

MID-FLORIDA PSYCHIATRY CENTER

A TelePsychLive Service Provider

PATIENT INFORMATION AND CONSENTS

Name: _____
First Name Middle Last Name Date of Birth

Sex: _____ Marital Status: _____ Social Sec No: _____

Address: _____
Street number and Name City State ZIP

Home Phone: _____ Mobile Phone: _____ Email: _____

Emergency Contact: _____ Relation: _____ Phone No: _____

I agree that I am responsible for the payment of all the bills for services rendered to the patient/myself by the Mid-Florida Psychiatry Center/ physician (s). I understand that as a courtesy and when appropriate, the clinic will bill my third-party payor* on my behalf, and I agree any remaining balance** will become my responsibility. In order for the Mid-Florida Psychiatry Center/ physician (s) to bill correctly, I agree that it is my responsibility to verify that Mid-Florida Psychiatry Center/physician (s) has the correct insurance information for my third-party payor (s). (*Your third-party payor may be your insurance company, your HMO, Medicare and Medicaid as examples. ** Statutes controlling Medicare and Medicaid and Workers Compensation for example, may reduce remaining balance and contracts with insurance companies. We will automatically deduct these amounts from your balance before we bill you.) **Please upload the insurance cards.**

Notice of Privacy Practice Acknowledgement:

I have reviewed, agree and consent for Mid-Florida Psychiatry Center's Notice of Privacy Practices.

Email use Policy:

I have reviewed policy, agree and consent to email communication between myself and Mid-Florida Psychiatry Center.

Telepsychiatry Service:

I have reviewed the policy regarding Telepsychiatry at Mid-Florida Psychiatry Center, I further agree and consent to follow the guidelines.

Consent to treatment with medication, including controlled medication.

I have reviewed and consent to medication treatment and therapy as appropriate.

Signature of the patient/ legal guardian

Date

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ DOB: _____

I HEREBY Authorize the Mid-Florida Psychiatry Center PL/ Vidyasagar Vangala, MD, to release and/ or obtain any and all the information it possesses relating to my evaluation(s), treatment and illness (es)including the psychiatric and psychological information which may be part of the medical records to/from:

Name: _____
(Name of Physician, psychotherapist, legal representative/ agency, or facility)

Street Address: _____

City: _____ State: _____ ZIP: _____

Phone: _____ . Fax: _____

If the information being released and/or obtained contains alcohol and/or drug use, diagnosis, treatment, rehabilitation, or education for prevention, or content related to HIV status, AIDS diagnosis or treatment, you must give further consent as follows:

- a) I give my consent for the Mid-Florida Psychiatry Center PL/ Vidyasagar Vangala, MD, to release and/or obtain information from my records concerning my alcohol and/or drug use in conjunction with the above.
- b) I give my consent for the Mid- Florida Psychiatry Center PL/ Vidyasagar Vangala, MD, to release and/or obtain information from my records concerning my HIV status, AIDS in conjunction with the above.

Signature of the patient/ legal guardian

Date

MEDICAL INFORMATION

Primary Care Doctor: _____ Ph: _____

Who Referred you: _____

Reason for visit _____

How long you have this problem: _____

A brief description of your problems: _____

At PRESENT taking any Psychiatric Medication, Treatment, Counseling for this: _____

Have you been in psychiatric treatment in the PAST:

In patient or outpatient . Any Suicide attempts in the past: Yes No

List medication tried before if you can remember: _____

Substance use history: IF THIS DOES NOT APPLY TO YOU CHECK HERE:

Alcohol: Yes No Cigarettes: Yes No

Soda/Coffee: Yes No Drugs: yes No

Social/personal History: Marital status: _____ Children: _____

Education: _____ Working/ Retired: _____

Any history of abuse: _____

Any family history of Psychiatric Problems: Yes: No: _____

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Medical and Surgical History:

High BP	CHF	Asthma/COPD	GERD
Anemia	Seizures	Glaucoma	Obesity
High Cholesterol	Prostate Disease	Sleep Apnea	COVID
Hypothyroidism	Headaches	Diabetes	Lupus
Urinary problems	Arthritis	Chronic Pain	Hearing loss
Head Injuries	Fibromyalgia	Dementia	Parkinson's
Appendectomy	Tonsillectomy	Gallbladder	Stents in heart
CABG	Back Surgery	Hysterectomy	Lumpectomy
Prostatectomy	Neck Surgery	Bariatric Surgery	C-Sections

In women: Are you pregnant Yes No NA

Breast feeding Yes No NA

Allergies to medication: yes No

List if YES: _____

Last Physical Exam: _____ Last Blood/ Lab work: _____

Are you taking any Narcotic Pain Medication: Yes No

Are you taking any Steroid treatment for COVID/ Chronic pain and other Yes No

Your Pharmacy name: _____ Phone: _____

List of Current Medication: Add a separate sheet if more medication to list.

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

10. _____ 11. _____ 12. _____

MID-FLORIDIA PSYCHIATRY CENTER PL

1 South Blvd E #1020~ Davenport, FL 33837

Phone: (863) 419-7645~Fax: (863) 419-7655

Consent for Pre- Surgical Evaluations

I request Dr. Vidyasagar Vangala at Mid-Florida Psychiatry Center to evaluate me psychologically as required by my surgeon prior to the surgical intervention as below.

- 1) Bariatric Surgery: (Includes Mini Gastric By Pass, Lap Band and Roux en- Y procedures and other weight loss Procedures)

It's my understanding that this assessment is a pre requisite for me to be scheduled for the above surgery, and Dr. Vangala' s role is to evaluate me, if I have any major mental illnesses that require an attention, stabilization prior to the above surgery. Dr. Vangala has no influence on my decision to get this particular surgery done. _____ (Initials) OR

- 2) Neuro-Stimulator Implantation:

It's my understanding that this assessment is a pre requisite for me to be scheduled for the above surgery, and Dr. Vangala' s role is to evaluate me, if I have any major mental illnesses that require an attention, stabilization prior to the above surgery. Dr. Vangala has no influence on my decision to get this particular surgery done. _____ (Initials) OR

- 3) Pain Medication Infusion Pump Implantation: (such as Morphine, Dilaudid etc.)

It's my understanding that this assessment is a pre requisite for me to be scheduled for the above surgery, and Dr. Vangala' s role is to evaluate me, if I have any major mental illnesses that require an attention, stabilization prior to the above surgery. Dr. Vangala has no influence on my decision to get this particular surgery done. Also it's my understanding that the scope of this assessment is not to assess my pain symptoms and to recommend what and how much pain medication is needed etc. _____ (Initials) OR

It's my understanding that Dr. Vangala has no formal association with the surgeon/ pain management specialist, who has recommended me for the evaluation. We release Dr. Vangala from any of the future medical malpractice issues arising from the above surgical interventions.

I HEREBY Authorize the Mid-Florida Psychiatry Center PL/ Vidyasagar Vangala, MD, to release any and all the information it possesses relating to my evaluation(s), treatment and illness (es) including the psychiatric and substance abuse related information which may be part of this assessment to:

Dr. _____
(Name of Physician)

OR

Signature of patient or legal guardian

Date

RATING SCALES

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____

Date: _____

If this questionnaire is completed by an informant, what is your relationship with the individual? _____

In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past TWO (2) WEEKS , how much (or how often) have you been bothered by the following problems?	None Not at all	Slight Rare, less than a day or two	Mild Several days	Moderate More than half the days	Severe Nearly every day	Highest Domain Score (clinician)
I.	1. Little interest or pleasure in doing things?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	□
	2. Feeling down, depressed, or hopeless?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	□
III.	4. Sleeping less than usual, but still have a lot of energy?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	□
	5. Starting lots more projects than usual or doing more risky things than usual?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input checked="" type="radio"/> 3	<input type="radio"/> 4	□
	7. Feeling panic or being frightened?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	
	8. Avoiding situations that make you anxious?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	□
	10. Feeling that your illnesses are not being taken seriously enough?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	
VI.	11. Thoughts of actually hurting yourself?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	□
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	□
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	□
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	□
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	□
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	□
XII.	19. Not knowing who you really are or what you want out of life?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	□
	20. Not feeling close to other people or enjoying your relationships with them?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	□
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	<input type="radio"/> 0	<input type="radio"/> 1	<input type="radio"/> 2	<input type="radio"/> 3	<input type="radio"/> 4	
Total							□