9263 Medical Plaza Dr, Ste A
North Charleston, SC 29406
843-377-1600 (phone)
843-377-1601 (fax)
www.tricountybehavioral.com

FREQUENTLY ASKED QUESTIONS

What should I bring to my first appointment?

1) COMPLETED paperwork (pages 2-6)
2) Pill bottles of all current medications (prescribed and over-the-counter)
3) Health insurance card
4) Driver's license
5) Payment. Payment is due at time of service. We accept cash, check, & major credit cards.

Why do you need my credit card information and will you charge my credit card?
Credit card information is necessary prior to scheduling an appointment in order to reserve your appointment time. We will obtain your credit card information when you schedule your initial appointment. *Your credit card will be charged $65 only if you "no show" or call to cancel your appointment within 24 hours of the scheduled appointment time. Otherwise, your credit card will not be charged.*

How early should I arrive to my first appointment?
If you have already completed the required paperwork listed above, please plan to arrive at least 10 minutes early so that we can make copies of necessary identification cards. If you have not completed the required paperwork, please plan to arrive 30 minutes prior to your scheduled appointment time.

How much will my appointment cost?
Please call you insurance company if you have any questions about how much your appointments will cost. Cost for an appointment with a psychiatrist depends on several factors, such as the complexity and length of the appointment, copay amount, and deductible.

Have questions that are not answered here?
Please visit our website at www.tricountybehavioral.com or call us at 843-377-1600

******PLEASE REMEMBER TO BRING COMPLETED PAPERWORK TO YOUR FIRST APPOINTMENT******

ADULT INTAKE FORM

Date ______________

Full Name ________________________________ Date of Birth ___________________________________
Address __________________________________ Primary Phone __________________________________
____ Secondary Phone ________________________________
Primary Care Physician _____________________ Email ____

Please describe your reason(s) for seeking treatment at this time ________________________
____

Current Symptoms/Behaviors (check all that apply)

____ Depression
____ Crying spells/tearfulness
____ Energy increase
____ Appetite increase
____ Trouble sitting still
____ Withdrawal
____ Loss of interest
____ Feelings of guilt
____ Feelings of grief
____ Compulsions/rituals
____ Difficulty falling asleep
____ Excessive sleeping
____ Irritability
____ Lack of motivation
____ Energy decrease
____ Appetite decrease
____ Trouble concentrating
____ Verbally abusive
____ Sexual dysfunction
____ Hallucinations/delusions
____ Anxiety/worry
____ Marital/family problems
____ Middle night awakenings
____ Suicidal ideas/attempts
____ Agitation
____ Mood swings
____ Binge eating
____ Weight change (↑/↓amount____)
____ Phobias/fears
____ Physically abusive/violence
____ Purging after meals
____ Sexual acting out
____ Panic attacks
____ Feeling hopeless or worthless
____ Early morning awakenings
____ Homicidal ideas/attempts
____ Other ____

Former psychiatric care (psychiatrist, psychologist, counselor, therapist, psychological testing)

For what reason	When	By whom	Type of treatment

Current medications (include over-the counter, sleeping pills, birth control, vitamins, & supplements). If unsure of dosage please check your pill bottle or contact your pharmacy.

Name of medication	Dosage	For what reason	How long	Is it helpful?	Side effects (if any)

Previous psychiatric medications (see list of common medications below)

Name of medication	Dosage	For what reason	How long	Was it helpful?	Side effects (if any)

Common medications: Prozac/fluoxetine, Lexapro/escitalopram, Zoloft/sertraline, Celexa/citalopram, Paxil/paroxetine, Effexor/venlafaxine, Pristiq/desvenlafaxine, Cymbalta/duloxetine, Wellbutrin/bupropion, Buspar/buspirone, Viibryd, Fetzima, Brintellix, Elavil/amitriptyline, Abilify/aripiprazole, Haldol/haloperidone, Risperdal/risperidone, Invega/paliperidone, Saphris/asenapine, Zyprexa/olanzapine, Seroquel/quetiapine, Geodon/ziprasione, Latuda/lurasidone, Xanax/alprazolam, Ativan/lorazepam, Klonopin/clonazepam, Valium/diazepam, Provigil, Nuvigil, Topamax/topiramate, Remeron/mirtazapine, Ambien/zolpidem, Lunesta, Sonata, Rozerum, Trazodone, Restoril/temazepam, Neurontin/gabapentin, Lyrica, Atarax/Vistaril/hydroxyzine, lithium, Lamictal/lamotrigine, Depakote/valproate, Tegretol/carbamazepine, Trileptal/oxcarbazepine, Ritalin, Focalin, Concerta, Adderall, Dexedrine, Vyvanse, Strattera, Tenex, clonidine, Intuniv, Campral, Methadone, Antabuse, Naltrexone, Suboxone

Current/past medical problems______________________________________
Surgeries (dates)______________________________________
Medical or psychiatric hospitalizations (dates)______________________________
Medication allergies or adverse reactions (if none please indicate) ________________
Have you ever had a seizure? __________ **Have you ever had a concussion?** __________
Have you ever attempted to harm/kill yourself? (date/method) ____________________

Have you ever had any problems with any of the following:

____ Skin problems	____ Wounds not healing/easy	____ Easy bruising
____ High blood pressure	____ Heart disease/chest pain	____ Glaucoma/vision problems
____ Cancer	____ Teeth/gums	____ Asthma/breathing problems
____ Hearing loss	____ Head injuries	____ Sickle cell
____ Snoring	____ Stomach ulcers	____ Fainting/black outs
____ Gallstones	____ Liver disease/jaundice	____ Numbness/tingling
____ Lead/chemical exposure	____ Kidney/bladder problems	____ HIV/AIDS

Females: date of last menstrual period______________________________________
Current birth control method (if none, please state)______________________________

FAMILY HISTORY	**Which family member**		**Which family member**
Heart Disease	________________	Psychosis/hallucinations	________________
Abnormal heart rhythm	________________	Schizophrenia	________________
Cancer	________________	Panic disorder	________________
Asthma	________________	Anxiety/worry	________________
Diabetes	________________	Learning disability	________________
Neurologic problems	________________	ADHD	________________
Seizures	________________	OCD	________________
Thyroid problems	________________	Bipolar/manic depressive	________________
Depression	________________	Tics (involuntary movements)	________________
Drug problems	________________	Eating Disorder	________________
Alcohol problems	________________	Suicide/attempted suicide	________________
Genetic Disorder	________________	Psychiatric hospitalization	________________

SUBSTANCE USE HISTORY	Age at first use	How often (Last 6 months)	How much	Date last use
Caffeine (coffee/tea/sodas)	________	________	________	________
Cigarettes/cigars/tobacco	________	________	________	________
Sedatives (sleeping pills)	________	________	________	________
Alcohol	________	________	________	________
Amphetamine/Speed	________	________	________	________
Marijuana	________	________	________	________
Cocaine/Crack	________	________	________	________
Hallucinogens/LSD/acid/mushrooms	________	________	________	________
Prescription Pain Pills	________	________	________	________
Opioids/Heroin	________	________	________	________
PCP/Angel Dust	________	________	________	________
Ecstasy	________	________	________	________
Diuretics/laxatives	________	________	________	________
IV Drug Use	________	________	________	________
Benzodiazepines (Xanax/Ativan/ Valium/Klonopin/Restoril)	________	________	________	________

SUBSTANCE USE SYMPTOMS/CONSEQUENCES

DUI/legal problems	Y/N	Thought about or tried to cut down	Y/N
Complaints from others	Y/N	View substance as a problem	Y/N
Delirium tremens (DTs)	Y/N	Black outs	Y/N
Seizures	Y/N	Needing to use more to get same high	Y/N

OTHER INFORMATION

Names, ages, and relationships of everyone in household ____
____
Any significant changes in the past year? ____

Religion _________________________ Highest Educational Degree ______________________________

Occupation ______________________ Spouse's Occupation (if applicable)_________________________

Marital Status ____________________ Number of Marriages ________ Number of Children_________

Any legal problems or arrests (please describe) ____

*****COMPLETE THE REMAINDER OF THIS PAGE ONLY IF YOU ARE HAVING DIFFICULTY SLEEPING OR ARE TIRED/FATIGUED DURING THE DAY*****

USUAL SLEEP HABITS

1. The average total number of hours of sleep I get at night is __________
2. The amount of time I usually take to fall asleep is __________
3. I usually exercise at (time of day)__________for __________ minutes
4. I nap about __________ days each week for __________ minutes
5. The number of times that I usually wake up during the night is __________
6. The reason I wake up is (pain, nightmares, restroom, noise, room temp, etc.) ______________________
7. If I wake up during the night, the time it takes to fall asleep again is ________________
8. The dozing time I generally spend between awakening and getting out of bed is __________
9. During the first 30 minutes after waking up in the morning, I usually feel (circle appropriate answer)
   Very groggy Somewhat drowsy Slightly drowsy but awake Alert

Please place a check besides any of the following statements that are true for you:

________ I have a job that involves shift work or night work

________ I often have frightening dreams

________ My sleep is disturbed because of my bed partner

________ I am a very restless sleeper

________ When I try to sleep my mind races with many thoughts

________I have been told that I snore loudly

________ I have been told I stop breathing when I sleep

________ I often wake up with a headache

________ I wake up in the morning long before I need to

________ I have creeping, crawling sensations in my legs when I lie down to sleep

DAYTIME SLEEPINESS SCALE: How likely are you to doze off or fall asleep in the following situations? 0=would never dose 1=slight chance of dozing 2=moderate chance of dozing 3=high chance of dozing

________ Sitting and reading

________ Watching TV

________ As a passenger in a car for an hour without a break

________ Sitting and talking to someone

________ Sitting quietly after a lunch without alcohol

________ In a car, while stopped for a few minutes in traffic

________ Sitting, inactive in a public place (e.g., a theatre or meeting)

________ Lying down to rest in the afternoon when circumstances permit

OFFICE POLICY STATEMENT

*****PLEASE INITIAL NEXT TO EACH SECTION*****

__________**APPOINTMENT CANCELLATION POLICY:** When you schedule an appointment with us, that time is specifically set aside for you. **IF YOU MISS AN APPOINTMENT WITHOUT CALLING TO CANCEL AT LEAST 24 HOURS IN ADVANCE YOU WILL BE CHARGED $65.** The only exception to this fee is if you can provide documentation you were hospitalized. You will be charged a no-show fee if you arrive late and have to be rescheduled for another day. If you come to your appointment without canceling ("no show") you will be required to provide a credit card number in order to schedule another appointment. On the second "no show" or less than 24 hour cancelation, the missed appointment fee will be collected. Please note that although we do offer courtesy email, text message, and phone call reminders, the patient is responsible for remembering his/her appointment. Not receiving an appointment reminder will not be considered an excuse for missing an appointment. Insurance companies do not reimburse for these fees. After two no shows you may be no longer be able to be seen in our clinic.

__________**PRESCRIPTION REFILLS:** Prescription refills consume a surprisingly large portion of staff time. There is a small fee (see Physician Ancillary Charges below) for refills given and refills may be denied due to missed or overdue appointments. To help ensure safety and well-being patients are expected to follow-up within the time frame recommended by their provider. Prescriptions will be given at each appointment with enough refills to last until the recommended time of your next appointment. If your refills are running low, it likely means it is time to schedule a follow-up appointment. **BEFORE CALLING OUR OFFICE TO REQUEST A REFILL, PLEASE CHECK YOUR BOTTLE OR CALL YOUR PHARMACY TO SEE IF YOU HAVE ANY REFILLS REMAINING. PLEASE ALLOW AT LEAST 48 HOURS FOR REFILL REQUESTS. NO REFILLS WILL BE GIVEN ON FRIDAYS.**

__________**FEES:** There is a $25 charge for returned checks. Balances over 90 days may be sent to a collections agency. Medical record fees are $15 plus 65¢ per page.

__________**PHYSICIAN ANCILLARY CHARGES:** It is in the patient's best interest to have as much communication as possible in person as this increases the safety and efficacy of treatment. Insurance companies do not reimburse the fees listed below and therefore patients are responsible for all accrued charges. **WITH THE EXCEPTION OF SIGNIFICANT MEDICATION SIDE EFFECTS OR AN EMERGENCY, PLEASE DO NOT ASK YOUR DOCTOR TO CHANGE MEDICATION OVER THE PHONE.** If you think your medication isn't working or would like to discuss treatment options please schedule an appointment. This helps ensure optimal patient care.

• Telephone or e-mail consultation	$10 each 5 minutes
• Emergency calls after hours	$15 each 5 minutes
• Reports/letters/consultations	$10 per page
• Prescription refills due to overdue appointment or replacement of lost prescription	$10 per prescription

__________**DRUG SCREENING:** In accordance with prescribing guidelines any patient may be asked to submit a urine sample for drug screening at any time. Failure to comply with the test may result in the patient no longer being prescribed his/her medications. The purpose of dug screening is to confirm medication adherence, reduce diversion of medications, and to prevent accidental overdose due to overusing prescribed medications or drug-drug interactions.

__________**PRIOR AUTHORIZATIONS:** if a prior authorization is required for a medication it is the responsibility of your pharmacy to notify our office. It is important we have your current insurance information on file. **After we submit the required paperwork, insurance companies can take up to one week to make a decision.** We cannot call insurance companies for approval during this waiting period. We appreciate your patience and will notify you as soon as a decision has been made.

__________**INSURANCE:** As a service to our patients, claims for visits are submitted to your insurance company by a contracted vendor. Our office will make every effort possible to obtain accurate information about your insurance benefits including limits of coverage, deductibles, and co-payments. You are responsible for all charges not covered by your insurance. **Payment is required in full at time of service**. Your physician's referral and verification of insurance benefits by our office are not a guarantee of insurance coverage. We recommend you contact your insurance company to ensure that you understand your coverage and to ensure you have coverage for mental health services. Do not assume that you will not owe anything if you have more than one insurance policy.

CONFIDENTIALITY: Information regarding your treatment will not be released unless there is prior written consent, indication of clear and immediate danger to self or others, certain legal circumstances required by law, or disclosure of neglect or abuse of a child or members of vulnerable populations.

AUTHORIZATION TO RELEASE INFORMATION: By my signature below I authorize Tricounty Behavioral Health to release information about me to my insurance company and the referring provider. This information is protected under the Privacy Act, the Drug Abuse Office and Treatment Act, and the Comprehensive Alcohol Abuse & Alcoholism Prevention & Rehabilitation Act.

INFORMED CONSENT/ACKNOWLEDGEMENT OF UNDERSTANDING AND AGREEMENT: I consent to have Tricounty Behavioral Health perform or order clinical assessments, psychotherapy, provide consultations, recommendations, and/or related mental health treatment. I have read all of the information listed above regarding policies and procedures. My signature below indicates my understanding and agreement.

Signature:_______________________________________ Date: ___________________

Printed Name:___________________________________