PRINCETON MEDICAL INSTITUTE
NEW PATIENT REGISTRATION

PLEASE PRINT INFORMATION

Name:				**Date:**	
	First	**Middle**	**Last**		
Date of Birth:				Age:	
Gender: ☐ Male ☐ Female	Race:		☐ Hispanic ☐ Non-Hispanic		
Currently Employed? ☐ Yes ☐ No	Occupation (CURRENT OR PREVIOUS)				
Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single					

CONTACT INFORMATION

Primary Phone:	☐ Home ☐ Cell ☐ Work ☐ Other		
Secondary Phone:	☐ Home ☐ Cell ☐ Work ☐ Other		
Email Address:	SSAN:		
Street Address:		Apt #	
City:	State:	Zip:	

EMERGENCY CONTACT INFORMATION

Name:		Relationship:	
Phone:		2ND Phone:	

ALLERGIES (MEDICATION, FOOD, OTHER)

Allergy	Reaction

Indication of Study:	
Referral Source:	

PRINCETON MEDICAL INSTITUTE

NEW PATIENT REGISTRATION

Name:	Date of Birth:

Please list below any surgeries, hospitalizations, seizure history, cancer or other significant medical events / diagnoses that you have had. We need AT LEAST your best guess for the year of each date.

Condition / Event	Date Diagnosed	Date Resolved	Continuing?	Treated with Medication?
			~	

Please list below any medications you currently take, or have taken in the past 3 months. We need AT LEAST your best guess for the year of each date.

Medication	Indication	Dose	Frequency	Route	Start Date	Stop Date	Continue? Y or N

PRINCETON MEDICAL INSTITUTE

NEW PATIENT REGISTRATION

Name:	**Date of Birth:**

Please list below any pharmacies you may have used in the past 3 years:

Name	Address	City/Town	Phone	Fax

Please list below any doctors you have seen in the past 5 years:

Name	Specialty	Address/City	Phone	Fax

PRINCETON MEDICAL INSTITUTE
NEW PATIENT REGISTRATION

Name:	Date of Birth:

TOBACCO USE

Have you ever smoked/used tobacco products?	☐ Yes ☐ No
If yes, do you currently smoke/ use tobacco products? Specific product: Average daily consumption:	☐ Yes ☐ No
If no, when did you stop? (please, at least, give the year):	

CAFFEINE/STIMULANT CONSUMPTION

Do you currently consume caffeine, or xanthenes or other stimulants? Specific product: Average daily consumption:	☐ Yes ☐ No

ALCOHOL CONSUMPTION

Do you currently consume alcohol?		☐ Yes ☐ No
If Yes:	What Is your average weekly consumption of beers (1 beer = 12oz)?	
	What Is your average weekly consumption of wines (1 wine = 5oz)?	
	What Is your average weekly consumption of spirits (1 spirit = 1.5oz)?	

RECREATIONAL DRUG USE

Have you ever used recreational drugs?		☐ Yes ☐ No
If Yes:	Please check all that apply and last date used.	

☐ Amphetamine ☐ Phencyclidine

☐ Barbiturate ☐ Inhalant

☐ Cannabinoid ☐ Hallucinogens

☐ Cocaine ☐ Controlled Substance Analogs (Designer Drugs)

☐ Opiate ☐ Other

PRINCETON MEDICAL INSTITUTE

NEW PATIENT REGISTRATION

I hereby authorize Dr. Jeffrey T. Apter and/or his staff to contact my physician to request information concerning any medical information available regarding my health records.

I, the undersigned, hereby authorize and request you to release and/or send my records as indicated below:

Patient Name (Please Print):

Patient Signature / Date:

Guardian Signature / Date:
(If patient is a minor)

Physician's Name:	Physician's Name:
Area of Specialty:	Area of Specialty:
Address:	Address:
Phone:	Phone:
Fax:	Fax:

PLEASE MAIL / FAX THE REQUESTED INFORMATION TO:
PRINCETON PSYCHIATRIC CENTER
WOODLANDS PROFESSIONAL BUILDING
256 BUNN DRIVE, SUITE 6
PRINCETON, NJ 08540
TEL: (609) 921-3555
FAX: (609) 921-3620

☐ Psychological Records	☐ CT of the Head	☐
☐ Medical Records	☐ Chest X-Ray	☐ Records For Period From _____ to _____
☐ Lab Results	☐ EKG	☐ Most Current Records Only

PRINCETON
MEDICAL INSTITUTE
A Global Medical Institutes®, LLC Company

CREDIT AUTHORIZATION FORM

** Please note if you OPT out of filling this form out we will call or text you before scheduled appointments
To collect your copay amount. If we do not have a card on file and cannot get ahold of you, your appointment will be cancelled.
If you choose to keep a card on file the card will be charged the morning of your appointment*

Account Name: _____

Account Number: _____

Credit Card: _____

Expiration Date: _____

CVC Code: _____

I hereby authorize Princeton Psychiatric Centers to charge my credit card in the amount of _____ for the services rendered.

Cardholder's name: _____

Signature: _____ **Date:** _____

Date of service: _____

******.Keep on file for future visits x _____

To our patients: this-notice describes how health information about you, as a patient of this practice, may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulation created as a result of the Health Insurance Portability and Accountability Act of 1996 (HIPPA). Enforcement of this law began April 14, 2003.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information:

USE AND DISCLOSURE OF YOUR HEALTH INFORMATION IN CERTA IN SPECIAL CIRCUMSTANCES.

The following circumstances may require us to use or disclose your health information:

1. To public health authorities and health oversight agencies that are authorized by law to collect information.
2. Lawsuits and similar proceedings in response to a court or administrative order.
3. If required to do so by a law enforcement official.
4. When necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public. We will only make disclosures to a person or organization able to help prevent the threat
5. If you are a member of U.S. or foreign military forces (including veterans) and if required by the appropriate authorities.
6. To federal officials for intelligence and national security activities authorized by law.
7. To correctional institutions or law enforcement officials if you are an inmate or under the custody of a law enforcement official.
8. For Workers Compensation and similar programs.

YOUR RIGHTS REGARDING YOUR HEALTH INFORMATION

1. Communications. You can request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. For instance, you may ask that we contact you at home, rather than work. We will accommodate reasonable requests.

2. You can request a restriction in our use or disclosure of your health information for treatment payment, or health care operation. Additionally, you have the right to restrict our disclosure of your information to only certain individuals involved in your care or the- payment for your care, such as family members and friends. We are not required to agree to your request; however, if we do agree, we are bound by our agreement except when otherwise required by law, in emergencies, or when the information is necessary to treat you.

3. You have the right to inspect and obtain a co-pay of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. You must submit your request in writing to our office either by mail or fax to the attention of your provider. If you have any questions you may call 609.921.3555

4. You may ask us to amend your health information if you believe it is incorrect or incomplete, and as long as the information is kept by or for our practices. To request an amendment, your request must be made in writing and submitted to Ms. Kaylee White. If you need further information call 609.921.3555.

You must provide us with a reason that supports your request for amendment

5. Right to a copy of this no tice. You are entitled to receive a copy of this Notice of Privacy Practices. You may ask us to give you a copy of the Notice at any time. To obtain a copy of this notice, contact our front desk receptionist.

6. Right to file a complaint if you believe your privacy rights have been violated, you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. To file a complaint with our practice, contact Ms. Kaylee White. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

7. Right to provide an authorization for other uses and disclosures. Our practice will obtain your written authorization for uses and disclosures that are not identified by this notice or permitted by applicable law.

If you have any questions regarding this notice or our health information privacy policies, please contact Ms. Kaylee White in our office.

I hereby acknowledge that I have been presented with a copy of HIPPA Notice of-Privacy Practices.

Patient Signature: _____

Patient Print Name: _____

Date: _____/_____/_____
DD MMM YYYY

Princeton Psychiatric Centers, PA
Office Policies and Consent for Treatment

The following information describes my office policies and serves as consent for treatment. I will be happy to answer any questions. This consent will serve as an agreement between us, which either of us may revoke at any time.

Confidentiality: I acknowledge that you will be presenting personal and sensitive information. Information is treated as confidential and privileged and will not be revealed to anyone else without written consent, except under the following conditions:

1) when a child is being abused
2) when someone's life is in danger
3) when collaboration is needed with another mental health professional. If I need to consult with or send reports to health care providers or other outside agencies (e.g., insurance companies, attorneys; schools, etc.), a release of information form must be first signed by you.

Length of Sessions and Fee Policy: Please make every effort to arrive for your scheduled appointment on time. Unless there is an emergency, I will rarely keep you waiting. If you arrive late, your session will still end at the scheduled time.

Initial Psychiatric Evaluation	60 minutes	$400.00
Initial Ketamine Consultation	60 minutes	$450.00
Initial Psychological Evaluation	60 minutes	$350.00
Medication Management/Follow up Appts	30 minutes	$250.00
Follow up Therapy Sessions	60 minutes	$200.00
Reports and Letter Preparation (minimum 1 hour)	Hourly rate	$150.00
Missed Appointment (No Show/Cancel within 24 Hours)		$200.00

Payment: Payment is expected at each session unless advance arrangements have been made. The fee will be collected at the start of each session. We accept cash, personal checks, VISA/MC/AMEX/Discover as forms of payment. We do not work with a sliding scale. Reports and letters are prorated on an hourly rate of $150.00 with a minimum charge of $150.00.

Cancellations: All appointments are scheduled in advance and that time is reserved for you. A 24-hour notice is required for cancellations, ***otherwise you will be charged $200 for a missed appointment or late cancellation.*** Please anticipate situations in advance that are not considered an emergency and for which the fee will be charged. In the event of a dangerous weather condition, we may provide a telephone or telemedicine session. Please note that insurance companies do not reimburse for missed appointments charges.

Insurance: You are responsible for the payment of all services. Insurance companies differ as to their coverage. You will need to check with your carrier to determine if treatment is covered and their reimbursement policy. Filing claims and collecting from your insurance company is your responsibility. Reimbursement from insurance companies should go directly to you unless you have insurance for which we participate in this office. Because of the complexities of insurance coverage, I do not accept direct reimbursement from insurance carriers (other than from those where we are credentialed). We will be happy to assist you in completing forms or providing necessary information to your insurance company so that you can receive reimbursement. We will give you a statement receipt after each session for your submission to insurance. Your bill contains all the necessary information required for most insurance carriers. **It is your responsibility to tell the office if your insurance has changed. Please bring in a**

copy or text the office a copy of your insurance card (front and back) your new insurance card so there are no billing disputes prior to your next visit.

NOTE: Should we receive payment from insurance, and then it is later determined that you did not qualify for benefits at that time, requiring that we reimburse monies previously received, you will immediately be responsible for the FULL amount of the appointments for which services were rendered.

Telephone calls: Our office number is as follows:

Princeton: 609.921.3555
9:00 am – 5:30 pm, Monday – Friday.

In the event you have a question that cannot be handled by our secretary, you can leave a message stating you need to speak to one of us and what the matter is regarding. We will make every attempt to return your call within 24 hours, Monday – Friday. If you are calling outside of these hours, please note that voicemail is available but not checked during the evening or on weekends or holidays. If you have an acute emergency, please dial 911 or go to the nearest emergency room.

Termination: Termination is an important part of the treatment process. When completing psychotherapy treatment, it is strongly recommended that you allow at least two (2) sessions to work through the termination process. This permits integration of therapeutic gains and also prevents premature termination due to difficult points or impasses during psychotherapy.

Acknowledgement of Informed Consent: I have read this form, discussed all concerns, and understand the office policies. I fully agree to comply with these policies and consent for treatment by Cindy Gaskins, APN, and/or Nicole Peniston PsyD, and/or Sanjay Varma, MD, MPH and/or Jeffrey T. Apter, MD.

Signature of Client _____ **Date** _____
(if client is 18 years or older)

Signature of Parent or Guardian _____ **Date** _____

Princeton Psychiatric Centers, PA
Office Policies and Consent for Pharmacological Therapy

After an initial psychopharmacological evaluation, medication may be prescribed. The purpose, pharmacological action, proper use of, and potential side effects of your medication will be fully discussed with you.

Typically, your weight and blood pressure will be taken and monitored if you are prescribed medication. Laboratory tests will be initially ordered to evaluate your health status and to determine baseline blood levels and ordered periodically to monitor your health status during the time you are taking the medication. With your consent, I usually like to consult with your therapist and primary care practitioner to promote continuity of care.

Medication, for most people, is used primarily to alleviate physical and psychological symptoms. In general, medication provides symptom relief, but it does not get at root causes of problems or provide psychological growth. Psychotherapy is necessary for this, and it is important that you are receiving psychotherapy as well as taking your prescribed medication. Thus, for most people, medication is used as a "bridge" until sufficient psychological growth through psychotherapy is achieved. However, for others, medication may be necessary for long periods of time, especially when there are long-standing biochemical imbalances or chronic psychiatric disorders.

After new medications are prescribed, a second appointment will be scheduled in approximately two weeks. This appointment is to review progress and make necessary adjustments. Weekly to biweekly appointments are then scheduled for approximately the next 6 to 12 weeks. If you are stable on the medication, visits are then scheduled every 3 months. The least often I see people for medication maintenance is every 3 months. This is a necessary requirement to monitor your health status and is a standard of care practice. Please schedule your 3-month appointment at the time of your visit. If you do not schedule your appointment at the time of your visit, please call me 2 weeks before you run out of medication to schedule an appointment. Appointments are necessary for medication renewals. This office does not routinely call-in medication renewals to pharmacies.

In the event of medication reactions or other urgent questions, please call the office immediately. Your phone call will be returned as soon as possible.

Acknowledgement of Informed Consent: I have read this form, discussed all concerns, and fully understand the office policies for pharmacological therapy. I fully agree to comply with these policies and consent for treatment by Cindy Gaskins, APN, and/or Sanjay Varma, MD, MPH and/or Jeffrey T. Apter, MD. to prescribe and monitor my psychiatric medication.

☐ I give my consent for my primary care practitioner to be contacted.

☐ I DO NOT give my consent for my primary care practitioner to be contacted.

☐ I give my consent for my therapist to be contacted.

☐ I DO NOT give my consent for my therapist to be contacted.

Signature of Client _____ **Date** _____
(if client is 18 years or older)

Signature of Parent or Guardian _____ **Date** _____

Princeton Medical Institute
Patient Information and Consent Form for Teletherapy with (clinician name)_____

Client Name: _____ **DOB:** _____

Introduction

Teletherapy is the delivery of mental health services using interactive audio and visual electronic systems where the clinican and the client are not in the same physical location. The interactive electronic systems used in teletherapy incorporate network and software security protocols (encryption) to protect the confidentiality of client information and audio and visual data.

Potential benefits of teletherapy

- Increased accessibility to mental health care
- Client convenience

Potential Risks with teletherapy

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

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for the same level of interpersonal connectedness as in face to face sessions
- Delays in treatment may occur due to deficiencies or failures of the equipment
- A lack of access to all the information that might be available in a face to face visit but not in a teletherapy session may result in missed opportunities for in vivo therapeutic interventions

Alternatives to the use of teletherapy

- Traditional face to face sessions in your clinicians office

Confidentiality Standards required for teletherapy:

- During a teletherapy session, both locations shall be considered a therapy room regardless of a room's intended use.
- Both sites shall be appropriately chosen to provide audio and visual privacy.
- Rooms shall be designated private for the duration of the session with the provider and no unauthorized access shall be permitted.
- Both sites shall take every precaution to ensure the privacy of the consult and the confidentiality of the client. All persons in the therapy room at both sites shall be identified to all participants prior to the consultation and the client's permission shall be obtained for any visitors or clinicians to be present during the session.
- HIPAA confidentiality requirements apply the same for teletherapy as for face-to-face consultations.

My Rights

1. I understand that the laws that protect the privacy and confidentiality of medical information also apply to teletherapy.
2. I understand that the video conferencing technology used by my clinician is encrypted to prevent unauthorized access to my private medical information.
3. I have the right to withhold or withdraw my consent to the use of teletherapy during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
4. I understand that my clinician has the right to withhold or withdraw their consent for the use of teletherapy during the course of my care at any time.

5. I understand that the all rules and regulations which apply to the practice of medicine/psychology/social-work in the state of New Jersey also apply to teletherapy.
6. I understand that my clinician will not record any of our teletherapy sessions without my prior written consent.
7. My clinician will inform me if any other person can hear or see any part of our session before the session begins.

My Responsibilities

1. I will not record any teletherapy sessions without prior written consent from my clinican.
2. I will inform my clinician if any other person can hear or see any part of our session before the session begins
3. I understand that third-parties may be required to join in the meeting with my provider and me to provide technical support. I understand that I may be asked to interact with the technical support person on camera in order to fix the problem. I understand that if I decline this request and my equipment is rendered unusable for teletherapy, I may forfeit my option to use teletherapy.
4. I understand that I, not my clinician, am responsible for the configuration of equipment on my device which is used for teletherapy. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I may need to contact a designated third party for technical support to determine my device's readiness for telemedicine prior to beginning teletherapy sessions with my clinician.
5. I understand that I must be a resident of the state(s) of _____ to be eligible for teletherapy services from my clinician.

Client Consent To The Use of Teletherapy

I have read and understand the information provided above regarding teletherapy, have discussed it with my clinician and all of my questions have been answered to my satisfaction.

I hereby give my informed consent for the use of teletherapy in my medical care and authorize my clinician to use telemedicine in the course of my treatment.

Signature of Client (or person authorized to sign for client):

_____

If authorized signer, relationship to client:

_____

Date:_____ Time: _____

Signature of Clinician: _____

Date: _____ Time: _____

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

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. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	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?	☐	☐	☐	☐	☐

Part A

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?	☐	☐	☐	☐	☐

Part B

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ **DATE:**_____

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	☐	☐	☐	☐
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 figety 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	☐	☐	☐	☐
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

TOTAL:

10. 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 ☐

A2663B 10-04-2005

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (☑) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...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 you didn't really miss it?	☐	☐
...you were much more talkative or spoke 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? *Please check 1 response only.*	☐	☐
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious problem		
4. Have any of your blood relatives (ie, 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?	☐	☐

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.