Castle Healthcare Services Inc/Anavota Behavioral Health PLLC

Mailing Address: 6666 Harwin Drive Suite 155, Houston TX 77036
Main Office: 832-834-3830 Fax: 972-947-5309
Phone: 877-895-3830 Fax: 608-305-8664 for Arizona, Nevada, Washington, Wiscosin.

NEW PATIENT INTAKE FORM

Patient Full Name:			Date of Birth:	Soc Sec #:
Mailing Address:			Home Phone:	Mobile Phone:
City:	State:	Zip Code:	Email:	
Gender:	Marital Status:		Ethnicity/Race:	Preferred Language:

Responsible Financial Party (mark self if over 18):		Date of Birth:	Soc Sec #:
Address:		Home Phone:	Mobile Phone:
Employer Name:		Employer Address:	

Primary Insurance			**Secondary Insurance**		
Insurance Name:			Insurance Name:		
Policy/Member ID #:			Policy/Member ID #:		
Group #:			Group #:		
Primary Subscriber Name:			Primary Subscriber Name:		
Date of Birth:	Soc Sec #		Date of Birth:	Soc Sec #	
Insurance PO Box Address:			Insurance PO Box Address:		
City:	State:	Zip:	City:	State:	Zip:

Emergency Contact Name:	Phone:	Relationship:

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I authorize release of my personal information including medical treatment, scheduling and billing information to the individuals listed below. For the protection of my private health information, I understand that Serenity will ***not*** disclose information related to my personal health records to any individual not listed here. **Initial**

Full Name	**Relationship**

Primary Care Provider/Practice:	PCP Phone:
Please list any other doctors you are currently seeing (i.e. neurologist, internist, etc)	
Please list all current and past therapists' names and approx. dates of therapy:	
Preferred Pharmacy Name: Pharmacy Address:	

_____ _____

Signature of Patient/Patient Representative: **Date:**

Is patient under the age of 18? ☐ **Yes** ☐ **No**

IF YES, PARENT / GUARDIAN MUST FILL OUT IF NO, PLEASE STOP HERE AND SIGN BELOW

Parent Name:_____ Date of Birth: _____/_____/_____ Last
First
Address: _____SS#: _____-_____-_____ City:
_____ State: _____ Zip_____ Home Phone: (____)_____
Employer: _____ Work Phone: (____)_____x_____
Relationship to patient: _____

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Signature of Patient/Parent/Guardian _____ Date _____

How did you hear about Castle/Anavota? (Check all that apply): ☐ Search Engine (ex. Google) ☐Insurance ☐ Friend/Family: ☐ Web Directory (Yelp, WebMD, Healthgrades, etc) ☐ Social Media (Facebook, Instagram, Twitter) ☐ News Story ☐ Event ☐ Other: _ ☐ Referred by another provider. Name: Phone:_

Consent To Treatment

INSURANCE RELEASE OF INFORMATION/ASSIGNMENT OF BENEFITS:

I authorize Castle Healthcare Services (CHCS) Inc /Anavota Behavioral Health (ABH) PLLC , to release to my Medicare carrier or the Insurance carrier listed on file/EHR, any medical information needed for authorization or payment of this or a related claim. I also authorize payments directly to this office for the mental health benefits. I understand that I am responsible for all pre-authorizations required by my insurance. Furthermore, I understand that I am financially responsible for all charges whether or not paid by my insurance company.

AUTHORIZATION FOR MEDICAL TREATMENT, STATEMENT OF RESPONSIBILITY, CONFIDENTIAL INFORMED CONSENT, PATIENT RIGHTS & RESPONSIBILITIES, and MAGELLAN MEMBER RIGHTS & RESPONSIBILITIES.

Authorization for Medical Treatment:

I authorize the physician/practitioner(s), psychologist(s), therapists(s), their assistants and/or designees in charge of my medical care to administer any treatment as may be necessary or advisable in my diagnosis and treatment at Castle Healthcare Services Inc/Anavota Behavioral health PLLC (Facility). This authorization includes, but is not limited to, routine diagnostic procedures, rehabilitation therapy, laboratory tests, and the use of prescription medication. I also authorize copies of the medical records to be released to other physicians and healthcare facilities as deemed necessary by any physician(s)/practitioner(s) or therapist(s) whose care I am under. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been

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made to me as to results of examination and treatment received at this Facility. I acknowledge that my care is under the direction of my treating physician/practitioner(s) and the Facility will follow the instructions of my physician/practitioner(s) in the provision of said care.

Statement of Responsibility: I understand that I am financially responsible to the Facility(s) as the patient, parent, guardian, and conservator or insured for all charges not covered by the above assignments. Charges may include medical insurance deductibles, co-insurance, or out-of-pocket expenses. An estimated payment is due at time of service by cash, Visa, MasterCard, Discover, or American Express. Depending on the level of service provided there may be an additional fee that is patient responsibility to pay within 30 days of receipt of our statement. Any balance on an account greater than 30 days old is considered past due. In the event that payment cannot be made, a statement will be mailed and payable within 10 days of receipt. If your account is overdue for more than 30 days, we reserve the right to assess a penalty of $50 per 30-days overdue, and potentially use legal means to secure payment. This includes charging your credit card on file and/or utilizing a collections agency or small claims courts. Payment plans are offered upon request.

Patient Rights & Responsibilities: I have been given the opportunity to review the Facility's Patient Rights & Responsibilities. I understand that the Facility has the right to change the Patient Rights & Responsibilities at any time, and that I may obtain a current copy at the Facility's office during normal business hours.

The undersigned certifies that he or she has read the foregoing, is the patient, patient's guardian, power of attorney, parent, or is duly authorized by or on behalf of the patient to execute the above and accept its terms.

_____ _____

Signature of Patient or Personal Representative: **Date:**

_____ _____

Printed Name of Patient or Personal Representative Relationship to Patient:

****Castle Healthcare Services Inc/Anavota Behavioral Health PLLC Office Policies****

The providers and staff of Castle Health Services, Inc feel that we can better serve your health care needs if you are familiar with the following policies and procedures:

Identification: State ID/Driver's License **MUST** be presented at the time of visit via telehealth/in person.

Office Hours and Appointments: The office is open Monday through Friday from 9 a.m. to 5:00 p.m. and our office is closed 12:00 pm to 1:00 pm for lunch. Appointments are available on Saturdays (appointment only). The providers are available on an

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emergency basis at all times during business hours. Follow up appointments should be made when leaving the office. However, appointments may also be scheduled by calling **832-834-3830 or 877-305-8664** or self scheduling online.

Appointment No-Show Policy:

If you are unable to keep your appointment, please cancel at least **48-hours** prior to your appointment time via EHR or by calling the office and we will be happy to reschedule your visit. Some other patients who can be seen during the open time will be grateful for your thoughtfulness. CHCS Inc/ABH PLLC also reserves the right to charge for patient no-shows for medical appointments. I have been advised that there will be a no show fee charged for appointments canceled with less than 48 hours notice. ***A $75.00 no show fee for initial evaluation appointments and for existing patients $50.00 no show fee. This fee is not covered by any insurance plan.*** But if you have missed more than four consecutive appointments or have consistent no shows, we reserve the right to discharge you from psychiatric services and refer you to a different provider within the community. If you miss a Saturday appointment, you will be charged the appropriate no show fee and will not be rescheduled for any future Saturday appointments as this is a convenience day and we expect for you to be present. If you leave before being seen by the provider, you will not receive a refund. This will be considered a **NO SHOW**. No refunds are given after a service has been rendered as per appointment policy.

Initial_____

Cellular devices, camera, camcorders or any other recording/phot taking devices are prohibited:

- To reduce the potential risk of a Federal HIPAA Violation recording and/or photo taking devices are prohibited, including but not limited to: cellular devices, camcorders, recorders.

Insurance: Our providers are currently in network with Major insurances including United Healthcare, Compsych, Blue Cross Blue Shield, Texas Children Plan, Cigna, Humana, Magellan, Multiplan/PHCS,UMR, all savers and Tricare. We are not accepting Medicare or Medicaid as primary insurance.

Self-Payment: For self pay and at your request, we can provide you a "superbill" which highlights services provided which you can submit to your insurance company for reimbursement. It is your responsibility to know if your insurance will cover the services provided. Fees may be subject to change period. If our fees are to increase, we will provide you a 30-day notice to alert you of all the changes.

Payment will be due before services rendered and billed to a credit card on file.

Emergency Situations / After Office Hours: For non-urgent matters, please allow business hours for response. Please note that there will be a $25 fee for all after-hour urgent calls. If you encounter a true medical emergency, call 911 or to go to the nearest Emergency room.

Prescription Policy: It is important that we closely monitor your medication and therefore, we require that you schedule an

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appointment prior to requesting a prescription refill. For refills of medication that require a written prescription, please call our office at 832-834-3830 for an appointment. For all other medications, please call your pharmacy to request a refill and we will respond to your pharmacy as soon as possible. As a client, it is your responsibility to schedule your refill appointment in a timely manner so that you do not run out of medications. Your medication will only be refilled once in a 30-day period and you will be required to schedule an appointment. Please note that most medications require insurance authorization and this process can take 3-4 days. All stolen controlled prescriptions require a police report. If you miss your appointment, no refills will be given.

PRESCRIPTION REFILL DISCLAIMER

We do not refill any medication without an appointment. Patients must have a follow up appointment scheduled with their provider for refills to be sent. If you need your medication adjusted or would like to be started on a new medication, you will need to make an appointment with your provider. This cannot be done by email. If you are having side effects from the medications, please send a nurse message to your provider to make an appointment to address any medication side effects.

• I understand that if I have no-showed, canceled, or rescheduled (1) follow up appointment, a maximum of a 10-day bridge will be sent. Follow up visit **MUST** be scheduled within 10 days.

Initial_____

• I understand that if I have no-showed, canceled, or rescheduled (2) consecutive appointments, no refills will be sent-must be seen in the office before any refills will be sent.

Initial_____

Patients can request non-controlled substance refills up to 7 days in advance.

90-day supplies will not be sent on behalf of insurance purposes unless provider has sent out 30 days with refills. If only 30 days was sent, medical necessity for the 30-day supply should be provided to the insurance to get coverage for patients.

Medication refills will only be sent for active prescriptions, medication changes will need to be reviewed by provider prior to sending.

Moving or Switching to New Provider (Outside of Castle Healthcare Service Inc./Anavota Beahvioral Health PLLC)

• I understand that if I am discontinuing care with Serenity, ONLY a 3-month supply of medications will be sent. Additional refills will not be sent.

Initial_____

Consent to Obtain Patient Medication History

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Patient medication history is a list of prescriptions that healthcare providers have prescribed for you. A variety of sources, including pharmacies and health insurers, contribute to the collection of this history.

The collected information is stored in the practice electronic medical record system and becomes part of your personal medical record. Medication history is very important in helping providers treat your symptoms and/or illness properly and avoid potentially dangerous drug interactions.

It is very important that you and your provider discuss all your medications in order to ensure that your recorded medication history is 100% accurate. Some pharmacies do not make prescription history information available, and your medication history might not include drugs purchased without using your health insurance.

Also over-the-counter drugs, supplements, or herbal remedies that you take on your own may not be included.

I give my permission to allow my healthcare provider to obtain my medication history from my pharmacy, my health plans, and my other healthcare providers.

By initialing this consent form you are giving your healthcare provider permission to collect and share your pharmacy and your health insurer information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. This includes prescription medicines to treat AIDS/HIV and medicines used to treat mental health issues such as depression

_____ _____

Signature of Patient/Legal Guardian **Date**

Controlled substance Policy:

Benzodiazepines (medications such as Xanax, Ativan, and Klonopin) will **RARELY** be prescribed at Castle Healthcare Services, Inc/Anavota Behavioral Health PLLC. This reflects the current understanding that benzodiazepines can worsen anxiety and contribute to cognitive decline over long periods of time. In addition, benzodiazepines carry the risk of tolerance, dependence and abuse and are potentially lethal in overdoses, particularly when mixed with alcohol and/or opioid pain medications. Stimulant medications are a first line treatment for the symptoms of ADHD, however, they carry the risk of tolerance, dependence and abuse. For this reason, their use is tightly regulated. There are non controlled substances that are FDA approved for treatment of ADHD in children and adults. Please be advised that these prescriptions expire in 21 days of the earliest fill date. Prescriptions are sent electronically to your pharmacy of choice. If your pharmacy does not have the proper quantity to fill your prescription, then you must contact the office with a secondary pharmacy to resend the prescription. Please allow up to 72 hours to resend the prescription electronically. All clients taking controlled substances are required to submit a urine drug screen on initiation of any controlled substance and every quarter thereafter. Urine Drug Screen (Mandatory) for all patient on Controlled medication.

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Paperwork Policy

We realize that patients may need to have forms completed for disability or work. We have developed a paperwork policy to assist our clients with getting their paperwork completed in a timely manner. If you have forms that need to be completed, you must schedule an appointment with your provider to get the paperwork completed. Please read, initial, and sign below to acknowledge our paperwork policy.

Formal Letters/504 Letter for School/Emotional Support Pet Letter/FMLA Paperwork: 1. You will need to sign a release of information 2. Make an appointment for completing your FMLA paperwork 3. Please allow up to 7-10 business days to complete the paperwork. Our office will not fill out any paperwork, forms or write any letters regarding CHL (concealed handgun license) clearance.

Fee Discolsure:

1. Paperwork Fee Scale (Not billable to insurance):
2. Diagnosis and/or Treatment Physician Letter: $25.00
3. Authorization letter to administer medication by a school nurse, Letter to employer/school: $25.00
4. Medical Record Processing Fee (20-pages or less): $25.00
5. Medical Record Processing Fee (More than 20-pages): $75.00
6. FMLA Paperwork: $75.00 to start & $50 & up for add. forms

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

_____ _____

Signature of Patient or Legal Guardian: Date:

_____ _____

Patient's Full Name: Relationship to Patient

Telehealth Informed Consent

Definition of Telehealth

Telehealth involves the use of electronic communications to enable professionals to connect with individuals using interactive video and audio communications. Telehealth includes the practice of psychological health care delivery, diagnosis, consultation, treatment, referral to resources, education, and the transfer of medical and clinical data.

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I understand that I have the rights with respect to telehealth:

I understand privacy and the confidentiality laws apply to telehealth, and that no information obtained through the use of telehealth services will be disclosed to researchers or other entities without my written consent.

My health care provider has explained how the videoconferencing technology will be used to conduct a telehealth session, that unlike a direct patient/provider in person, I will not be in the same room as my health care provider.

I understand the potential risks to technology including interruptions, unauthorized access and technical difficulties. I understand my health care provider or I can discontinue the videoconference consult/visit if it is believed videoconferencing technologies are not adequate for the situation.

I understand that I have the right to withhold or withdraw my consent to the use of telehealth in the course of my care at any time, without affecting my right to future care or treatment.

I understand that telehealth may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.

I understand that no results for anticipated can be guaranteed or assured by my provider.

I understand my healthcare information may be shared with other individualsfor purposes of scheduling and billing. Individuals othersthan my healthcare provider may be present during the session in order to operate videoconferencing equipment. I further understand that I will be informed of their presence, and that such individuals will maintain confidentiality on information obtained during the session. Furthermore, I have the right to request the following:

• ask non-medical personnel to leave the telehealth examination room; and/or

• terminate the consultation at any time.

I agree certain situations – such as emergencies and crisis -- are inappropriate for audio-/video-/computerbased psychotherapy services. If I am in crisis or in an emergency, I should immediately call 911 or seek help from a hospital or crisis-oriented healthcare facility in my immediate area.

Consent to The Use of Telehealth

By signing this form, I certify:

• That I have read or had this form read and/or had this form explained to me.

• That I fully understand its contents including the risks and benefits of the procedure(s).

• That I have been given ample opportunity to ask questions and that any questions have been answered to

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my satisfaction.

_____ _____

Signature of Patient/Legal Guardian **Name of Patient/Legal Guardian(Print Name)**

_____

Date

Castle Healthcare Services/Anavota Behavioral Health Parenting Policy

We require a custodial parent or guardian to be present for each visit for children under 18.

We require a valid photo identification card of the custodial parent(s), foster parent, or any adult in in which you have submitted a notarized statement indicating they may consent to any and all treatment for that child.

A **valid photo ID** includes any state issued ID card, valid state driver's license, military ID card, or valid government passport.

If a custodial parent is not able to be present, we must have a notarized power of attorney or notarized letter of consent on file giving permission for another adult to be present and consent for the care or treatment of the minor child.

The parent or authorized adult bringing in the minor child in responsible for any monies owed for copays, deductibles, and coinsurance or denied claims **at the time of visit.** We will be happy to let you know an **estimated** amount due for the visit at the time you schedule the appointment. Please be advised that the amount given is **only an estimate.** There may be additional fees charged that we are unaware of, or that insurance does not cover, etc. We are equipped to take these payments over the phone prior to the visit as an option.

It is not the responsibility of the physician and/or staff to communicate visit information to each custodial parent separately.

The providers and office staff of Castle Healthcare Services Inc/Anavota Behavioral Health PLLC will not be put in the middle of domestic issues or disagreements. If we feel this is becoming an issue and compromising the care of the minor child/and or if at any time a family OR non-family member becomes abusive with the staff, we maintain our right to discharge the family from the care of the practice.

Only in situations where there is a **confirmed, documented Court Order** will one of the parent's be denied access to the minor child's health records or visits at the office. Castle Healthcare Services Inc/Anavota Behavioral Health PLLC **must** have a copy of this Court Order on file in the minor child's electronic chart.

Stepparents, fiancés, girlfriends, boyfriends, or non-legal partners are not considered parents authorized to consent care without a valid **notarized letter signed by both custodial parents.**

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I have read and agree to abide by the above policy.

_____ _____

Child's Full Legal Name – PLEASE PRINT **Child's Date of Birth**

_____ _____

Custodial Parent Name – PLEASE PRINT **Custodial Parent Signature**

_____ _____

Custodial Parent Name – PLEASE PRINT **Custodial Parent Signature**

NOTICE OF PRIVACY POLICIES
FOR
CASTLE HEALTHCARE SERVICE INC/ANAVOTA BEHAVIORAL HEALTH PLLC

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

All items outlined in this policy apply to both paper and electronic formats of medical records and protected health information.

INTRODUCTION

Castle Healthcare Services Inc is committed to treating and using protected health information (PHI) about you responsibly. We are permitted to use and disclose health information about you for the treatment, to obtain payment for treatment, for administrative purposes and to evaluate the quality of care you receive. This notice describes our privacy practices. We may change our policies and this notice at any time. You can request a paper copy of this notice, or any revised notice, at any time. This notice is effective October 1, 2019 and applies to all PHI as defined by federal regulations. For more information about this notice or our privacy practices and policies, please contact the person listed at the end of this document.

HOW WE MAY USE AND/OR DISCLOSE YOUR HEALTH INFORMATION

We are permitted to use and disclose your health information to those involved in your treatment. Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example: results of laboratory tests and procedures will be available in your medical record to all health professionals who may provide treatment or who may be consulted by staff members.

We are permitted to use and disclose our health information to bill and collect payment for the services we provided to you.

Your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated in order

to pay for the service rendered to you.

We are permitted to use and disclose your health information for the purposes of health care operations, which are the activities that support this practice and ensure that quality care is delivered. For example: information on the services you received may be used to support budgeting and financial reporting, and activities to evaluate and promote quality.

DISCLOSURES THAT CAN BE MADE WITHOUT YOUR AUTHORIZATION

These are situations in which we are permitted to use or disclose your health information without your written authorization or an opportunity to object.

Public Health: We may disclose your health information for public health activities mandated by federal, state or local government for the collection of information about disease, vital statistics or injury by a public health authority.

Abuse or Neglect: Because Texas law requires clinicians to report child abuse or neglect, we may disclose health information to a public agency authorized to receive reports of child abuse or neglect.

Healthcare Oversight: We may disclose your health information to a health oversight agency for those activities authorized by law. Examples of these activities are audits, investigations, licensure applications and inspections.

Law Enforcement and Legal Proceedings: We may disclose your medical information if asked by a law enforcement official. We may also release information if we believe the disclosure is necessary to prevent or lessen imminent threat to the health or safety of a person. We may disclose our health information in the course of judicial or administrative proceedings in response to an order of the court or other appropriate legal process.

Worker's Compensation: We may disclose your health information as required by worker's compensation law.

Military and National Security: We may disclose your health information for specialized governmental functions.

Research and Medical Examiners: We may release health information to researchers for research purposes. We may release your health information to a coroner or medical examiner to identify a deceased person or a cause of death.

Business associates: We may disclose your health information to "business associates" to perform our day-to-day operations. These "associates" require your health information in order to accomplish the tasks that we ask them to provide. Some examples of "business associates" might be a billing service, collection agency, answering services and computer software/hardware provider.

Appointment reminders: We may contact you by telephone, e-mail, mail or all to provide appointment reminders.

Required by Law: We may release your health information when the disclosure is required by law.

Other Uses or Disclosures: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

YOUR RIGHTS UNDER FEDERAL LAW

You have certain rights under the federal privacy standards. These include:

- The right to request restriction on the use and disclosure of your PHI. WE DO NOT HAVE TO AGREE TO THIS RESTRICTION.
- The right to limit disclosure to family members, relative or friends who may or may not be involved in your care. Restrictions must be submitted in writing to the person listed at the end of this document.

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- The right to request that we send communications concerning health information by alternative means or to an alternative location. The request must be submitted in writing to the person at the end of this document and we are required to accommodate only reasonable request.
- The right to inspect and copy your PHI that is within the designated record set. Texas law requires that request for copies are made in writing and we require requests for inspection also be made in writing. Texas law requires us to provide copies or a narrative within 15 business days from receipt of your proper request. If we deny access, we will inform you in writing. HIPAA permits us to charge a reasonable cost-based fee.
- The right to amend or submit corrections to your PHI in the designated record set. If we refuse to allow amendment, we will inform you in writing.
- The right to receive an accounting of disclosures that are other than for treatment, payment, health care operations or made via an authorization signed by either you or your representative.
- The right to receive a printed copy of this notice.

FOR MORE INFORAMTION OR TO REPORT A PROBLEM

If you believe that your privacy rights have been violated, please contact the aforementioned practice Privacy Official, or, you may file a complaint with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the practice's Privacy Official or with the Office for Civil Rights. The address for the Office for Civil Rights is listed below:

OFFICE FOR CIVIL RIGHTS

U.S. Department of Health and Human Services

200 Independence Avenue, S.W. Room 509F, HHH Building

Washington, D.C. 20201

OUR RESPONSIBLITIES

Castle Healthcare Services Inc/Anavota Behavioral Health is required by law and regulation to protect the privacy of your health information, to provide you with this notice of our privacy practices with respect to protected health information and to abide by the terms of the notice of privacy practices in effect.

If you have complaints, questions, or would like additional information regarding this notice or the privacy practices of Castle Healthcare Services Inc please contact our Privacy Official:

Castle Healthcare Services Inc/Anavota Behavioral Health PLLC.

6666 Harwin Drive Suite 155

Houston TX 77036

(832)-834-3830

REVIEW ACKNOWLEDGEMENT OF NOTICE OF PRIVACY POLICIES AND PRACTICES

I have reviewed Castle Healthcare Services Inc/Anavota Behavioral Health 's Notice of Privacy Practices, which explains how my health information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

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_____ _____

Name of Patient or Personal Representative Date

_____ _____

Signature of Patient or Personal Representative Description Personal Representative's Authority

Optional:

_____ _____

Additional Authorized Patient Personal Representative Relationship

_____ _____

Additional Authorized Patient Personal Representative Relationship

_____ _____

Additional Authorized Patient Personal Representative Relationship

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Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

PHQ-9	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little 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 fidgety or restless that you have been moving around a lot more than usual.	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself in some way.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

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

Castle Healthcare Services Inc/Anavota Behavioral Health PLLC

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- ☐ **Not difficult at all**
- ☐ **Somewhat difficult**
- ☐ **Very Difficult**
- ☐ **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems? Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over half the days**	**Nearly every day**
1. Feeling nervous, anxious, or on edge.	0	1	2	3
2. Not being able to stop or control worrying.	0	1	2	3
3. Worrying too much about different things.	0	1	2	3
4. Trouble relaxing.	0	1	2	3
5. Being so restless that it's hard to sit still.	0	1	2	3
6. Becoming easily annoyed or irritable.	0	1	2	3
7. Feeling afraid as if something awful might happen.	0	1	2	3
Add the score for each column				

Total Score (add your column scores): _____

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

- ☐ **Not difficult at all**
- ☐ **Somewhat difficult**
- ☐ **Very Difficult**
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