DIRECTIONS TO:

PSYCHIATRIC SERVICES, P.C.

CENTER POINTE BUILDING
9239 W. Center Road, Suite 211
Omaha, NE 68124-1900
www.psychiatricservicespc.com

From Interstate 680 — take Center Street east approximately 1½ miles to stoplight at Paddock Road. Turn right (south) curving down the road to the glass and brick building called Center Pointe Building on the right (just before Earl May Nursery).

OR

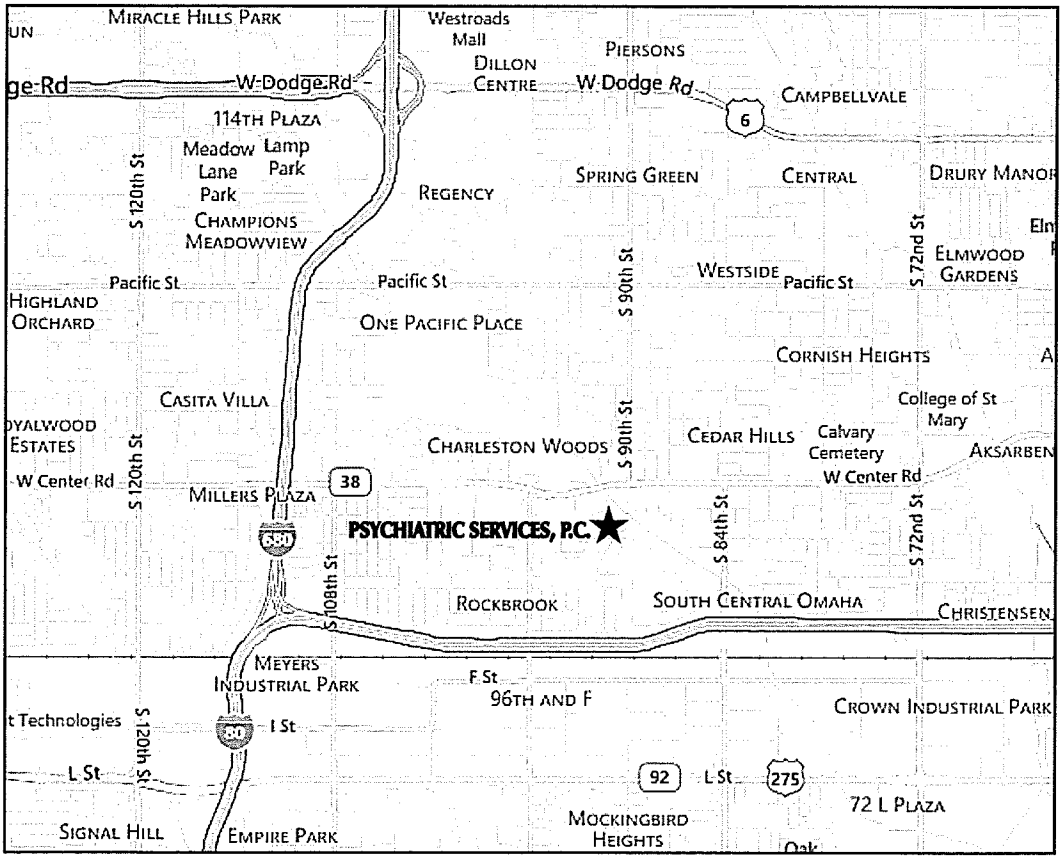
From Interstate 80 — take 84th Street exit heading north approximately 1 mile to Center Street. Turn left (west) on Center Street. After passing through the 90th and Center Street Intersection, move to the left lane to turn left at the light at Paddock Road. You will curve down the road to the glass and brick building called Center Pointe Building on the right (just before Earl May Nursery).

THEN

Entering the north doors, take the elevator to the second floor.

Turn left after exiting the elevator and another immediate left at the end of the hall.

Our reception area/window is straight ahead. Our physicians' names are on the wall.



PATIENT'S PERMISSION TO DISCLOSE INFORMATION

At Psychiatric Services, PC, we are committed to treating and using protected health information about you responsibly. Below are listed ways in which your personal information may be used. We ask that you *read the following carefully*. Please check the lines to indicate your permission.

Telephone messages: At times, Psychiatric Services, PC, may need to contact you by phone. We also make appointment reminder calls. Please indicate if we may leave detailed messages and/or reminder calls on:

Home phone/cell phone:
_____ Answering machine/voice mail
_____ With a family member
OR
_____ Leave callback number only

Work phone:
_____ Answering machine/voice mail
OR
_____ Leave callback number only

Written communication:
_____ You may send mail (medical records, prescriptions, and or any other health information) to:
_____ My home address
_____ My work address
_____ You may communicate with me by fax at this number: _____

Please check the following for which you give permission:

_____ If my spouse calls Psychiatric Services, PC, requesting information in regard to my appointments or billing.

_____ If a family member calls Psychiatric Services, PC, requesting information in regard to appointments or billing.

_____ My Power of Attorney may need to be present at time of examination, may need to telephone or write Psychiatric Services, PC, for information regarding my health, appointments or billing.

_____ If I have someone accompany me into the doctor's or therapist's office, I give permission for the doctor or therapist to discuss my case, test results, or any other health information in the person's presence.

_____ I give permission to Psychiatric Services, PC, to allow someone other than myself to pick up my medication.

Signature _____ Date _____

Please print name _____

Unless otherwise noted, this release will remain in effect until the patient's treatment is completed.

Name_____ Date_____

Please circle the items which apply to you in the last 6 months:

Weight gain or loss Binge or purge Worried about your weight or appearance Poor motivation
Anxious or nervous Panic Crying spells Restlessness/difficulty sitting still Anger
Recurrent thoughts or actions Sexual problems Hearing or seeing things Confusion
Thoughts of self-harm Thoughts of suicide Forgetful or memory problems Nightmares
Difficulty being in public No memory for certain period of time

Are any of these symptoms worse at any time of the day, month, or year? ☐ Yes ☐ No
Have you ever had counseling/therapy or medication for any of the above? ☐ Yes ☐ No
If Yes – where, when and from whom?_____
Previous Hospitalizations for substance abuse, alcoholism, eating disorders, or other psychiatric disorders? ☐ Yes ☐ No
Details:_____
Do you drink alcohol? ☐ Yes ☐ No How many times a week?_____ How many drinks per time? _____
Do you use nicotine? ☐ Yes ☐ No Do you use caffeine? ☐ Yes ☐ No
Do you currently use illicit drugs? ☐ Yes ☐ No Have you ever abused prescription or illicit drugs? ☐ Yes ☐ No
Do you exercise regularly ☐ Yes ☐ No Do you gamble? ☐ Yes ☐ No
What is your Height?_____ Weight? _____
List all medication allergies:_____

Current Medical Conditions and Medications: **Primary Care Dr:**_____ **Last exam date:**_____

Condition	Medication/Supplement	Amount	When Prescribed

Circle other medical conditions: thyroid disease cancer kidney disease high blood pressure irregular heart beat/pacemaker falling loss of consciousness liver disease chest pain heart attack high cholesterol headaches osteoporosis asthma/COPD stroke HIV/AIDS hepatitis stomach ulcer arthritis congestive heart disease

Circle all current positive findings:

Constitutional: wt loss fever chills
Eyes: blurry vision dry eyes double vision
ENT: hoarseness hearing loss nose bleeds swallowing problems
Cardiovascular: chest pain palpitations swelling of legs or feet
Respiratory: short of breath cough
Gastrointestinal: nausea vomiting diarrhea constipation pain
Genitorurinary: increased urinary frequency incontinence
Skin: rash hives hair loss itching
Musculoskeletal: joint pain muscle aches muscles weakness back pain
Endocrine: increased thirst excessive sweating heat/cold intolerance
Neurological: seizures tremors headaches/migraines loss of balance dizziness
Hem/Lymphatic: easy bruising swollen lymph nodes
Allergic/Immunologic: allergic reactions hay fever frequent infections

Name _____ Date _____

FAMILY HISTORY

Children's Names and Ages _____

_____

Were you raised by: Both Parents? _____ Single Parent? _____ Relative? _____ Other? _____

Father's Name/Occupation _____

Mother's Name/Occupation _____

Brothers/Sisters in birth order: (Include Ages) _____

Family History of: (who, what)

Alcoholism or Substance Abuse? _____

Mental Illness? _____

Prolonged Physical Illness? _____

Your Education: Highest Degree: _____ Field of Study: _____

Religious Background: _____ Current Religion: _____

I, or _____, will be responsible for any charges for evaluation or treatment by Drs. Sarah L. Jones, Michael J. Sedlacek, Janet P. McGivern, Todd K. McKee, Cheryl J. Buda, Brian Lubberstedt and his/her associates in this office. I understand that I am responsible for payment for consultation not canceled 24 hours in advance. I understand that payment if charges incurred is due at the time of service, unless other definite financial arrangements have been made prior to treatment. I hereby authorize the clinician to furnish information to insurance carriers concerning my treatment. I understand that I am responsible for all payments. Any monies received by the clinician from above insurance companies, over and above my indebtedness, will be refunded to me when my bill is paid in full. I understand any returned checks will subject me to a $25.00 returned check charge.

I have read and fully understand the above consent for treatment, financial responsibility, release of medical information, and insurance authorization.

Patient's Signature _____ Date _____

Parent/Guardian's Signature _____ Date _____

We will be happy to file your insurance claim, but your co-payment and/or your portion of the bill is expected at the time of service. We will be happy to discuss fees, schedule of payment, or any other question relating to billing or insurance.

ACKNOWLEDGMENT OF PRIVACY NOTICE

The undersigned hereby acknowledges receipt of the Notice of Privacy Practices of Psychiatric Services, PC.

Signature _____

Print name _____

Date _____