VITAG HEALTH LLC
2816 Morris Avenue, Suite 22
UNION, NJ 07083

PATIENT INFORMATION

Full Name: ________________________________ **Date of Birth:** ______________________________
Address: _____________________________**City:** ______ **State:** _______ **Zip Code:** __________________
Home Phone: _______________ **Cell Phone:** ______________ **Social Security#:** __________________
Email Address: ____**Sex:** ▫**Male** ▫**Female**
**Please note that email is not considered to be a confidential medium of communication.

Race: _______________________________
Marital Status: ☐**Never Married** ☐**Married** ☐**Domestic Partnership** ☐**Separated** ☐**Divorced** ☐ **Widowed**
Occupation: _________________ **Employer:** ____

EMERGENCY CONTACT INFORMATION

Full Name: _____________________________ **Relationship:** ______________________________________
Address: ________________________ **City:** _________ **State:** _________ **Zip Code:** ______________
Phone Number: ______________________

PHARMACY INFORMATION

Name: ____________________ **Phone Number:** ____________**Town/Zip Code:** ___________________
Allergies (include medications): ____

WHO MAY WE THANK FOR YOUR REFERRAL?

Name: _________________________________ Phone Number: _____________________________________
Address: ____
☐Google Search ☐Health Grades ☐Psychology Today ☐ ZocDoc ☐Yelp ☐Don't Recall ☐Other _________________

INSURANCE INFORMATION PRIMARY SECONDARY	
Insurance Company	Insurance Company
Insurance Contact Number	Insurance Contact Number:
Insurance ID #	Insurance ID #
Group#	Group#
Copay	Copay:
Name of Insured	Name of Insured
Date of Birth:	Date of Birth
Insured' Employer	Insured' Employer

Worker's Comp: ☐ Yes ☐ No Auto Accident: ☐ Yes ☐ No Date of Accident/Injury: _______________
WCB/NF. Insurance Company: _________________________ Agent Name: __________________________
Address: ____ Phone Number: ______________________
Claim Number: _______________________________ Case/Policy Number: ____________________________

Please give your insurance card and Picture ID to the receptionist.

I hereby authorize my insurance benefits (e.g. Medicare & Madigan) to be paid directly to VITAG HEALTH LLC. I will accept financial responsibility for non-covered services. If my account is sent to a collection agency, I agree that I will be responsible for all collection costs. I also authorize the office to release information about services rendered by my provider(s) to my insurance carrier(s) and allow a photocopy of my signature to be used to file insurance claims.

SIGNATURE: _____________________________________ DATE: _______________

VITAG HEALTH

OFFICE PROCEDURES AND INSTRUCTIONS

Please call us during our normal business hours 9:00AM to 5:00PM at phone number 908-623-3365 If it is a serious emergency situation, do not leave a message in the voice messaging system. Please call back and contact a person. If the office is closed, you will be transferred to our answering service and will be able to talk to an attendant. Please note, we do not check our voicemail or messages when the office is closed or over the weekend and holidays.

If there is a delay in the call back and you are in a serious life-threatening emergency, immediately proceed to the following steps:

- Call 911. In some cases, and depending on the situation, you may call the police or try to reach your PCP, a friend, relative, or neighbor.
- Go to the nearest emergency room for immediate help. If you live close to our offices you may go to the emergency room at overlook hospital.
- You may also call 908-522-2000 for psychiatric emergencies.

For regular appointments, please call us at least 1-2 weeks before you run out of your medications. On your regular visits, please inform us of any changes in your health, abnormal lab work, pregnancy or new medications prescribed by other doctors.

On each office visit, please make sure you have enough medication to cover you until your next visit and also over weekends and holidays.

Our office is no longer able to call/fax routine prescriptions to the pharmacy for renewals.

In case you cannot come for your scheduled appointment, please give us at least one to three business days' notice to call your pharmacy. As a courtesy, we will call your pharmacy to cover you until your next visit. Please note that we are unable to call any prescriptions over weekends, holidays, or after our normal business hours.

We do not authorize renewal of narcotics or controlled medications over the phone/fax at any time!

If you need to cancel/reschedule an appointment, we request a 24-hour notice. Our office will bill a sum of $50 for missed appointments.

To prevent being billed for unauthorized visits, please provide us with appropriate referrals, authorizations, and changes in your insurance information. Our secretary will gladly help you and provide information. If the office does not have your most current insurance information, you will be responsible for the services provided by the doctor.
For billing questions/problems, please contact 908-623-3365. If you are not satisfied with the response, contact the doctor directly.

I, ___________, have read and understood all the above procedures and instructions at VITAG HEALTH LLC.
(Print Name.)

____ ________________ Patient
Signature (If under 18, Patient's Parent/guardian) Date

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LIMITS OF CONFIDENTIALITY

Content of all therapy sessions are Considered to be Confidential. Both Verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the healthcare professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults: If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances: Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Insurance Providers (when applicable): Insurance companies and other thirty-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, ______________________________, authorize this office and its staff to release protected health information
Patient's Name [Please Print]

related to my evaluation and treatment to the following:

PCP NAME: ____________________________________ PCP PHONE NUMBER: ______________________________

THERAPIST NAME: ____________________________ THERAPIST PHONE NUMBER: ________________________

FAMILY MEMBER NAME: ____________________________ RELATIONSHIP:_________________________

FAMILY MEMBER PHONE NUMBER: ____________________________________

_____________________________________ ________________________

Patient Signature **Date**
(If under 18, patient's parent/guardian)

VITAG HEALTH

MEDICAL HISTORY

1. Do you currently have a primary care physician? ▫Yes ▫No When was your last physical? ______________

If yes, Dr's Name __________________________________ Phone Number: _________________________________
Address: ____

2. Are you currently seeing more than one Medical Health Specialist? ▫Yes ▫No
If yes, why? ____

3. Please list any persistent physical symptoms or health concerns (e.g. strokes, headaches, epilepsy, glaucoma, asthma, heart, liver, and lung problems, hypertension, diabetes, recent surgeries ... etc.)

____

____ 4. Are you currently on medication to manage a physical health concern? ▫Yes ▫No
If yes, please list: ____

____

FAMILY MENTAL HEALTH HISTORY

Are you adopted? ▫Yes ▫No
Has anyone in your family (immediate and/or extended relatives) experienced difficulties with the following:

Difficulty	Yes	No	Family Member
Depression	☐ Yes	☐ No	
Bipolar disorder	☐ Yes	☐ No	
Anxiety disorder	☐ Yes	☐ No	
Panic attacks	☐ Yes	☐ No	
Schizophrenia	☐ Yes	☐ No	
Alcohol/Substance Abuse	☐ Yes	☐ No	
Eating Disorder	☐ Yes	☐ No	
Learning disabilities	☐ Yes	☐ No	
Trauma history	☐ Yes	☐ No	
Suicide attempts	☐ Yes	☐ No	
Chronic illness	☐ Yes	☐ No	
ADHD/ADD	☐ Yes	☐ No	
Anger Management	☐ Yes	☐ No	

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING?

Extreme depressed mood	☐ Yes	☐ No	If yes, since when?
Dramatic mood swings associated with rapid speech, high energy, and decreased sleep	☐ Yes	☐ No	If yes, since when?
Extreme anxiety	☐ Yes	☐ No	If yes, since when?
Panic attacks	☐ Yes	☐ No	If yes, since when?
Hallucinations	☐ Yes	☐ No	If yes, since when?
Sleep disturbances	☐ Yes	☐ No	If yes, since when?
Repetitive thoughts (e.g. obsessions)	☐ Yes	☐ No	If yes, since when?
Repetitive behaviors (e.g. frequent checking, hand washing ...)	☐ Yes	☐ No	If yes, since when?
Phobias	☐ Yes	☐ No	If yes, since when?
Unexplained losses of time	☐ Yes	☐ No	If yes, since when?
Unexplained memory lapses	☐ Yes	☐ No	If yes, since when?
Eating disorder	☐ Yes	☐ No	If yes, since when?
Body image problems	☐ Yes	☐ No	If yes, since when?

VITAGHEALTH

PAST PSYCHIATRIC HISTORY

1. Are you currently receiving psychiatric services, counseling, or psychotherapy?
   ☐ Yes, currently with (therapist/psychiatrists' name): ______________________________
   ☐ No, but in the past with (therapist/practitioner's name): ______________________________

2. Have you ever been admitted to a facility for mental health treatment?
   ☐ Yes ☐ No If yes, where: ______________________________

3. In the last year, have you experienced any significant life changes or stressors? ▫Yes ▫No
If yes, please explain: ______________________________

5. **Do you self-harm?** ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

6. **Have you had suicidal thoughts recently?** ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never

7. **Have you ever attempted suicide or tried harming yourself?** ☐ Yes ☐ No
   If yes, when? ______________________________

8. Which medications have you **taken in the past**? ______________________________
   ____

9. Which medications are your **currently taking**? ______________________________
   ____

10. Why are you here today? ______________________________

ALCOHOL & DRUG HISTORY

1. Do you drink alcohol? ☐ Yes ☐ No If yes, how much do you drink a day? ________ A week? ________

2. Do you engage in recreational drug use? ☐ Daily ☐ Weekly ☐ Monthly ☐ Rarely ☐ Never
   If yes, please list . 1.________________ 2. ________________ 3. __________
   Since when? ______________________________

3. Have you been in detox or rehab? ☐ Yes ☐ No
If yes, when? ________________________

4. Do you smoke cigarettes or use other tobacco products? ☐ Yes ☐ No
If yes, which ones? ____________________________

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PSYCHOTROPIC MEDICATION INFORMED CONSENT AND CONSENT FOR TREATMENT

NAME_______________________________________ DOB _________________

I have reviewed the following medications and information with the psychiatrist.

1. _________ ___________ _____________
Medication Date Initials

2. _________ ___________ _____________
Medication Date Initials

3. _________ ___________ _____________
Medication Date Initials

4. _________ ___________ _____________
Medication Date Initials

5. _________ ___________ _____________
Medication Date Initials

6. _________ ___________ _____________
Medication Date Initials

7. _________ ___________ _____________
Medication Date Initials

8. _________ ___________ _____________ _____
Medication Date Initials

9. _________ ___________ _____________ _____
Medication Date Initials

10. _________ ___________ _____________ _____
Medication Date Initials

11. _________ ___________ _____________ _____
Medication Date Initials

12. _________ ___________ _____________ _____
Medication Date Initials

13. _________ ___________ _____________ _____
Medication Date Initials

14. _________ ___________ _____________ _____
Medication Date Initials

The following topics have been discussed:

- Name and description of the medication
- Potential for interactions
- Risks and benefits
- Expected outcomes
- Potential complications
- Risks and precautions related to driving
- Risks of addictions, withdrawals, and weight gain
- Risks of falls and other accidents
- Reasonable alternative medications and alternative of NO medication
- In females, risks association with pregnancy and lactation. Please inform us immediately if you become pregnant.
- Risk of concomitant drinking or using other drugs.
- Risk of tardive
- dyskinesia Which may be a permanent condition (certain medications

I agree and consent to be treated by Vida Sarkodie or the covering doctor/nurse practitioner when not available.

I understand and give permission to the office to contact me for appointment reminders, billing/health concerns, and other matters.

I agree to allow the office to message, text, or email me.

I have been given the opportunity to ask questions about the information.

I agree to take the above medications.

I have discussed treatment options in emergency situations with the doctor.

_________________________________ _________________________

PATIENT/LEGAL GUARDIAN SIGNATURE **PHYSICIAN SIGNATURE**

_________________________________ _________________________

Date **Date**

Notice of Privacy Practices
Patient Acknowledgement

VITAG HEALTH LLC
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PH: 908-623-3365
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Patient Name: ____

Date of Birth: ____

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how may I exercise these rights, and the practice's legal duties with respect of my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice.

I understand I can obtain this practice's current notice of Privacy Practice on request.

Signature: ___________________________________

Date: ____

Relationship to Patient: ____

(If signed by a personal representative of the patient)