VADIM BARAM, INC.
ADULT + GERIATRIC PSYCHIATRY

10420 Old Olive Street Road, Suite 205
St. Louis, MO 63141
314-692-8516
www.barampsychiatry.com

PATIENT INFORMATION

NAME: _____ SEX: M ☐ F ☐ O ☐

DOB (MM/DD/YYYY): _____ SS#: _____ MARITAL STATUS: S ☐ M ☐ W ☐ D ☐

ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

DAYTIME PHONE: _____ ALTERNATE PHONE: _____

EMAIL ADDRESS: _____ PREFERRED LANGUAGE: _____

ETHNIC GROUP: _____ HISPANIC (CHECK ONE): Y ☐ N ☐

PRIMARY CARE PHYSICIAN: _____ PHONE: _____

☐ I consent for you to contact my Primary Care Physician

EMERGENCY CONTACT INFORMATION

NAME: _____ I consent for the office to contact this person

RELATIONSHIP: _____ PHONE: _____

HEALTH INSURANCE INFORMATION (If we have good copies of the cards, write health insurances NAMES ONLY)

PRIMARY INSURANCE NAME: _____ SUBSCRIBER NAME: _____

SUBSCRIBER SS#: _____ EMPLOYER: _____

POLICY NUMBER: _____ GROUP NUMBER: _____

PHONE: _____

SECONDARY INSURANCE NAME: _____

SUBSCRIBER NAME: _____ SUBSCRIBER SS#: _____

EMPLOYER: _____ POLICY NUMBER: _____

GROUP NUMBER: _____ PHONE NUMBER: _____

Your portion of the payment for services is expected on the day of services. Payment is accepted by credit card or cash.

I authorize Vadim Baram, Inc. to release any information acquired in the course of examination or treatment to my insurance company in order to file a claim. I also understand that there may be a balance due from me after my insurance pays their portion. I authorize payment directly to and assign to Vadim Baram, Inc. any medical benefits. A photocopy of this release shall be as valid as the original. I understand that if my account is when due, I will be responsible for all costs incurred in the collection process of my account. I further understand that my account could be reported to the credit bureau.

Vadim Baram, Inc. does not deny any benefits or services because of race, color, national origin, age, sex, disability, religious or political beliefs. If you feel that you have a complaint, you may file a complaint with the Administrator of this facility. You will not suffer any penalty because you file a complaint.

☐ I consent to treatment by my physician.

_____

PATIENT SINGATURE DATE

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PATIENT INFORMATION - PLEASE PRINT LEGIBLY

EMAIL INFORMATION

EMAIL ADDRESS: _____

I CONSENT TO RECEIVE ☐ TEXT OR ☐ VOICE MESSAGES FOR APPOINTMENT REMINDERS

CELL PHONE NUMBER: _____

PHARMACY INFORMATION

PHARMACY NAME: _____

PHARMACY ADDRESS: _____

_____

_____

PHARMACY PHONE NUMBER: _____

SMOKING QUESTION - UNDER FACE SHEET - SOCIAL HISTORY

SMOKES: YES ☐ NO ☐

IF YES, WE NEED TO CHECK TOBACCO USE CESSATION COUNSELING

CHECK ONE:

- ☐ CURRENT EVERY DAY SMOKER
- ☐ CURRENT SOME DAY SMOKER
- ☐ FORMER SMOKER
- ☐ NEVER SMOKED
- ☐ SMOKER - CURRENT STATUS UNKNOWN
- ☐ UNKNOWN IF EVER SMOKED
- ☐ HEAVY TOBACCO SMOKER
- ☐ LIGHT TOBACCO SMOKER

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HIPAA NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED, AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes*your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information that may identity you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician and facility that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

TREATMENT

We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related service. This includes the coordination or management of your health care with a third party. For example: we would disclose your protected health information, as necessary, to your physician, the pharmacy, lab or medical specialist, or hospital that provides care to you. Your protected health information will be disclosed to ensure that the necessary information to diagnose or treat you is provided.

PAYMENT

Your protected health information will be used, as needed, to obtain payment for your health care services. For example: obtaining approval for outpatient visits or hospital visits, may require that your relevant protected health information be disclosed to the health plan to obtain approval and payment for your doctors' visits and tor to obtain approval and payment for the doctors' visits to the hospital.

HEALTHCARE OPERATIONS

We may use or disclose as needed, your protected health information in order to fulfill state and federal requirements. For example: We are required to complete certain assessment instruments and report specific data to the Division of Health and Senior services.

We also may use or disclose your protected health information in the following situations without your authorization. These situations include: as required by Law: Public Health issues, Communicable Diseases, Health Oversight, Abuse or Neglect. Food and Drug Administration requirements. Legal Proceedings, Law Enforcement. Coroners, Funeral Directors, Organ Donation. Research, Criminal Activity, Military Activity, National Security, Wc^rkers' Compensation, required uses and Disclosures. Under the law, we must make disclosures to you and when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made Only with Your Consent, Authorization or Opportunity to Object unless required by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician practice has taken an action in reliance on the use or disclosure indicated in the authorization.

CONTINUED ON NEXT PAGE.

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YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information.

YOU HAVE THE RIGHT TO INSPECT AND COPY YOUR PROTECTED HEALTH INFORMATION. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding, and protected health information that is subject to law that prohibits access to protected health information.

YOU HAVE THE RIGHT TO REQUEST A RESTRICTION OF YOUR PROTECTED HEALTH INFORMATION. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your case or for the notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your Physician is not required to agree to a restriction that you may request. If your physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

YOU HAVE THE RIGHT TO REQUEST TO RECEIVE CONFIDENTIAL COMMUNICATIONS FROM US BY ALTERNATIVE MEANS OR AT AN ALTERNATIVE LOCATION. You have the right to obtain a paper copy of this notice from us, upon request.

YOU MAY HAVE THE RIGHT TO HAVE YOUR PHYSICIAN AMEND YOUR PROTECTED HEALTH INFORMATION. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of such rebuttal.

YOU HAVE A RIGHT TO RECEIVE AN ACCOUNTING OF CERTAIN DISCLOSURES WE HAVE MADE, IF ANY, OF YOUR PROTECTED HEALTH INFORMATION.

We reserve the right to change the terms of this notice and will inform you of any changes. You then have a right to object or withdraw as provided in this notice.

COMPLAINTS

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

We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please inform the office by calling 314-504-4698.

Signature below is only an acknowledgement that you have received this notice of our Privacy Practices.

_____

Signature of Client/Legal Guardian/Personal Representative Date

_____

If someone else signs on behalf of the client, state relationship Date

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Dear Patients,

This is to inform you that, Vadim Baram Inc. has a policy regarding controlled substance medications that will be implemented in this office.

We are sorry for any inconvenience that this may cause but, we will be unable to refill any lost controlled substance medications and /or prescriptions, until the scheduled refill date.

Please be careful with these medications and prescriptions and keep them in a safe place.

Sincerely,
Administration of Dr. Baram's Office

Please sign that you have read and agree with this policy.

_____

Patient's Name Date

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PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: _____ **DATE:** _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Check the box to indicate your answer.

	NOT AT ALL	SEVERAL DAYS	MORE THAN HALF THE DAYS	NEARLY EVERY DAY
1. Litte interest or pleasure in doing things	0 ☐	1 ☐	2 ☐	3 ☐
2. Feeling down, depressed, or hopeless	0 ☐	1 ☐	2 ☐	3 ☐
3. Trouble falling or staying asleep, or sleeping too much	0 ☐	1 ☐	2 ☐	3 ☐
4. Feeling tired or having little energy	0 ☐	1 ☐	2 ☐	3 ☐
5. Poor appetite or overeating	0 ☐	1 ☐	2 ☐	3 ☐
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0 ☐	1 ☐	2 ☐	3 ☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	0 ☐	1 ☐	2 ☐	3 ☐
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	0 ☐	1 ☐	2 ☐	3 ☐
9. Thoughts that youw ould be better off dead, or of hurting yourself	0 ☐	1 ☐	2 ☐	3 ☐

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:** ☐

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Please mark medication(s) below that you have taken in the past.

Antidepressants	Taken
amitriptyline (Elavil)	☐
bupropion (Wellbutrin)	☐
citalopram (Celexa)	☐
clomipramine (Anafranil)	☐
desipramine (Norpramin)	☐
desvenlafaxine (Pristiq)	☐
doxepin (Sinequan)	☐
duloxetine (Cymbalta)	☐
escitalopram (Lexapro)	☐
fluoxetine (Prozac)	☐
fluvoxamine (Luvox)	☐
imipramine (Tofranil)	☐
levomilnacipram (Fetzima)	☐
mirtazapine (Remeron)	☐
nortriptyline (Pamelor)	☐
paroxetine (Paxil)	☐
selegiline (Ensam)	☐
sertraline (Zoloft)	☐
trazodone (Desyrel)	☐
venlafaxine (Effexor)	☐
vilazodone (Viibryd)	☐
vortioxetine (Trintellix)	☐

Mood Stabilizers	Taken
carbamazepine (Tegretol)	☐
gabapentin (Neurontin)	☐
lamotrigine (Lamictal)	☐
lithium (Eskalith)	☐
oxcarbazepine (Trileptal)	☐
topiramate (Topamax)	☐
valproic acid/divalproex (Depakote)	☐

ADHD	Taken
amphetamine salts (Adderall)	☐
atomoxetine (Strattera)	☐
clonidine (Kapvay)	☐
dexmethylhenidate (Focalin)	☐
dextroamphetamine (Dexedrine)	☐
guanfacine (Intuniv)	☐
lisdexamfetamine (Vyvanse)	☐
methylphenidate (Metadate, Daytrana)	☐
methylphenidate (Ritalin, Concerta)	☐

Other	Taken
Nuedexta	☐
Austedo	☐
Ingrezza	☐
Ketamine/Spravato	☐

Anxiolytics & Hypnotics	Taken
alprazolam (Xanax)	☐
buspirone (BuSpar)	☐
chlordiazepoxide (Librium)	☐
clonazepam (Klonopin)	☐
clorazepate (Tranxene)	☐
diazepam (Valium)	☐
eszopicolone (Lunesta)	☐
hydroxyzine (Atarax/Vistaril)	☐
lorazepam (Ativan)	☐
oxazepam (Serax)	☐
propranolol (Inderal)	☐
temazeapm (Restoril)	☐
zolpidem (Ambien)	☐

Antipsychotics	Taken
ariprazole (Abilify)	☐
asenapine (Saphris)	☐
brexpiprazole (Rexulti)	☐
cariprazine (Vraylar)	☐
chlorpromazine (Thorazine)	☐
clozapine (Clozaril)	☐
fluphenazine (Prolixin)	☐
haloperidol (Haldol)	☐
iloperidone (Fanapt)	☐
lurasidone (Latuda)	☐
olanzapine (Zyprexa)	☐
paliperidone (Invega)	☐
perphenazine (Trilafon)	☐
quetiapine (Seroquel)	☐
risperidone (Risperdal)	☐
thioridazine (Mellaril)	☐
thiothixine (Navane)	☐
ziprasidone (Geodon)	☐

Long Acting Injectable	Taken
Abilify Maintena (aripprazole)	☐
Aristada (ariprazole)	☐
Haldol (haloperidol)	☐
Invega Sustenna (paliperidone)	☐
Invega Trinza (paliperidone)	☐
Perseris (risperidone)	☐
Prolixin (fluphenazine)	☐
Risperdal Consta (risperidone)	☐
Zyprexa Relprevv (olanzapine pamoate)	☐

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GENDER IDENTITY

- ☐ Male
- ☐ Female
- ☐ Transgender Male/Trans Man/Female-to-Male
- ☐ Transgender Female/Trans Woman/Male-to-Female
- ☐ Genderqueer, neither exclusively Male nor Female
- ☐ Additional gender category or other (please specify)
- ☐ Patient declines to specify

SEXUAL ORIENTATION

- ☐ Straight or heterosexual
- ☐ Lesbian, gay, or homosexual
- ☐ Bisexual
- ☐ Something else, please describe
- ☐ Don't know
- ☐ Patient declines to specify

CURRENT TOBACCO USE

- ☐ Non-smoker
- ☐ Ex-smoker
- ☐ Ex-user of moist powdered tobacco
- ☐ Current nonsmoker but past smoking history unknown
- ☐ Light cigarette smoker (1-9 cigs/day)
- ☐ Moderate cigarette smoker (10-19 cigs/day)
- ☐ Heavy cigarette smoker (20-39 cigs/day)
- ☐ Very heavy cigarette smoker (40+ cigs/day)
- ☐ Cigar smoker
- ☐ Pipe smoker
- ☐ Chews tobacco
- ☐ Chews products containing tobacco
- ☐ Snuff user