QSR Psych Solutions, LLC

PATIENT INFORMATION

Name: _____

Name you prefer to be called: _____

Date of birth: _____ SSN: _____ Gender: Male Female

Current address: _____

City: _____ State: _____ ZIP Code: _____

Cell Phone: _____ May we leave a message at this number? _____

Home Phone: _____ May we leave a message at this number? _____

Alternate Phone: _____ May we leave a message at this number? _____

Marital Status: _____ Name of Spouse: _____

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Current address: _____

City: _____ State: _____ ZIP Code: _____

Cell Phone: _____ May we leave a message at this number? _____

Alternate Phone: _____ May we leave a message at this number? _____

GENERAL INFORMATION

Referred by: _____ Phone Number: _____

Primary Care Physician: _____ Phone Number: _____

Primary Language: _____

List all Medication Allergies: _____

Do you have any visual, auditory or other forms of disability that affect your daily living? Yes No

If Yes, please explain: _____

FOR OFFICE USE ONLY

OPI: ETOH: BZO: POLY: Other:

QSR Psych Solutions, LLC
12855 N Outer 40 Rd. Suite 385
Saint Louis, MO 63141

QSR Psych Solutions, LLC

INSURANCE INFORMATION

PRIMARY INSURANCE

Policyholder's Name: _____

Patient's Relationship to Policyholder: _____

Policyholder's Address (if different from patient's): _____

Policyholder's Social Security Number: _____

Policyholder's Date of Birth: _____

Employer Holding Insurance Policy: _____

Employer's address: _____

City: _____ State: _____ ZIP Code: _____

Insurance Company: _____ Insurance Phone: _____

Plan Name: _____

Enrollment Date: _____ ID #: _____ Group #: _____

SECONDARY INSURANCE ☐ I acknowledge that I do not have a secondary insurance _____

Policyholder's Name: _____

Patient's Relationship to Policyholder: _____

Policyholder's Address (if different from patient's): _____

Policyholder's Social Security Number: _____

Policyholder's Date of Birth: _____

Employer Holding Insurance Policy: _____

Employer's address: _____

City: _____ State: _____ ZIP Code: _____

Insurance Company: _____ Insurance Phone: _____

Plan Name: _____

Enrollment Date: _____ ID #: _____ Group #: _____

I understand that billing my insurance company is an additional service being provided and that it is my responsibility to provide complete and accurate information to aid the billing process. It is my responsibility to keep QSR aware of any changes or modifications to my insurance coverage. Use of this billing service does not remove my responsibility for any or all changes incurred in treatment.

_____ _____ _____

Patient or Responsible Party's Signature Print Name Date

QSR Psych Solutions, LLC
12855 N Outer 40 Rd. Suite 385
Saint Louis, MO 63141

QSR Psych Solutions, LLC

Consent for Treatment

I, _____ (patient's name), voluntarily request to receive medical treatment from QSR Psychiatric Solutions. I understand that this consent is for any of the services or programs which are provided by QSR Psychiatric Solutions. I consent to the administration of treatment deemed necessary by my physician(s) who attend me, their associates, employees of QSR, and other healthcare professionals responsible for my care. I understand that care may consist of a physical exam, medical assessment, nursing and counseling/social work assessments, laboratory tests, treatment planning, individual and group treatments, discharge planning, care coordination, as well as prescribing and administration of medications.

The purpose of my participation in treatment has been described to me. I understand that the specific care proposed for me, including the benefits and risks, may be further discussed with me by my physician, nursing or counseling staff. I agree to attend and participate in all scheduled treatment activities as described in my treatment/services plan. I understand that I have the right to ask for clarification of services and interventions and to decline the services and interventions at any time. I acknowledge that no guarantees have been made to me as to the effect of treatment or prognosis of my condition.

I understand that in the event of an emergency I may be transferred to a hospital or emergency medical facility better equipped than QSR to provide emergency and/or comprehensive medical care.

Assignment of Benefits and Release of Information

I understand that my express consent is required to release any health care information relating to testing, diagnosis, medications and or treatment for psychiatric disorders or drug/alcohol abuse/dependence. I give my consent for QSR to release medical including information for psychiatric and or drug/alcohol abuse or dependence and other relevant information as required by my insurance company to process medical billing. I authorize direct payment to QSR of all insurance benefits applicable to this episode of care which are now or which shall become due and payable to me. In addition, I authorize direct payment to the company of all insurance benefits applicable to medical services rendered by physicians for whom QSR is authorized to charge and bill. I understand that QSR works with physicians who are independent contractors. I consent to the assignment of benefits and release of information stated above as it may pertain to those independent contractors.

Financial Responsibility

In accordance with the above terms in consideration of the service rendered to the patient designated herein, I guarantee and agree to pay QSR charges for those services rendered, including any deductibles, coinsurance or amounts not paid by my insurance plan, health service plan or health maintenance organization. By signing this document, the patient and guarantors acknowledge and agree they are responsible for payment of billed charges rendered in any case in which payment may be denied by the health

maintenance organization (or preferred provider organization), or other insurance provider.

Release of Information

I acknowledge that there are instances when QSR must release information concerning my care, including information related to my mental health, substance abuse, HIV and/or AIDS, including copies of my medical records, to certain individuals or entities who are involved in my care, payment for my care, and other activities related to my care. Information may be released to: any healthcare provider within QSR who is participating in providing my care or supervision of those who are providing my care, any federal, state or other governmental or quasi-governmental agencies or other such parties as required by law for the purposes of reporting, any person or entity participating in quality studies, utilization review or similar studies of the care rendered by the Organization. Also, any partner/referral agencies with signed MoU's, for the purpose of continuity of care.

I understand that my failure to comply with any of the above conditions will be regarded by the staff as my request for immediate discharge.

I acknowledge that I been provided a copy of QSR's Notice of Privacy Practices and a copy of the Patient Rights and Responsibilities.

Patient Name (Print): _____ Patient DOB: _____

Patient Signature: _____ Date: _____

Staff Witness Name: _____

Staff Signature: _____ Date: _____

QSR Psych Solutions, LLC

I, ______________________________________ (patient or guardian), authorize the treatment team of the QSR Psychiatric Solutions **(hereinafter referred to as "QSR"), its employees or agents to** release specified confidential medical, psychiatric, substance abuse/dependence, HIV/AIDS test results or diagnosis, and/or information obtained in the diagnosis and treatment at the organization to the below indicated persons/agencies and for the stated reasons. I understand that this authorization extends to all or any part of the records/information and I understand that QSR will not condition treatment on whether this authorization is signed. Unless expressly stated by the patient/guardian, release of information is authorized from the date of **signature through 30 days' post discharge.** The patient/guardian may revoke the release at any time by notifying the Organization in writing to the address listed on the bottom of this form. Such revocation will not have any effect on any actions that QSR took before receiving the revocation.

QSR asks that you consider giving release for coordination with: Primary care physician, Community psychiatrist, Community therapist, Family members, Pharmacy, PO, and DFS/DCFS.

Name/Agency	Relationship	Address and Phone Number	Purpose	Information to use or disclose
Type of release ☐ Oral/Verbal ☐ Written Revocation Date			☐ Coordination of Care ☐ Legal needs ☐ Insurance/Benefits ☐ Continuity of Care ☐ Prescription Management ☐ ___________	☐ Admission/Discharge Notification ☐ Participation/Attendance ☐ Progress ☐ Treatment Plan ☐ Discharge Plan/Summary ☐ Lab Results ☐ Prescriptions ☐ ___________
Type of release ☐ Oral/Verbal ☐ Written Revocation Date			☐ Coordination of Care ☐ Legal needs ☐ Insurance/Benefits ☐ Continuity of Care ☐ Prescription Management ☐ ___________	☐ Admission/Discharge Notification ☐ Participation/Attendance ☐ Progress ☐ Treatment Plan ☐ Discharge Plan/Summary ☐ Lab Results ☐ Prescriptions ☐ ___________
Type of release ☐ Oral/Verbal ☐ Written Revocation Date			☐ Coordination of Care ☐ Legal needs ☐ Insurance/Benefits ☐ Continuity of Care ☐ Prescription Management ☐ ___________	☐ Admission/Discharge Notification ☐ Participation/Attendance ☐ Progress ☐ Treatment Plan ☐ Discharge Plan/Summary ☐ Lab Results ☐ Prescriptions ☐ ___________
Type of release ☐ Oral/Verbal ☐ Written Revocation Date			☐ Coordination of Care ☐ Legal needs ☐ Insurance/Benefits ☐ Continuity of Care ☐ Prescription Management ☐ ___________	☐ Admission/Discharge Notification ☐ Participation/Attendance ☐ Progress ☐ Treatment Plan ☐ Discharge Plan/Summary ☐ Lab Results ☐ Prescriptions ☐ ___________

QSR Psych Solutions, LLC

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Type of release ☐ Oral/Verbal ☐ Written Revocation Date			☐ Coordination of Care ☐ Legal needs ☐ Insurance/Benefits ☐ Continuity of Care ☐ Prescription Management ☐ ______________	☐ Admission/Discharge Notification ☐ Participation/Attendance ☐ Progress ☐ Treatment Plan ☐ Discharge Plan/Summary ☐ Lab Results ☐ Prescriptions ☐ ________________
Type of release ☐ Oral/Verbal ☐ Written Revocation Date			☐ Coordination of Care ☐ Legal needs ☐ Insurance/Benefits ☐ Continuity of Care ☐ Prescription Management ☐ ______________	☐ Admission/Discharge Notification ☐ Participation/Attendance ☐ Progress ☐ Treatment Plan ☐ Discharge Plan/Summary ☐ Lab Results ☐ Prescriptions ☐ ________________
Type of release ☐ Oral/Verbal ☐ Written Revocation Date			☐ Coordination of Care ☐ Legal needs ☐ Insurance/Benefits ☐ Continuity of Care ☐ Prescription Management ☐ ______________	☐ Admission/Discharge Notification ☐ Participation/Attendance ☐ Progress ☐ Treatment Plan ☐ Discharge Plan/Summary ☐ Lab Results ☐ Prescriptions ☐ ________________

By signing this, Release of Information, you are in agreement with the terms and conditions of any MoU that has been signed and agreed upon by any partner/referral agency and QSR Psychiatric Solutions, LLC for the purpose of continuity of care.

Patient Name (Print): ______________________________ Patient DOB: ______________

Patient Signature: ______________________________ Date: ______________

Staff Witness Name: ____

Staff Signature: ______________________________ Date: ______________

QSR Psych Solutions, LLC

This notice describes how medical information about you may be used and disclosed and how you can get access to this information.

I. Our Privacy and Confidentiality Obligations

- We are required by law to maintain the privacy and confidentiality of information about your health, health care, and payment for services related to your health (referred to in this notice as "protected health information"), and to provide you with this notice of our legal duties and privacy practices with respect to your protected health information. When we use, or disclose this information, we are required to abide by the terms of this notice (or other notice in effect at the time of the use or disclosure).
- **Protected Health Information in connection with alcohol or drug services:** 42 CFR Part 2 protects your health information if you are applying or receiving treatment services for alcohol or drugs. This includes protecting diagnosis, treatment, or referrals related to alcohol or drug treatment. Generally, if you are applying for or receiving services for drugs or alcohol, we may not acknowledge to a person outside of QSR that you are receiving services from our program, except under certain circumstances that are listed in this notice.
- **All Protected Health Information, including alcohol or drug services:** the Health Insurance Portability and Accountability Act ("HIPAA") Privacy Regulations (45 CFR Parts 160 and 164), also protect your health information whether or not you are applying for or receiving services for drugs or alcohol. Generally, if you are receiving services that are not related to alcohol or drugs, the laws regulating disclosure of protected health information differ slightly and is less restrictive. Since our treatment at QSR is specifically for alcohol or drugs, we follow the stricter rules, as stated in 42CFR, which also satisfies HIPAA standards.

II. Uses and Disclosures With Your Authorization: All Protected Health Information

- Generally, we may use or disclose your protected health information when you give your authorization to do so in writing on a form that specifically meets the requirements of laws and regulations that apply.
- There are some exceptions and special rules that allow for uses and disclosures without your authorization or consent. They are listed in this notice.
- You may revoke your authorization except to the extent that we have already taken action upon the authorization. If you are currently receiving care and wish to revoke your authorization, you will need to deliver a written statement to a QSR staff member. If you wish to revoke authorization after discharging, you can send us a written notice of your revocation to 6651 Chippewa, Suite 224, Saint Louis, Missouri, 63109.

III. Uses and Disclosures Without Your Authorization: All Protected Health Information

- Even when you have not given your written authorization, we may use and disclose information under the circumstances listed below. This list applies to all protected health information, including the information we get when you are applying for or receiving services for drugs or alcohol.
  - i. Treatment: We may use or disclose your protected health information for treatment purposes among staff at QSR. Treatment includes diagnosis, treatment and other services, including discharge planning. For example, therapists may disclose your health information to each other or to nursing staff to coordinate your treatment, improve treatment, or discuss treatment alternatives.
  - ii. Health Care Operations: We may use or disclose your protected health information for the purposes of health care operations that include internal administration and planning and various activities that improve the quality and effectiveness of care. For example, we may use information about your care to internally evaluate the quality and competence of our staff. In any case, QSR staff would continue to maintain your privacy and confidentiality as a person who received services at QSR.
  - iii. Medical Emergencies: We may disclose your protected health information to medical personnel to the extent necessary to ensure your safety in a medical emergency (as defined by 42 CFR part 2).
  - iv. Judicial and Administrative Proceedings: We may disclose your protected health information in response to a court order that meets the requirements of federal regulations, 42 CFR Part 2 concerning Confidentiality of Alcohol and Drug Abuse Patient Records.
  - v. Commission of a Crime on Premises or against QSR Staff or other building staff: We may disclose your protected health information to the police or other law enforcement officials if you commit a crime on the premises or against staff, or if you threaten to do so.
  - vi. Child Abuse or Neglect, or Elder Abuse: We may disclose your protected health information for the purpose of reporting child or elder abuse and neglect to the appropriate authorities for abuse reporting.
  - vii. Duty to Warn: When the program learns that a patient has made a specific threat of serious physical harm to another specific person or the public, and disclosure is otherwise required under statute and/or common law, the program will carefully consider appropriate options that would permit disclosure.

viii. Audit and Evaluation Activities: We may disclose protected health information to those who perform audits or evaluation activities for certain health oversight agencies, e.g. state licensure or certification agencies, the Joint Commission on Accreditation of Health Care Organizations, which oversees the health care system and ensures compliance with regulations and standards.

IV. Your Individual Rights Regarding Your Protected Health Information

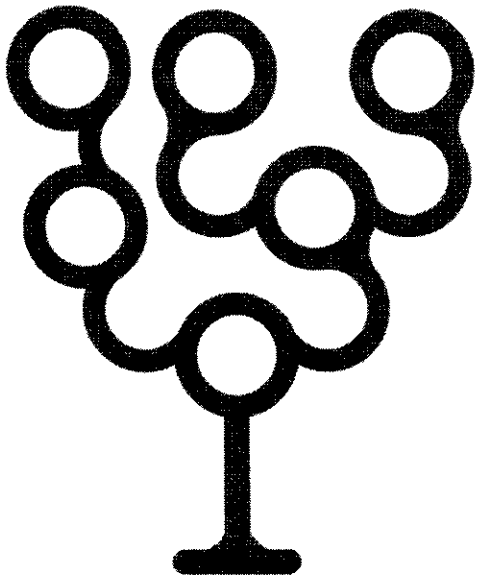
- Right to Receive Confidential Communications
- Right to Request Restrictions: You may request additional restrictions on our use and disclosure of protected health information for treatment, payment and health care operations. While we consider requests for additional restrictions carefully, we are not required to agree to a requested restriction. If you wish to request additional restrictions and you are currently receiving services, please notify your therapist or the Assistant Clinical Director. Once you are no longer receiving services, you may contact us in writing to request restrictions. We will send you a written response.
- Right to Inspect and Copy Your Health Information: You may request access to your clinical file and billing records maintained by us in order to inspect and request copies of the records. Under limited circumstances, we may deny you access to a portion of your records. If you desire access to your records and you are currently receiving services, please ask your counselor or therapist for the records. Once you are no longer receiving services, you can contact QSR directly in writing. If you request copies, there will be a charge for each page copied and you will be told the cost prior to the copies being made.
- Right to Amend your Records: You have the right to request that we amend protected health information maintained in your clinical file or billing records. If you desire to amend your records and you are currently receiving services, please contact your therapist or counselor. Once you are no longer receiving services, you may request an amendment to your records in writing. Under certain circumstances, QSR has the right to deny your request to amend your records and will notify you of this denial as provided in the HIPAA regulations. If your requested amendment to your records is accepted, a copy of your amendment will become a permanent part of the medical record. When we "amend" a record, we may append information to the original record, as opposed to physically removing or changing the original record. If your requested amendment is denied, you will be informed of your right to have a brief statement of disagreement placed in your medical records.
- Right to Receive Accounting of Disclosures: Upon request, you may obtain a list of instances that we have disclosed your protected health information other than when you gave written authorization OR those related to your treatment and payment for services, or our health care operations. The accounting will apply only to covered disclosures prior to the date of your request provided such period does not exceed six years. If you request an accounting more than once during a 12 month period, there will be a charge. You will be told the cost prior to the request being filled.
- Right to Receive a Paper Copy of this Notice: Upon request, you may obtain a paper copy of this notice.
- For Further Information and Complaints: I you desire further information about your privacy and confidentiality rights, you may contact the QSR Executive Director at (314) 645-6840 ext. 3757. You may call this number if you are concerned that we have violated your privacy rights, if you disagree with a decision that we made about access to your protected health information, or if you wish to complain about our breach notification process. You may also file a written complaint with the Secretary of the United States Department of Health and Human Services. Upon request, we will provide you with the correct address. We will not retaliate against you if you file a complaint.

- Violation of federal law and regulations on Confidentiality of Alcohol and Drug Abuse Patient Records is a crime and suspected violations of 42 CFR Part 2 may be reported to the United States Attorney in the district where the violation occurs.

V. Effective Date and Duration of This Notice

- Effective Date: May 20, 2013
- Right to Change Terms of This Notice: We may change the terms of this notice at any time. If we change this notice, we may make the new notice terms effective to all protected health information that we maintain, including any information created or received prior to issuing the new notice. If we change this notice, we will post the new notice in public areas at QSR and on our website at QSRmidwest.com. You may obtain any new notice by contacting the QSR Executive Director, Suneal Menzies, at (314) 645-6840, ext. 3757.

Receipt of Notice of Privacy Practices



By signing below, I the patient, certify that I have read, understand, and received a copy of the Notice of Privacy Practices form.

_____ _____

(Print Name) (Signature)

_____ _____

(Witness Name) (Witness Signature)

For Office Use Only

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

_____ Individual refused to sign

_____ Communications barriers prohibited obtaining the acknowledgement

_____ An emergency situation prevented us from obtaining acknowledgement

_____ Other (Please Specify)

_____

MISSED APPOINTMENT AGREEMENT

M.SAMIR ARAIN, MD/ ROOMANA ARAIN, MD

Patient Name_____

A key factor in behavioral health care is treatment compliance. This includes attending scheduled appointments and actively participating in your care and develop a mutual level of trust and confidence in your behavioral health provider.

As such, I expect that all scheduled appointments be kept or canceled a **minimum of 24 hours** in advance, unless a true emergency prevents keeping your scheduled appointment. If you do not show for your appointment or do not cancel at least 24 hours in advance, I reserve the right to **charge a fee for service of $75.00**

Note: This is the responsibility of the patient/guarantor, NOT your insurance company.

Frequently missed appointment may lead to termination of treatment.

Patient agreement:

I have read and understand this expectation for my participation in treatment including attending all scheduled appointments. I agree to honor the $75.00 fee for service for any missed or late canceled appointments, if so assessed.

_____ _____

Patient/Guardian Signature Date

_____

S.Arian.M.D/Roomana, Arain M.D

QSR Psychiatric Solutions, LLC

Preferred Pharmacy

Please indicate your preferred pharmacy for your prescriptions to be sent electronically (if applicable):

Pharmacy Name

Phone Number

QSR Psych Solutions, LLC

FMLA Disclaimer and Patient Responsibility

Dear Patient,

Due to the time and detail required to complete FMLA paperwork and the respective processing requirements, starting November 1, 2020 all requests to have FMLA paperwork completed will be subject to a base fee of $100.00.

Please allow up to 5 business days from the time the paperwork and payment is received by the office for the request to be completed and processed.

If you have any additional questions or concerns, please contact the office directly at 314-548-6162.

Sincerely,

QSR Staff

Patient Name (Print):_____

Patient Signature:_____Date:_____

QSR Psychiatric Solutions, LLC
12855 North Outer 40 Rd. #385
Saint Louis, MO 63141

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	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?	O	O
...you were so irritable that you shouted at people or started fights or arguments?	O	O
...you felt much more self-confident than usual?	O	O
...you got much less sleep than usual and found you didn't really miss it?	O	O
...you were much more talkative or spoke much faster than usual?	O	O
...thoughts raced through your head or you couldn't slow your mind down?	O	O
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	O	O
...you had much more energy than usual?	O	O
...you were much more active or did many more things than usual?	O	O
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	O	O
...you were much more interested in sex than usual?	O	O
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	O	O
...spending money got you or your family into trouble?	O	O
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	O	O
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 manic-depressive illness or bipolar disorder?	O	O
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	O	O

The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

Over the past 2 weeks, how often have you been bothered by any of the following problems?	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 asleep, 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're 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

Column Totals _____ + _____ + _____

Add Totals Together _____

10. If you checked off any problems, how difficult have those problems made it for you to Do your work, take care of things at home, or get along with other people?

☐ Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult