga			
Cardio/Aerobics (walking, jogging, biking, etc.)			
Strength-training (weight lifting, pilates, some yoga)			
Sports or leisure			
Other (specify, or describe)			

Allergies

List all allergies. Be sure to include medication allergies. Write none if no allergies.

Problems

List all past and present medical problems, as well as any surgeries or accidents. Please list the age of onset or occurrence.

Check if you have had:

____Head injury ____ CAT scan or MRI of the brain ____ Seizure
____ EEG ____ Neurological exam

Have you ever had a time lasting more than several days when you were feeling "up" or "high" or "hyper" or so full of energy OR persistently irritable that you got into trouble, or that other people thought you were not your usual self? (Do not consider times when you were under the influence of drugs or alcohol). Yes____No____

Current Medications:

Include prescriptive, herbal, and over-the-counter medications (add additional page if needed)

Medication name	Dosage and frequency	Prescribing Physician	How long?

Past Psychiatric Medications:

This is a list of commonly prescribed psychotropics. Please indicate all that you have tried in the past. Both trade and generic names are provided. If you have taken any, please indicate those that were particularly helpful or unhelpful, and any negative side effects you experienced.

Check If taken	Medication Name	Helpful? Yes/No	Did you have Side Effects?
	Prozac/Fluoxetine		
	Paxil/Paroxetine		
	Zoloft/Sertraline		
	Celexa/Citalopram		
	Lexapro/Escitalopram		
	Luvox/Fluvoxamine		
	Viibryd/Vilazodone		
	Trintellix/Vortioxetine		
	Effexor XR/Venlafaxine		
	Cymbalta/Duloxetine		
	Fetzima/Levomilnacipran		
	Pristiq/Desvenlafaxine		
	Remeron/Mirtazepine		
	Wellbutrin/Bupropion		
	Anafranil/Clomipramine		
	Elavil/Amitriptyline		
	Pamelor/Nortriptyline		
	Tofranil/Imipramine		
	Desyrel/Trazodone		
	Serzone/Nefazodone		
	Risperdal/Risperidone		
	Zyprexa/Olanzapine		
	Seroquel/Quetiapine		
	Symbyax/Olan-Fluoxetine		
	Geodon/Ziprasidone		
	Abilify/Aripiprazole		
	Saphris/Asenapine		
	Invega/Paliperidone		
	Rexulti/Brexipiprazole		
	Vraylar/Cariprazine		
	Latuda/Lurasidone		
	Fanapt/Iloperidone		
	Clozaril/Clozapine		
	Mellaril/Thioridazine		
	Prolixin/Fluphenazine		
	Navane/Thiothixene		
	Trilafon/Perphenazine		
	Haldol/Haloperidol		
	Provigil/Modafinil		
	Nuvigil/Armodafinil		
	Revia/Naltrexone		
	Campral/Acomprosate		

Check If taken	Medication Name	Helpful? Yes/No	Did you have Side Effects?
	Antabuse/Disulfiram		
	Eskalith/Lithobid/Lithium		
	Depakote/Divalproex		
	Tegretol/Carbamazepine		
	Trileptal/Oxcarbamazepine		
	Lamictal/Lamotrigene		
	Topamax/Topiramate		
	Gabitril/Tiagabine		
	Neurontin/Gabapentin		
	Buspar/Buspirone		
	Inderal/Propranolol		
	Catapres/Clonodine		
	Atarax/Vistaril/ Hydroxyzine		
	Ambien/Zolpidem		
	Sonata/Zaleplon		
	Lunesta/Eszopiclone		
	Somnote/Chloral Hydrate		
	Restoril/Temazepam		
	Halcion/Triazolam		
	Silenor/Doxepin		
	Dalmane/Flurazepam		
	Rozerem/Ramelteon		
	Belsomra/Suvorexant		
	Xanax/Alprazolam		
	Klonopin/Clonazepam		
	Valium/Diazepam		
	Ativan/Lorazepam		
	Serax/Oxazepam		
	Tranxene/Clorazepate		
	Librium/Chlordiazepoxide		
	Ritalin/Concerta/ Methylphenidate		
	Adderall/D-amphetamine/ Amphetamine		
	Vyvanse/Lisdexamfetamine		
	Strattera/Atomoxetine		
	Evekeo/Amphetamine		
	Intuniv/Guanfacine		
	List any other medications here:		

REVIEW OF SYSTEMS (General Health Questions)

Constitutional	Yes	No	Respiratory	Yes	No	Hematology/Lymph	Yes	No
Weight loss			Cough			Easy Bruising		
Fatigue			Coughing Blood			Bleeding gums		
Fever			Wheezing			Enlarged glands		
Eyes			Chills			**Musculoskeletal**		
Glasses/Contact			**Gastrointest.**			Joint Pain/Swelling		
Eye Pain			Heartburn/ Reflux			Stiffness		
Double vision			Nausea/Vomitting			Muscle Pain		
Cataracts			Constipation			Back Pain		
Ear, Nose, Throat			Change in BMs			**Skin**		
Difficulty hearing			Diarrhea			Rash/Sores		
Ringing in the ears			Jaundice			Lesions		
Vertigo			Abdominal Pain			Itching/Burning		
Sinus trouble			Black or Bloody Stools			**Neurological**		
Nasal stuffiness			**Genitourinary**			Loss of Strength		
Frequent sore throat			Burning/ Frequency			Numbness		
Cardiovasc			Nighttime Frequency			Headaches		
Murmur			Blood in Urine			Tremors		
Chest Pain			Erectile Dysfunction			Memory Loss		
Palpitations			Abnormal Discharge			**Addictive Behaviors**		
Dizziness			Bladder Leakage			Gambling		
Fainting Spells			**Allergic**			Shopping/Spending		
Shortness of Breath			Hives/Eczema			Internet		
Difficulty lying flat			Hay Fever			Pornography		
Swelling ankles			**Psychiatric**			Sex		
Endocrine			Anxiety			Gaming		
Loss of hair			Depression			Food		
Heat/cold Intolerant			Mood swings			Reviewed by:	**Date:**	

Controlled Substances Agreement

Controlled substance medications (Buprenorphine products, stimulants, some sleep medications, and benzodiazepines) are very useful, but have a high potential for tolerance, dependence, and misuse. Therefore, these medications are closely monitored by local, state, and federal governments. Some can cause withdrawal when trying to discontinue. It is important to talk to your provider when wanting to discontinue for safety purposes. As a patient of Norman Psychiatry, I agree to the following (please initial):

____1. I am responsible for the controlled substance medications prescribed to me. I will keep them in a safe place. If my prescriptions are misplaced, stolen, or if "I run out early," I understand this medication will not be replaced regardless of the circumstances.

____2. Refills of controlled substance medications will be made only during regular office hours. Refills will not be made on the same day as requested, nights, holidays, or weekends.

____3. I will not increase my controlled substance medication on my own.

____4. I will not get controlled substances from any other doctor or clinic. If I am prescribed another controlled substance, I will let the other provider know what I am taking and I will call Norman Psychiatry to discuss the new medication with my provider before taking it.

____5. I understand that my provider may ask for a routine or random urine drug screen if he/she feels that it is necessary. I understand that my insurance may not pay for this test and I will be responsible for the cost of this test.

____6. I understand that there is risk of addiction, physical dependence, and withdrawal from controlled substances. I will not discontinue without talking to my provider so a safe taper can be discussed if it is needed.

____7. I understand that mixing controlled medication with things such as pain medicine, muscle relaxants, alcohol, illicit drugs, or other substances that relax the central nervous system can be dangerous to my health and could result in death.

____8. I understand that this office monitors my access to controlled substances through the Oklahoma's Bureau of Narcotics and Dangerous Drugs Prescription Monitoring Program.

____9. I understand that if I violate this controlled substance contract due to non-compliance, the medication will be discontinued or a safe taper will be prescribed if needed. Termination of services could occur.

I have been fully informed regarding psychological dependence (addiction) of controlled substance medications. I know some individuals can develop a tolerance to the medications, necessitating a dose increase to achieve the desired effect, and doing so can result in increase in the risk of becoming physically dependent on the medication. If I need to stop this medication, I must do so under medical supervision. By signing below, I understand and accept the above agreement.

Signature of patient/Legal representative:_____
Description of Legal representative:_____
Date:_____

NORMAN PSYCHIATRY

Informed Consent for Telemedicine Services

Circumstances may occur when it necessary for your provider to conduct services through video conferencing

Introduction

Telemedicine involves the use of electronic communications to enable health care providers to share individual patient medical information, for the purpose of improving patient care. The information may be used for diagnosis, therapy, follow-up, and/or education, and may include any of the following:

- Patient medical records
- Medical images
- Live two-way audio and video
- Output date from medical devices and sound and video files

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

Expected Benefits:

- Improved access to medical care by enabling a patient to remain in his/her location
- More efficient medical evaluation and management
- Obtaining expertise of a provider in areas that are underserved

Possible Risks:

As with any medical procedure, there are potential risks associated with the use of telemedicine. These include:

- In rare cases, information transmitted may not be sufficient to allow appropriate medical decision-making by the provider
- Delays in medical evaluation and treatment could occur due to difficulties or failures with equipment
- In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information

Tips for a Successful Telemedicine Visit

- Check your internet connection
- Make sure your audio and video (webcam) is working
- Find a quiet, private location if possible
- Check your lighting
- Write down problems and questions ahead of time
- Dress appropriately for the visit

Scheduling your Telemedicine Appointment

- A Norman Psychiatry Associate will contact you with an available appointment date and time
- An email with Telemedicine Services information, directions, and consent will be emailed to you; please read, sign, and either:
    - fax to (405) 579-4223
    - email back to us at info@normanpsychiatry.com
    - drop off or mail to our office 2201 Westpark Drive, Norman, OK 73069
    - if you are unable to get this form back to us, we can take a verbal consent during your visit as a last resort
- The email will include a link to click on for access to your telemedicine appointment, **do not click the link or check in for the appointment** until a few minutes before your appointment
- A Norman Psychiatry Associate will contact you the day before your appointment to confirm the appointment, collect your credit card information for payment if you owe anything for the appointment (the card will not be charged until the day of the appointment), and take verbal consent for services over the phone if needed

Logging in to your Telemedicine Visit

- **You MUST use GoogleChrome, Firefox, or Safari.** These browsers allow for your mic and camera to work properly. You can easily download any one of these browsers from the internet.
- Instead of clicking on the link provided to your email, another option is to enter the web address with the correct provider's name in your browser as listed below:

Dr. Ripperger	www.doxy.me/drripperger
Dr. Raju	www.doxy.me/Draraju
Amy Boggs	www.doxy.me/amyboggs
Laura Hall	www.doxy.me/LHall616
Shannon Dukes	www.doxy.me/Dukeslpc
Kari Workman	www.doxy.me/kworkmanwaitingroom
Rock Richardson	www.doxy.me/mrrichardsonlpc
Bob Moore	www.doxy.me/bobmoorelpc
Brooke Braziel	www.doxy.me/brookewaitingroom
Brenda James	www.doxy.me/bjames
Shelby Lucas	www.doxy.me/lucaspac

- Please ensure that your microphone and webcam are enabled and functioning upon logging in
- Enter your name and click "Check In"
- You will appear in the provider's que as "Arrived" and your appointment will begin promptly, please wait for your provider to start the video call

Norman Psychiatry

Informed Consent for Telemedicine Services

Patient Name:_____Date of Birth:_____

1. Purpose: The purpose of this form is to obtain your consent to participate in a telemedicine consultation.
2. Medical Information and Records: All existing laws regarding your access to medical information and copies of your medical records apply to this telemedicine visit.
3. Confidentiality: Reasonable and appropriate efforts have been made to eliminate any confidentiality risks associated with the telemedicine visit, and all existing confidentiality protections under federal and Oklahoma State law apply to information disclosed during this telemedicine visit.
4. Rights: You may withhold or withdraw consent to the telemedicine visit at any time without affecting your right to future care or treatment.
5. Disputes: You agree that any dispute arriving from the telemedicine visit will be resolved in Oklahoma, and that Oklahoma law shall apply to all disputes.
6. It is important to use a secure internet connection rather than public/free Wi-Fi.
7. It is important to be on time. If you need to cancel or change your telemedicine appointment, you must notify the office at 405-579-4111. 24 hours notice is expected or you could be charged a fee.
8. If you are not 18, we need the permission of your parent or legal guardian.
9. Payment of Services: You agree that Norman Psychiatry, APRN-CNP, PLLC, reserves the right to bill a telemedicine visit to your respective insurance company. As well, you are responsible for any patient portion of the telemedicine visit, before your visit will take place. You should confirm with your insurance company that the video session will be reimbursed, if they are not, you are responsible for full payment.
10. Risks, Consequences, and Benefits: You have been advised of all potential risks, consequences, and benefits of telemedicine. You have had the opportunity to ask questions about the information presented on this form and the telemedicine visit. All of your questions have been answered, and you understand the written information provided above.

I agree to participate in telemedicine appointments.

Signature:_____Date:_____

Patient Representative Name: _____Relationship to pt_____

Patient Representative Signature:_____