Clinic Standards and Practices - Minors

STOP AND READ BEFORE COMPLETING

Currently for psychiatric Med Management services, Helios is only accepting patients 8 & up.

Behavioral Health Therapy Services accept both adults and minors 8 & up depending on staffing availability.

A list of accepted insurances can be found on our website.
www.heliospsych.com

Please be sure to check with your insurance that these services are covered.

Please note that insurance will not cover both Medication Management & Therapy on the same day. If you will be seeing a therapist & prescriber, you need to schedule them on different days.

If you do not have any insurance or have an insurance other than a Medicaid plan, and would like to pay out of pocket, we do offer CASH payment. You must pay for services prior to the appointment.

Prior to scheduling an Intake appointment, the following is required:
Intake forms filled out completely.

- **Picture of all insurance cards (front & back)**
- **Picture of patient's and/or legal guardian's ID (front & back)**
- **Additional forms/documents as necessary**
  - **Hospital Discharge paperwork**
  - **Any & all court ordered documents**
  - **Legal guardianship papers**

They can be emailed to: intake@heliospsych.com. Or faxed to 586-863-4004 Attention: Intake Department

If you have any questions regarding this information, please call our office at 586-863-4000 and inquire about New Patient Services prior to completing the attached forms.

Due to legislative changes, we are now requiring that patients who will need a controlled substance prescription be seen in person at least once prior to getting that prescription. We cannot make exceptions to the policy.

Per new Medicaid telehealth guidelines: Patients with any form of Medicaid insurance (including secondary) must have their initial evaluations in person. Follow-up appointments via telehealth will be up to the discretion of the Clinician.

Appointment requirements:

- **A parent or guardian must be present for all medication management appointments.**
- **A parent or guardian must accompany and be available during all therapeutic appointments. However, aside from the initial intake or evaluation appointment, it is not necessary for the parent/guardian to be physically present during the session.**
- **Children under the age of 13 cannot be left unattended in the Helios Psychiatry & Counseling lobby at any time.**

Patient Full Legal Name: __________________________________ Patient DOB: _______________

Sign here to acknowledge that you understand these requirements:

____ Date: ______________________

Signature of Parent or Legal Guardian

In this packet you will receive the following:

Notice of Privacy Policies and Practices
Client Financial Responsibilities
Client Bill of Rights
Code of Conduct for Patients
Permission for Telehealth
Discharge Policy

Please follow-up with office if you have any additional questions or concerns.

I have been encouraged to ask any questions about the forms.

Patient Full Legal Name: ___________________________________ **Patient DOB**: _______________

_______________________________ _______________________________

Parent/Guardian Printed Name **Date Signed**

____

Parent or Legal Guardian's Signature

Minor Patient Initial Intake Form

Patient's Legal Name: ____ DOB: ___/____/______

Patient's preferred name: ____

Street Address: ____

City: ____ State: ___________ Zip: ___________

Home phone: ____________ **Cell phone: ___________ Email Address: ______________________**

Phone number for reminders: ___________________________ Text: _______ or Call: ________

How did you hear about Helios Psychiatry?____

Primary Insurance:______________________ **Name of Ins Subscriber: ______________________**

ID#: ______________________ Group#: ___________ **Subscriber's DOB: ___/___/_____**

Subscriber's full address: ____

Secondary Insurance: __________________ Name of Ins Subscriber: ________________________

ID#: ______________________ Group#: ___________**Subscriber's DOB: ____/____/_____**

Subscriber's full address: ____

Third Insurance: ______________________ Name of Ins Subscriber: ________________________

ID#: ______________________ Group#: ___________**Subscriber's DOB: ____/____/_____**

Subscriber's full address: ____

Please print name(s) of parents: ____

**Other Caregivers involved with treatment: ____

**Please update Release of information to reflect the addition of any person(s) as necessary.

Emergency Contact: ____Relationship: ________________

Emergency Contact Phone: ______________________________ **(Please note this person should be added to ROI)**

Pharmacy: ____ Pharmacy Phone#: ________________

Pharmacy Address: ____

Does the patient have a legal guardian other than biological parents? Yes No

If legal guardian is court appointed, legal documentation is required prior to initial intake appointment.

Signing this document means that you agree that this information is true and accurate to the best of your knowledge.

☐Please take pictures of the front and back of your ID & all insurance cards and email them to:

intake@heliospsych.com <u>This information must be submitted in order to be scheduled.</u>

Minor Patient's Signature: ____ Date signed: ____________

Parent or Legal Guardian's signature: _______________________________________ Date signed: ___________

Helios Psychiatry & Counseling

Notice of Privacy Policies and Practices

The following notice describes how your medical information may be used and made known, and how you can get access to this information. Please review the information carefully. Helios maintains HIPAA compliance.

- Your private healthcare information may be released to other healthcare professionals within Helios Psychiatry and Counseling for the purpose of providing appropriate care.
- Your private healthcare information may be released to your insurance company for the purpose of Helios Psychiatry and Counseling receiving payment for providing you with needed healthcare services.
- Your private healthcare information may be released to public or law enforcement officials in the event of an investigation in which you are a victim of abuse, a crime or domestic violence.
- Your private healthcare information may be released to other healthcare providers in the event you need emergency care.
- Your private healthcare information may be released to a public health organization or federal organization in the event of a communicable disease or to report a defective device or problematic event to a biological product (food or medication).
- Your private healthcare information may not be released for any other purpose than that which is identified in this notice.
- Your private healthcare information may be released only after receiving written permission from you. You may withdraw your permission to release private healthcare information at any time.
- You may be contacted by Helios Psychiatry and Counseling to remind you of any appointments, healthcare treatment options or other health services that may be of interest to you.
- Helios Psychiatry & Counseling may order blood work and/or urine drug screenings to ensure we are providing the most complete care possible. Refusal to comply may result in discontinuation of services.
- You have the right to limit the use of your private healthcare information. However, the agency may choose to refuse your limitation if it is in conflict of providing you with quality healthcare or in the event of an emergency situation.
- You have the right to receive private communication about your health status.
- You have the right to review and photocopy any/all portions of your healthcare information.
- You have the right to make changes to your healthcare information.
- You have the right to know who has accessed your private healthcare information and for what purpose.
- You have the right to possess a copy of this Privacy Notice upon request. This copy can be in the form of an electronic transmission or on paper.
- Helios Psychiatry and Counseling is required by law to protect the privacy of its patients. It will keep private any and all patient healthcare information and will provide patients with a list of duties or practices that protect private healthcare information.
- Helios Psychiatry and Counseling will abide by the terms of this notice. The agency reserves the rights to make changes to this notice and continue to maintain the privacy of all healthcare information. Patients will receive a mailed copy of any changes to this notice within 60 days of making the changes.
- You have the right to complain to the agency if you believe your rights to privacy have been violated. If you feel your privacy rights have been violated, please mail your complaint to Helios Psychiatry and Counseling:

Helios Psychiatry and Counseling
ATTN: Office Manager
30472 23 Mile Road
Chesterfield, MI 48047

All complaints will be investigated. No personal issue will be raised for filing a complaint with the agency. For further information about this Privacy Notice, please call us at 586-863-4000.

Patient's Printed Name: ____ DOB: ____________________

Patient/Legal Guardian Signature: ______________________________________ Date signed: ______________

HELIOS PSYCHIATRY & COUNSELING
PATIENT FINANCIAL RESPONSIBILITIES

To reduce confusion and misunderstanding between our patients and practice, we have adopted the following financial policies. If you have any questions regarding these policies, please discuss them with our office manager. We provide the best possible care and service to you and regard your complete understanding of your financial responsibilities as an essential element of your care and treatment.

- It is the **patient's responsibility** to contact insurance carrier to review and confirm coverage for behavioral health services. Staff will work with patients on obtaining authorizations for select insurance carriers. A quote of benefits is not a guarantee of benefits or payment. Helios Tax ID# 46-2781294.

- It is the policy of Helios Psychiatry that full payment is due **at the time of service** unless other financial arrangements are made in advance. Payment plans must be arranged for outstanding balances, or the account will be sent to a collection agency. Any credit can be applied to future services. All accounts sent to collections are subject to the following additional fees: Amounts under $1000 will incur a $50 fee. Amounts over $1000 will incur a $100 fee.

- Please note, most insurances will not cover two behavioral health sessions in the same day. Helios policy states psychiatric & therapy services cannot be scheduled on the same day.

- Helios offers a cash payment option if you do not have insurance or do not want to utilize your insurance to cover services. This is NOT an option for people with a form of Medicaid insurance.
    - If you choose to use this option, and do NOT have a form of Medicaid insurance please initial here: ____
    - **Please select Waiver of Insurance billing packet from our website and complete along with this intake packet. Or call or office at 586-863-4000 to request that this packet be sent to you.**

- Helios Psychiatry is happy to complete forms as needed for patient care. Allow at least 5 business days for forms to be completed, and additional time if they need to be returned via mail. Please ensure that all patient information is complete including insurance information. Fees will be assessed as follows:
    - 1–2-page form: $30
    - 3 or more pages: $60
- Any Disability, FMLA, or government **forms** for any New Patients will require **2 - 3 office appointments** for proper evaluation and assessment by provider. Established patients must come in for a consult as these matters cannot be handled over the phone. This is not a guarantee of approval/ denial for such legal forms as it is up to the Provider's discretion for authorization.

- **Medical records request** – Paper copies will be charged as follows: $1.00 per page for the first 20 pages; $0.25 each for every additional page. Payment must be received in advance.

- **Active Balance Policy:** We will not schedule patients who carry a balance larger than $300, unless a payment plan has been set up with our Patient Support Specialist and is being adhered to. Payments must be made in a timely manner.

- Patients may incur a $75 fee for a no show or late cancellation, which is less than **48 hour's notice** prior to the scheduled appointment start time.

Printed Name of Patient: ____ DOB: _________

Signature of Patient or Guardian: ____ Date: ___________

Client Bill of Rights

- Each client has a right to impartial access to treatment, regardless of race, religion, sex, sexual preference, marital status, veteran status, ethnicity, age or disability. The personal dignity of each client is recognized and respected in all care or treatment provided.
- Each client has the right to accept or refuse all or part of his/her care and/or have the expected consequences explained.
- Each client has the right to exercise personal privacy by designating release of information, and to be informed of the possible consequences of that action.
- Each client has the right to be informed of the nature and purpose of any services rendered and the title of personnel providing that service.
- Each client has the right and expectation to participate in the development of treatment plan and implementation.
- An individualized treatment which includes:
  - Personalized treatment goals
  - Services provided in the least restrictive environment possible, related to patient's level of care needs.
  - Definition of clinical services to be offered.
  - Treatment plans will be reviewed periodically or as needed.
- The client has the right to request referrals for services not offered through Helios or to support the discharge process.
- The client will be informed of his/her rights in a language they can understand.
- Each client has the right to refuse to participate in any research projects without compromising their access to the organization's resources.
- Each client has the right to be notified of any/all costs of services rendered, the source of the organization's reimbursement, and any limitations placed on duration of services.
- Each client has the right to make decisions regarding the withholding or resuscitative measures with these decisions respected per agency policy.
- Patients have the right to report grievances and concerns to management staff.

Recipients have rights protected by state and federal law and promulgated rules. For information contact:

Office Manager
30472 23 Mile Road
Chesterfield, MI 48047

Patient Printed name: ____DOB: ______________

Patient or Legal Guardian Signature: ___________________________________ Date signed: ________

Helios Psychiatry & Counseling
Code of Conduct for Patients

To provide a safe and healthy environment for staff, visitors, patients and their families, *Helios Psychiatry and Counseling* expects visitors, patients and accompanying family members to refrain from unacceptable behaviors that are disruptive or pose a threat to the rights or safety of other patients and staff.

As a patient visiting our practice, please consider the following:

- Treat staff & fellow patients with dignity & respect.
- Bring grievances or concerns regarding services or care directly to our management team.
- Arrive on time to any appointments.
- Utilize appointment time appropriately.
- Follow Helios Psychiatry & Counseling cancellation policy.
- Questions about your billing can be addressed first with our Patient Support Specialist, and then with Elite Medical Billing.
- High balances will be investigated. Unless an agreed upon payment plan is set up and adhered to, there may be a disruption of services if the amount reaches $300 or more.
- Our practice follows a zero-tolerance policy for aggressive behavior directed by patients against our staff.
- Please be courteous with the use of your cell phone and other electronic devices. When interacting with any of our staff, please put your devices away. Set the ringer to vibrate before storing away.
- Minors are expected to be supervised at all times by parent/guardian.
- Helios does accommodate trained service animals only in accordance with ADA.
    - Helios requires appropriate documentation prior to bringing in a service animal.
    - Emotional Support animals are not permitted.

The following behaviors are prohibited & can lead to discharge from the clinic:

- Firearms or any weapon are not permitted on any Helios properties
- Intimidating or harassing staff or other patients
- Making threats of violence through phone calls, letters, voicemail, email or other forms of written, verbal or electronic communication
- Physically assaulting or threatening to inflict bodily harm to another person or property
- Making verbal threats to harm another individual or destroy property
- Making racial or cultural slurs or other derogatory remarks

If you are subjected to any of these behaviors or witness inappropriate behavior, please report to any staff member. Violators are subject to removal from the facility and/or discharge from the practice.

Your signature confirms understanding of Helios Code of conduct.

Patients printed name: ____ DOB: _______________

Patient or Legal Guardian signature: ________________________________ Date of signature: _________

Helios Psychiatry & Counseling Discharge Policy

- Helios Psychiatry & Counseling reserves the right to discharge any client who does not comply with practice policies and procedures.
- Helios Psychiatry & Counseling reserves the right to discharge any client who is not committed to and/or neglects personal responsibility in achieving mutually determined treatment goals.
- Discharge due to NCNS/Late Cancellations
  - A late cancellation is defined as any cancellation within 48 hours of the start of the appointment time. It is at the discretion of the provider to determine whether or not circumstances warrant an excused NCNS or cancellation.
    - Three unexcused no call no shows or late cancellations within a 6-month period may result in discharge from the practice.
    - All unexcused NCNS or late cancellations are subject to a cancellation fee. After 3 NCNS or late cancellations, all late fees must be paid prior to scheduling further appointments.
- A client who has an outstanding balance for 3 months or more, with the exception of having made incremental payments or maintaining compliance with a payment plan, is subject to being sent to collections as well as discharge from Helios Psychiatry & Counseling.
  - Clients who have been sent to collections more than once are not eligible to restart services with Helios Psychiatry & Counseling.

Any client discharged from Helios Psychiatry & Counseling, either partially or fully, has the option to contact front desk staff for other local provider information. Despite being discharged from therapeutic or medication management services at Helios, we sincerely wish for your continued success in your mental health journey.

Your signature confirms that you have read and understand the above Policy.

Patient Printed Name: ____ DOB: ________________

Patient or Legal Guardian Signature: ___________________________________ Date Signed:______________

Permission for Telehealth Visits

How do I use telehealth?

- You talk to your provider by phone, computer, or tablet.
- You use video and audio so you and your provider can see and hear each other.
- There are no apps to download.
- Helios Psychiatry and Counseling uses our website for accessing telehealth appointments using Doxy. Doxy is a secure telemedicine platform, which is HIPAA compliant.
- A few minutes before your scheduled appointment, you will need to visit our website at www.heliospsych.com. Scroll down to your Provider and click on the link that says 'CLICK HERE' under their picture, and follow the instructions. You will need to agree to allow access to your camera and microphone. This allows you to see and hear each other.
- It is the responsibility of the patient to ensure appropriate connectivity to avoid disruption of telehealth services.
- Call the office immediately, if you have any problems signing in for your scheduled appointment, or if you are experiencing connectivity issues.

Will my telehealth visit be private and safe?

- Helios uses Doxy.me for telehealth appointments, which is a secure telemedicine virtual platform, that is HIPAA compliant.
- Patients utilizing telehealth services must ensure they are in a safe & private location.
- If you are in your vehicle, the vehicle must remain in park for the duration of the session.

What if I want an office visit, not a telehealth visit?

- You can request in office appointment instead of telehealth. You may have to wait a little longer for an in-office appointment.

What if I try telehealth and don't like it?

- You can still get an office visit if you no longer want a telehealth visit.
- If you decide you do not want to use telehealth again:
  - call 586-863-4000 and let staff know that you need an in-office appointment.

<u>What does it mean if I sign this document?</u>

By signing this document, you agree that:

- You understand that you cannot be driving a vehicle during a telehealth appointment.
- You understand that you need to be in a location with good cellular service and/or strong WIFI signal.
- Understand that your provider may decide you still need an office visit.
- You agree that you are responsible to attend your scheduled appointment or call 48 hours prior to cancel.
- I reviewed and understood the above information.

____

Your name and patient's name, if patient isn't signing (please print all) Patient's DOB: ____________

____

Signature of patient or Legal Guardian Date of signature

Helios Psychiatry and Counseling
Psychiatric Intake

Client Name:____ Date of Birth:____________

Age:___ Sex:___ Race:______

What brings you in for an assessment today? ____

Past Psychiatric History:

Have you ever been in a psychiatric hospital/ward? Yes No

How many times: ______

When was the first time? ______

When was the last time? ______

Have you ever attempted suicide? Yes No

How many times: ______

When was the last time? __________________________

How have you attempted? ___________________________

Have you ever seen a psychiatrist before? Yes No

When was the last time? ____________

Please provide the name and phone number _____________

Do you currently have a therapist? Yes No

Please provide the name _____________

And phone number _____________

Your Medical History:

_____ Heart Disease
_____ Diabetes
_____ Asthma/COPD
_____ Arthritis
_____ Fibromyalgia

_____ N/A
_____ Stroke
_____ Hypertension / high blood pressure
_____ High cholesterol / lipids
_____ Thyroid Issues
_____ Cancer: Specify ________________

Other:

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

List any surgeries you have had:

__________________________________ __________________________________

__________________________________ __________________________________

__________________________________ __________________________________

Helios Psychiatry and Counseling
Psychiatric Intake

Who is your primary care doctor? ______________________________ **Dr office phone #:** ____________________________

Allergies: No known drug allergies _____ **OR** ____

Please list all the medicines you take, including over the counter medications/supplements/vitamins

Current Medications	Dose	When do you take it?	What is it taken for?

Family Psychiatric History:

Mother:

Father:

Brother:

Sister:

Grandmother:

Grandfather:

Anyone else:

Any Suicides in the family? Yes No

Helios Psychiatry and Counseling
Psychiatric Intake

Social History:

Marital Status: Married ____ Divorced ____ Widowed ____ Single ____

Please list the ages and sex of your children:

________________________________ ________________________________

________________________________ ________________________________

________________________________ ________________________________

Who do you live with? ________________________________

Which options below best describes your social situation?

Supportive social network Few friends No friends

Education level: High School Diploma Some College College Grad Post-Graduate Degree

Less than High School (Grade completed: ___) GED

Occupation:

Do you have any legal problems? Yes No

Substance Use History:

How frequently do you drink alcohol? __________________________

How much do you drink at a time? ____________________________

Have you recently (within the last month) used any street drugs? Yes No

Which? ____

Do you have a history of abusing street drugs or alcohol? Yes No

Alcohol: Age first used: ___________ Age last used: ___________

Cocaine: Age first used: ___________ Age last used: ___________

Marijuana: Age first used: ___________ Age last used: ___________

Heroin: Age first used: ___________ Age last used: ___________

Amphetamines: Age first used: __________ Age last used: ___________

Benzodiazepines: Age first used: __________ Age last used: ___________

Other: _______________ Age first used: __________ Age last used: ___________

Do you or have you taken more of your prescription medications than you are/were supposed to? Yes No

Have you ever been in treatment for any substances? Yes No

If yes, when & where? ____

Patient Preference Sheet

Patient's Preferred Name: ______________________________ **Pronouns:**______________

What Service Options are you looking for: ***Select all that apply***

- ☐ Psychiatric Medication Management
- ☐ Psychotherapy / Talk Therapy
- ☐ General Evaluation for Diagnosis
- ☐ Both Medication Management and Talk Therapy
- ☐ Special Request-_________________________

What is your Preferred method of Receiving Communication From Helios?

- ☐ Phone Call
- ☐ Text
- ☐ Any of the above

Do you give Helios Psychiatry & Counseling staff permission to leave detailed voicemails?

- ☐ Yes, I consent to Helios staff leaving detailed voicemails on the contact number provided.
- ☐ No, please leave a generic voicemail & I will return your call.

Provider Preference Requests*:

**At Helios we do our best to match patients with providers who meet the requested preferences, however, we can not guarantee that we will have available staff. Waitlist options are available.*

Type of Visits:

- ☐ In Office *(Select location)*: [ ]-Troy [ ]-Chesterfield
- ☐ Telehealth
- ☐ No preference

Appointment Time Preference: *(Select all that apply)*

- ☐ Morning
- ☐ Afternoon
- ☐ Evening

Provider Preferences:

- ☐ Female
- ☐ Male
- ☐ No preference

Life Experience Areas: (*Check all that apply*)

[ ]-Addiction, [ ]-Relationship Issues, [ ]- Aging Parents Concerns, [ ]-Parenting Concerns,

[ ]-Organizational Skill Building, [ ]-Chronic Illness/ Pain, [ ]-End of Life, [ ]-Career Concerns,

[ ]-LGBTQi + Concerns, [ ]-Trauma Processing, [ ]- Grief & Loss

PHQ-9

<u>This Must be filled out by the patient**</u>** **Patient:**

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please only select one answer per question. Failure to complete this form may delay scheduling your appointment.	**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

Total

GAD-7

<u>This Must be filled out by the patient**</u>**

Over the last 2 weeks, how often have you been bothered by any of the following problems?

Please only select one answer per question. Failure to complete this form may delay scheduling your appointment.	**Not at all**	**Several days**	**More than 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 is 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

Mood Disorder Questionnaire-Must be filled out by the patient

Please only select one answer per question. Failure to complete this form may delay scheduling your appointment.	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 much 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 into 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?		
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please circle one response only. No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had bipolar disorder?		
5. Has a health professional ever told you that you have bipolar disorder		

Generic Name	Trade Name	When Tried	Reaction (Positive/Negative)
Acamprosate	Campral		
Buprenorphine	Subutex, Suboxone		
Disulfiram	Antabuse		
Methadone	Dolophine		
Naltrexone	ReVia, Vivitrol		
Varenicline	Chantix		
Amphetamine salts	Adderall		
Atomoxetine	Strattera		
Clonidine	Kapvay		
Dexmethylphenidate	Attenade, Focalin		
Dextroamphetamine	Dexedrine, Dextrostat		
Guanfacine	Intuniv		
Lisdexamfetamine	Vyvanse		
Methylphenidate	Concerta, Daytrana, Methylin, Ritalin		
Alprazolam	Xanax		
Buspirone	BuSpar		
Chlordiazepoxide	Librium		
Clonazepam	Klonopin		
Diazepam	Valium		
Hydroxyzine	Atarax, Vistaril		
Lorazepam	Ativan		
Oxazepam	Serax		
Pregabalin	Lyrica		
Carbamazepine	Carbatrol, Equetro, Tegretol		
Gabapentin	Neurontin		
Lamotrigine	Lamictal		
Lithium salts	Eskalith, Lithobid		
Oxcarbazepine	Trileptal		
Topiramate	Topamax		
Valproic Acid	Depakote, Depakene		
Amitriptyline	Elavil		
Bupropion	Wellbutrin		
Citalopram	Celexa		
Clomipramine	Anafranil		
Desipramine	Norpramin		
Desvenlafaxine	Pristiq		
Doxepin	Sinequan		
Duloxetine	Cymbalta		
Escitalopram	Lexapro		
Fluoxetine	Prozac		
Fluvoxamine	Luvox		
Imipramine	Antideprin		
Mirtazapine	Remeron		
Nortriptyline	Pamelor		
Olanzapine/fluoxetine	Symbyax		
Paroxetine	Paxil		
Phenelzine	Nardil		
Sertraline	Zoloft,		
Tranylcypromine	Parnate		
Trazodone	Desyrel		
Venlafaxine	Effexor, Efexor XR		
Vilazodone	Viibryd		
Vortioxetine	Trintellix		
Amobarbital	Amytal Sodium		
Diphenhydramine	Benadryl		
Doxylamine	NyQuil, Unisom SleepTab		
Estazolam	ProSom		

Generic Name	Trade Name	When Tried	Reaction (Positive/Negative)
Eszopiclone	Lunesta		
Flurazepam	Dalmane		
Melatonin	Circadin		
Midazolam	Buccolam, Busulfex, Nayzilam, Seizalam		
Phenobarbital	Luminal		
Promethazine	Phenergan, Promethegan		
Ramelteon	Rozerem		
Sodium oxybate	Xyrem		
Temazepam	Restoril		
Triazolam	Halcion		
Zaleplon	Sonata		
Zolpidem	Ambien		
Zopiclone	Somnol		
Aripiprazole	Abilify		
Brexpiprazole	Rexulti		
Asenapine	Saphris		
Chlorpromazine	Thorazine		
Clozapine	Clozaril, Fazaclo		
lumateperone	Caplyta		
Fluphenazine	Prolixin		
Fluspirilen	Imap		
Haloperidol	Haldol		
Iloperidone	Fanapt		
Olanzapine	Zyprexa		
Paliperidone	Invega, Sustenna		
Perphenazine	Trilafon		
Lurasidone	Latuda		
Cariprazine	Vraylar		
Pimozide	Orap		
Quetiapine	Seroquel		
Risperidone	Risperdal, Consta		
Thioridazine	Melleril		
Thiothixene	Navane		
Trifluoperazine	Stelazine		
Ziprasidone	Geodon		
Pergolide	Permax		
Pramipexole	Mirapex		
Ropinirole	Requip		
Tramadol	Ultram		
Armodafinil	Nuvigil		
Modafinil	Provigil		
PLEASE LIST OTHER MEDS TRIED FOR PSYCHIATRIC PURPOSES (REASON ALSO)			

Request/Authorization for Release of Information

I ____ hereby authorize Helios Psychiatry and Counseling to release information contained in client records to the following individual(s) and/or organizations(s), and only under the conditions below:

- Name of person(s), organizations(s), address to who disclosure is to be made:

  ______________________________ Contact#: ______________________________
  ______________________________ Contact#: ______________________________
  ______________________________ Contact#: ______________________________

- □ Disclose entire record

  OR:

  □ Diagnosis □ Drug/Alcohol History □ Treatment Summary
  □ Attendance □ Mental Status Exam □ School Records
  □ Progress □ Physical Examination □ Prognosis
  □ Discharge Summary □ Other: _____________________________

- Purpose of disclosure:

  □ Continuity of Treatment □ P.O./Attorney/Judge/Court □ Provision of Mental Health Services
  □ Aftercare Planning □ Billing Purposes □ Family Involvement

- Without expressed revocation, this consent expires 90 days after discharged from treatment.

- This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding that the consent will continue unrevoked until the purpose of which the consent was given shall have been accomplished. However, any consent given under Subpart C, Federal Register, Volume 40, Number 127, July 1, 1975, shall have a duration no longer than that reasonably necessary to effectuate the purpose for which it is given.

____ _____________________

Name of Patient Patient's DOB

____ ______________________

Client (Guardian) Signature Date

____ _______________________

Staff Signature Date

Request/Authorization for Release of Information

I, ___________________, hereby authorize (other healthcare provider) _________________________

Contact # of Provider of information: __________________________

to release information contained in client records to the following organizations, and only under the conditions below:

- Name of person(s), organizations(s), address to who disclosure is to be made:

  Helios Psychiatry and Counseling
  30472 23 Mile Road — Phone: 586-863-4000
  Chesterfield, MI 48047 — Fax: 586-863-4004

- □ Disclose entire record
  OR:

□ Diagnosis	□ Drug/Alcohol History	□ Treatment Summary
□ Attendance	□ Mental Status Exam	□ School Records
□ Progress	□ Physical Examination	□ Prognosis
□ Discharge Summary	□ Other: _____________________________	

- Purpose of disclosure:

□ Continuity of Treatment	□ P.O./Attorney/Judge/Court	□ Provision of Mental Health Services
□ Aftercare Planning	□ Billing Purposes	□ Family Involvement

- Without expressed revocation, this consent expires 90 days after discharged from treatment.
- This consent is subject to revocation at any time except in those circumstances in which the program has taken certain actions on the understanding that the consent will continue unrevoked until the purpose of which the consent was given shall have been accomplished. However, any consent given under Subpart C, Federal Register, Volume 40, Number 127, July 1, 1975, shall have a duration no longer than that reasonably necessary to effectuate the purpose for which it is given.

____ ______________________

Patient's Name — Patient's DOB

____ ______________________

Client (Guardian) Signature — Date

____ _______________________

Staff Signature — Date