Zen Psychiatric Intake Assessment Form

Please complete all information on this form and email it to info@zenpsychiatric.com -OR- bring it to your first visit. It *is* long, but it's a one-time thing. The more more complete and accurate the information is that we have about your prior care and current issues, the better we can serve you. Take your time and help us help you by being as complete and accurate as you can be. Thank you!

Please confirm this basic information:
Name_____ Date of Birth _____

SECTION 1: What can we do to help?
What problem(s) trouble you the most *now*?
1._____
2._____
3._____

What are *your* treatment goals?
1._____
2._____

SECTION 2: Where do you get psychiatric and other medical care now?
What person or practice currently prescribes your *psychiatric* medications? _____
_____
Do you have another provider or practice prescribing *non-psychiatric* medications? Yes No
If yes, who is that?_____

What is your preferred pharmacy?_____
If you have a second pharmacy choice, what is it?_____

Are you currently in counseling or psychotherapy? ( )Yes ( )No
If yes, where, and how often?_____
_____

SECTION 3: *CRITICAL* Medical History:
To your knowledge, do you have any aneurysms in any blood vessels? ( )Yes ( )No
If yes, please explain as best you can. _____
_____

Have you ever had any kind of stroke? ( )Yes ( )No
If yes, please explain as best you can. _____
_____

Initials: _____

Do you have any metal of any kind implanted in your body? ( )Yes ( )No
If yes, please explain as best you can, but ESPECIALLY what kind of metal and where it is located!!

_____

_____

Have you ever had an EKG? ( ) Yes ( ) No If yes, when _____ .
Was the EKG ( ) normal ( ) abnormal or ( ) unknown?

For women only: Date of last menstrual period _____
Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No.
Are you planning to get pregnant in the near future? ( ) Yes ( ) No

Allergies & Medication Side-effects: – Please note: By allergies we mean things that you absolutely cannot take because they endanger your life. *Example: If Drug X gave you the shakes after taking for several weeks, that's a side-effect. If Drug X gave you a rash all over, or caused you to become so lightheaded you fell, that's an allergy!*
Do you have any known DRUG or ENVIRONMENTAL allergies? ( ) Yes ( )No
If yes, please tell us here:

Drug/Environmental Substance	What kind of Allergic Reaction

Drug Side-effects:

Drug	What kind of Side-effect

SECTION 4: Basic Medical History:

Personal and Family Medical History:	***You***	***Family:***	***Specific Diagnosis, if known:***
Thyroid Disease	( )	( )	_____
Anemia	( )	( )	_____
Liver Disease	( )	( )	_____
Chronic Fatigue	( )	( )	_____
Kidney Disease	( )	( )	_____
Diabetes	( )	( )	_____
Asthma/respiratory problems	( )	( )	_____
Stomach or intestinal problems	( )	( )	_____
Cancer (type)	( )	( )	_____

Initials: _____

SECTION 4: Continued - Basic Medical History:

Personal and Family Medical History:	***You***	***Family:***	***Specific Diagnosis, if known:***
Fibromyalgia ---------- ----------( )		( )	_____
Heart Disease ----------( )		( )	_____
Epilepsy or seizures ----------( )		( )	_____
High Cholesterol ----------( )		( )	_____
High blood pressure----------( )		( )	_____
Head trauma ----------( )		( )	_____
Liver problems ----------( )		( )	_____
Other ----------( )		( )	_____
Other ----------( )		( )	_____
Other ----------( )		( )	_____

Is there any additional personal or family medical history? If yes, please explain:

_____

_____

Did your mother have any complications before or during your birth? If so, please tell us what you know.

_____

MEDICAL/SURGICAL HOSPITALIZATIONS: If you've been hospitalized for MEDICAL or SURGICAL reasons, please explain.

Date (M/YR)	Why?	At Which Hospital?

Please list ALL current prescription medications – Psych and NON-Psych: (if none at all, write none)

Medication	Dose (in mg)	How often each day?	Since When?

Initials: _____

SECTION 4: continued

Please list any *current* over-the-counter medications (OTC) or supplements:

Supplement or OTC medication	Dose (in mg)	How often each day?	Since When?

SECTION 5: SOCIAL HISTORY

How far did you go in school? _____

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed

If married or in a relationship, for how long? _____

Any children and/or grandchildren? ( ) Yes ( ) No If yes, how many?_____

Are you satisfied with your current relationship? ( ) Yes ( ) No

Are you suffering any type of abuse in this relationship? ( ) Yes ( ) No

Have you ever been abused emotionally, sexually, physically, or by neglect? ( ) Yes ( ) No

Do any issues regarding your sexual orientation distress you? ( ) Yes ( ) No

Who are your personal emotional supports? (With whom are you close?)_____

_____

Do you belong to any particular religion or spiritual group? ( ) Yes ( ) No

Does your religion or spiritual group provide emotional support? ( ) Yes ( ) No

Do any issues regarding your religious or spiritual beliefs distress you? ( ) Yes ( ) No

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

If disabled, what is your legal disability? _____ _____

If working or retired, what is/was your occupation? _____

Have you ever served in the military? ( ) Yes ( ) No

If so, in what branch and for what time frame? _____

Is your current living situation stable? ( ) Yes ( ) No

If No, please tell us generally about the issues you face:_____

_____

Initials: _____

Does anyone in your home own firearms? ( ) Yes ( ) No
Are those weapons licensed and secured in accordance with local laws? ( ) Yes ( ) No

Do you have any current or pending legal problems? ( ) Yes ( ) No
If Yes, please tell us very generally about the issues you face:_____
_____

SECTION 6: SUBSTANCE USE HISTORY

In your ***entire*** life, have you ever had a problematic pattern of substance use – specifically, a pattern that caused you any social, academic, occupational, or legal problems? ( ) Yes ( ) No
If yes, please tell us what substance(s) you struggled with, and the problems it/they caused you:_____

_____
_____
_____
_____
_____
_____

Have you ever been *treated* for a substance use disorder? ( ) Yes ( ) No
If yes, where and when? _____
Are you in any ongoing recovery program? ( ) Yes ( ) No
If yes, what program?_____

Are you **currently** struggling with problematic substance use? ( ) Yes ( ) No
If yes, please tell us what substances(s) you currently struggle with, and the problems they are causing for you:_____

_____
_____
_____
_____
_____
_____

Are you currently recreationally using any illegal substances, or abusing/over-using any legally available and/or prescribed substances -- including alcohol, marijuana, delta-8, CBD, and kratom. ( ) Yes ( ) No
If yes, please tell us which substance(s) you are currently using, how often, and by what means:_____
_____
_____

SECTION 6: SUBSTANCE USE HISTORY - continued

Psychedelic Medication History:

Have you ***ever*** tried, even just once in your life, any of the following:

DRUG	???	COMMENTS
Ketamine	Y / N	
Dextromethorphan	Y / N	
MDMA (also called Ecstasy)	Y / N	
LSD ("acid")	Y / N	
Psilocybin "magic mushrooms" or "shrooms"	Y / N	
Mescaline	Y / N	
DMT (Ayuhuasca)	Y / N	
	Y / N	
	Y / N	

Alcohol History:

How many days per week do you drink any alcohol? _____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past three months:

What is the largest amount of alcohol you have consumed in one day? _____

Have you thought you should cut down on your drinking or drug use? ( ) Yes ( ) No

Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No

Have you felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you had a drink or a drug first thing in the morning to steady your nerves or fight a hangover? ( ) Yes ( ) No

Tobacco History:

Have you ever smoked cigarettes? ( ) Yes ( ) No

Do you still smoke? ( ) Yes ( ) No If yes, how many packs per day on average? _____

If you smoked in the past and quit: How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? ( ) Yes ( ) No In the past? ( ) Yes ( ) No

What kind? _____ How much per day on average? _____ For how long? _____

SECTION 7: PSYCHIATRIC HISTORY (finally, right?!)

Outpatient Treatment History:

Please describe when, by whom, and nature of treatment.

From M/Y to M/Y	Provider/Agency	Problems Treated?

Psychiatric Hospitalization History:

If you have ever been hospitalized for psychiatric reasons, please tell us what you can recall.

Date (M/YR)	Why?	Which Hospital?

Suicide Risk Assessment:

Have you ***ever*** actually tried to kill yourself? ( ) Yes ( ) No

Do you ***currently*** feel that you don't want to live? ( ) Yes ( ) No

Psychiatric Medication History:

Please indicate which of these medications you have taken. In the COMMENTS box, please tell us what you can about: 1. how long you took it (Days-Weeks-Months-Years); 2. the max dose you took; 3. if it helped, didn't help, or hurt you.

Antidepressants

MEDICATION	???	COMMENTS	MEDICATION	???	COMMENTS
Prozac	Y / N		Remeron	Y / N	
Zoloft	Y / N		Serzone	Y / N	
Luvox	Y / N		Anafranil	Y / N	
Paxil	Y / N		Pamelor	Y / N	
Lexapro	Y / N		Tofranil	Y / N	
Effexor	Y / N		Elavil	Y / N	
Cymbalta	Y / N		Wellbutrin	Y / N	
Trintillex	Y / N		Viibryd	Y / N	
Auvelity	Y / N				

Mood Stabilizers **Sedatives / Hypnotics**

MEDICATION	???	COMMENTS	MEDICATION	???	COMMENTS
Tegretol	Y / N		Ambien	Y / N	
Lithium	Y / N		Sonata	Y / N	
Depakote	Y / N		Rozerem	Y / N	
Lamictal	Y / N		Restoril	Y / N	
Topamax	Y / N		Trazodone	Y / N	
Trileptal	Y / N				

Initials: _____

Antipsychotics

MEDICATION	???	COMMENTS	MEDICATION	???	COMMENTS
Seroquel	Y / N		Clozaril	Y / N	
Zyprexa	Y / N		Haldol	Y / N	
Geodon	Y / N		Prolixin	Y / N	
Abilify	Y / N		Risperdal	Y / N	

Anti-Anxiety **STIMULANTS**

MEDICATION	???	COMMENTS	MEDICATION	???	COMMENTS
Xanax	Y / N		Adderall	Y / N	
Ativan	Y / N		Concerta	Y / N	
Klonopin	Y / N		Ritalin	Y / N	
Valium	Y / N		Strattera	Y / N	
Tranxene	Y / N		Vyvanse	Y / N	
Buspar	Y / N			Y / N	
Vistaril	Y / N				

Family Psychiatric History:

Has anyone in your family – *blood kin, as far and wide as you know* – ever tried to hurt or kill themselves? ( ) Yes ( ) No
If yes, please tell us who:_____
_____
_____

Is anyone in your family – *again, blood kin* – diagnosed, treated, or struggling with a mental illness? ( ) Yes ( ) No
If yes, please tell us who:_____
_____
_____

Is there anything else that needed more space to explain? Anything else you want us to know before your evaluation?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Initials: _____

Spravato and Ketamine Treatments: Standard treatment schedule is as follows: Twice a week for four (4) weeks, then once a week for four (4) weeks, then once every other week. All clients ***must*** be observed for two (2) full hours after medication is administered. All patients ***must*** have someone to drive them to and from treatments. Treatment duration is subject to change based upon the treatment plan established between yourself and the provider.

Signature_____Date_____

Emergency Contact _____ *Their* Telephone # _____

Initials: _____

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	**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
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	**Not at all sure**	**Several days**	**Over 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's 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
Add the score for each column				

Total Score (add your column scores): _____

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

UHS Rev 4/2020

SPRAVATO® REMS

Patient Enrollment Form - Outpatient Use Only

This section is to be completed by the Patient

Your healthcare provider will help you complete this form and provide you with a copy.

**** Indicates required field***

Patient Information

First Name*:	MI:	Last Name*:	Birthdate*: (MM/DD/YYYY):	Sex*: ☐ Male ☐ Female ☐ Other

Email*: (Email is required for online enrollment only)	Phone Number*:

Address 1*:	Address 2:

City*:	State*:	ZIP*:

Patient Agreement

By signing this form, I understand and acknowledge that:

Before my treatment begins, I will:

- Enroll in the SPRAVATO® REMS by completing this *Patient Enrollment Form* with my healthcare provider. Enrollment information will be submitted to the SPRAVATO® REMS.
- Receive counseling on safety risks and the need for monitoring to observe for resolution of sedation and dissociation, and for any changes in vital signs.

During treatment, and after administration I will:

- Use the SPRAVATO® nasal spray myself under the direct observation of a healthcare provider.
- Be observed at the healthcare setting where I get SPRAVATO® for at least 2 hours after each treatment until the healthcare provider determines I am ready to leave the healthcare setting.

I understand:

- Sedation and dissociation can result from treatment with SPRAVATO® and I must stay after each treatment.
  Until these effects resolve, I may feel:
  - sleepy and/or
  - disconnected from myself, my thoughts, feelings and things around me.
- I should make arrangements to safely get home.
- I should not drive or use heavy machinery for the rest of the day on which I receive SPRAVATO®.
- I should contact my doctor or inform him/her at my next visit if I believe I have a side effect or reaction from SPRAVATO®.
- In order to receive SPRAVATO® as an outpatient, I am required to be enrolled in the REMS, and my information will be stored in a database of all outpatients who receive SPRAVATO® in the United States.
- Janssen Pharmaceuticals, Inc. and its agents, including trusted vendors, may contact me or my prescriber via phone, mail, fax, or email to support administration of the REMS.
- Janssen Pharmaceuticals, Inc. and its agents, including trusted vendors, may use, disclose, and share my personal health information for the purpose of the operations of the REMS, including enrolling me into the REMS and administering the REMS, coordinating the dispensing of SPRAVATO®, and releasing and disclosing my personal health information to the Food and Drug Administration (FDA), as necessary, and as otherwise required by law.

Patient Name (please print):

Patient Signature*:	**Date*:**

Zen Psychiatric Services, PLLC
126 Fiddler's Run Blvd
Morganton, NC 28655
Main: 828-608-0892 Fax: 828-608-0373

INFORMED CONSENT: SPRAVATO TREATMENT FOR DEPRESSION

• I understand the risks include but are not limited to: Dissociation, Dizziness, Nausea, Sedation, Vertigo, Headache, Dysgeusia, Hypoesthesia, Anxiety, Lethargy, Blood pressure increased, Vomiting, Insomnia, and Diarrhea. I also understand that the potential side effects form Spravato nasal treatment may include: Nasal discomfort, Throat irritation, feeling drunk, Dry mouth, Hyperhidrosis, Euphoric mood, Dysarthria, Tremor, Oropharyngeal pain, Mental impairment, Constipation, Pollakiuria, feeling abnormal, and Tachycardia.

• I agree to remain abstinent from any illegal drugs, alcohol, and controlled medications that I am not prescribed. If I cannot remain abstinent from these substances, I agree to inform the office prior to my treatment session, as this could jeopardize my safety and affect my ability to continue treatment.

• I understand that I may not drive or operate machinery for at least 24 hours after my nasal treatment is completed, and that I will only be discharged to the care of a responsible adult.

• I understand that good results are expected but not guaranteed. My depression may not improve with Spravato treatment even if I follow the complete treatment protocol.

• I understand that to achieve the desired results that a series of nasal treatments are needed, and it is my full intent to complete the course of treatment.

• I understand that Spravato nasal treatment is not a substitute for continued behavioral medicine treatment. My psychiatrist or family doctor will determine if any oral medications or other treatments may be stopped if my depression improves.

• I have been explained thoroughly about the use of Spravato for Treatment-Resistant depression and have had the opportunity to ask all the relevant questions I felt necessary. I am confirming that I have received and reviewed the pre-treatment instructions, post treatment instructions and that I can fully comply.

• I voluntarily request Zen Psychiatric Services, PLLC to administer SPRAVATO for the treatment of my condition.

• I understand that I can revoke this consent at any time including during the 12 week treatment period. I further understand that if this consent is revoked during a treatment session and after I have received Spravato medication, I will voluntarily agree to stay the required two (2) hour observation period.

• I understand that SPRAVATO nasal spray is indicated and FDA approved, in conjunction with an oral antidepressant, for the treatment of treatment-resistant depression in adults.

• I fully consent and agree to Zen Psychiatric Services, PLLC bill my insurance company for services rendered. I am aware that I bear full financial responsibility for monies not received by Zen Psychiatric Services, PLLC from my insurance company.

Patient Name: _____ Date: _____

Patient Signature: _____

Provider Signature: _____ Date: _____

Zen Psychiatric Services, PLLC
126 Fiddler's Run Blvd
Morganton, NC 28655
Main: 828-608-0892
Fax: 828-608-0373

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Client:_____

DOB:_____

- Use this form to obtain client or legally responsible person/personal representative authorization for the release of information
- Form must indicate whether this is to release information, obtain information, or both.
- Form must be filled out before client or legally responsible person/persons representative signs
- File original form in client record. MUST GIVE COPY TO CLIENT

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION 45 C.F.R. Parts of 160; 42 C.F.R., Part 2; G.S. 122C

This form implements the requirements for client authorization to use and disclose health Information protected by the federal health privacy law (45 C.F.R. parts 160, 164), the federal drug and alcohol confidentiality law (42 C.F.R. part 2), and state confidentiality law governing mental health, developmental disabilities, and substance abuse services (G.S. 122C).

I,_____**, authorize** Zen Psychiatric Services, PLLC
(Client or client's legally responsible person or personal representative) (Agency or person authorized use or disclose the information)

☐to obtain from: ☐to release/disclose to:_____

_____

_____
(Agency or person to whom the requested use or disclosure will be made)

The following protected information:

☐ Assessments/Evaluations ☐ Emergency Contact ☐ Other (Specify): _____
☐ Service Notes ☐ History and Physical
☐ Transportation ☐ Medication Records

The Purpose of the disclosure is:_____

_____

_____
(Describe each purpose of the requested use or disclosure)

REDISCLOSURE

Once information is disclosed pursuant to this authorization, I understand that the federal health privacy law (45 C.F.R. Part 164) protecting health information may not apply to the recipient of the information and, therefore, may not prohibit the recipient from re-disclosing it. Other laws, however, may prohibit re-disclosure. When this agency discloses mental health and developmental disabilities information protected by state law (G.S. 122C), substance abuse treatment protected by federal law (42 C.F.R. Part 2), and HIV infection information which is protected by state law (G.S. 130A-143) we must inform the recipient of the information that re-disclosure is prohibited except as permitted or required by these two laws. Our Privacy Notice describes the circumstances where disclosure is permitted or required by these laws. I understand that the information to be released may include information regarding drug abuse Alcohol abuse, HIV infection, AIDS or AIDS related conditions, psychological, psychiatric, or physical impairments.

NOTICE OF VOLUNTARINESS

I certify that this authorization is made freely, voluntarily and without coercion. I understand that Zen Psychiatric Services, PLLC cannot deny or refuse to provide treatment, payment, and enrollment in a health plan or eligibility for benefits if I refuse to sign this authorization, except in limited circumstances, i.e. Research related treatment, services provided solely for reason of creating PHI for disclosure to 3rd party.

REVOCATION AND EXPIRATION

I understand that, with certain exceptions, I have the right to revoke this authorization at any time, except to the extent that action has been taken in reliance on it. The procedure for how I may revoke this authorization, as well as the exceptions to my right to revoke are explained in Zen Psychiatric Services, PLLC, a copy of which has been provided to me.
If not revoked earlier, this authorization automatically expires 1 year after the date of signature below unless otherwise indicated:

_____
(If Disclosure is for less than 12 months, enter date disclosure expires)

Signature: _____ **Date:** _____

Please explain authority of person signing above to act on behalf of client: _____

Signature: _____ **Date:** _____

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Disclosure Revoked on: ____/____/_____ **Signature:** _____
(Date)

Zen Psychiatric Services, PLLC

Notice of Privacy Practices

This notice describes how medical information about you may be used and shared and how you can get access to that information. Please review it carefully.

Please review it carefully

Protecting Your Privacy Zen Psychiatric Services, PLLC is committed to improving health, elevating hope, and advancing healing for all. To do so, we need to use and share your information among ourselves, with our vendors, and with providers and agencies involved with your care. We understand that health information is personal, and we are committed to protecting your privacy. This Notice outlines how we protect your information and your rights under the Health Insurance Portability and Accountability Act ("HIPAA"). We are required by law to: ·
*Maintain the privacy of your health information as outlined in this Notice
*Provide you with notice of our legal duties and privacy practices related to your health information
*Follow the terms of the Notice currently in effect

Right to A Paper Copy of This Notice You have the right to a paper copy of this Notice upon request. You may also obtain a copy of this Notice at any time from our website, unchealthblueridge.org, or from the location where you obtained treatment

Right to Request Changes to Your Health Information You can ask to change or add information to your health record that you think is wrong or incomplete. For example, you may remember telling the doctor that you fell riding your bike, but the record says you tripped over your dog. To request an amendment, call 828-608-0892 to request and submit the Health Information Amendment form. Your provider has the right to decide whether to accept or deny your request in whole or in part. We will let you know the decision within 60 days, though we may let you know if we need another 30 days and why. Regardless of the decision, your amendment request will be noted in your record, as well as your disagreement letter if you choose to send one.

Who Follows This Notice Our Notice of Privacy Practices applies to entities that are owned or controlled by Zen Psychiatric Services, PLLC, personnel who are employed by, contracted by, train with, volunteer or authorized to use or access protected health information.

Request Restrictions on Sharing Your Information You have the right to ask that we limit how we use or share your information for treatment, payment or health care operations. You can also ask us to limit sharing information with others involved in your care, such as a family member or friend. To request a restriction communication, please call 828-608-0892 and ask for the Request for Restrictions on Use and Disclosure of Information form. Note that we are not required to agree to your request, except as stated below. If we do agree to the restriction, it goes into effect when we notify you and even then, it may not be followed in some situations, such as emergencies or when required by law. If you restrict us from sharing information with your health plan by paying for the visit in full as self-pay, we will not share your information (note this does not affect our ability to share your information for treatment).

Request That We Change How We Contact You You can make reasonable requests to be contacted at different places or in different ways. For example, you may ask that we call you on your cell phone instead of your home number or that we send results to your office instead of your home. To request confidential communications, call 828-608-0892 to obtain the Request for Confidential or Alternative Means of Communication form. You are not required to tell us the reason for your request. We will accommodate all reasonable requests, but your request must specify how or where you wish to be contacted.

Request an Accounting of Disclosures You have the right to ask for a list of those we've shared your information over the last 2 years. Note the list will not include disclosures made to those involved in treatment, payment, or for health care operations, or certain other disclosures, such as those authorized by you. To request an accounting of disclosures, call 828-608-0892 and ask for the Request for Accounting form. You must include the time frame for the request. You can get one accounting of disclosures at no charge every 12 months; after that, there may be a fee. In most cases, we will send the accounting of disclosures within 60 days. If we need an extra 30 days, we will let you know.

Right to Be Notified of a Breach You have the right to be notified if your health information is acquired, used, or shared in a manner not permitted under law which results in more than a low risk of compromise to the security or privacy of your health information.

Changes to this Notice of Privacy Practices We reserve the right to change and update this Notice. The revised Notice will be effective for health information we already have about you, as well as for any health information we create or receive in the future. The effective date is listed on the first page of the Notice, and we will post the current copy at the front desk.

Complaints and Contacts If you believe we impermissibly shared or used your information or that your rights were denied under HIPAA, you can file a complaint with Zen Psychiatric Services, PLLC by calling our main number at (828) 608-0892 and ask to speak with the Privacy Department. You can file a complaint with the Secretary of the Department of Health and Human Services by going to hhs.gov/hipaa. You will not be punished for filing a complaint.

For Health Care Operations We may use and share your health information to carry out business activities that help us operate our health system, improve the quality and cost of patient care, and conduct other health care operations. For example, we may look at patient information to evaluate the performance of our staff, plan new services, identify new locations for services, or send you a survey about your experience. We may also use patient information to train personnel and students, respond to governmental agencies, support our licensing, analyze data, and for legal and other purposes. We can also share your information with other providers who have a relationship with you for their own health care operations.

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Right to Revoke or Cancel an Authorization You can sign an Authorization to give us permission to share your information with others, such as with your employer or a life insurance company. You can revoke (cancel) that permission at any time by going to the HIM website and submitting the Revocation of Authorization for Release of Information form. Once we have processed your revocation, we will no longer use or share your health information under the revoked Authorization. We cannot, however, take back information we have already shared.

Other State and Federal Laws Some state and federal laws require additional privacy protections for certain health information. For example, some states give unemancipated minors the legal right to consent to certain types of care and protects the privacy of those encounters, with specific exceptions. Other examples include:

How Your Information Is Used and Shared for Treatment We may use and share your health information to provide, coordinate, or manage your health care and related services, both with our own providers and with others involved in your care. Different personnel may also share your health information to coordinate the different things you need, such as prescriptions, lab work and X-rays. For example, a doctor treating you for a broken leg may need to know if you have diabetes so she can treat you properly and work with our dietitian so you can have low sugar meals. Our case manager will need to know about your diabetes so he can connect with other agencies to get you access to the proper resources after discharge. We may also share your information with a health registry so we can access information that may help us identify a different way to treat you. We may share and receive your health information from other providers, including within our system, to treat you.

Communicating With You We may use and share health information to contact you about treatment, care, or payment. For example, we may use your cell phone and email information to send you appointment reminders. We may also reach out to you for feedback about a recent visit or to see if you are feeling better. Unless you tell us otherwise, you agree we can send you reminders via phone calls, emails, text messages, or other means based on the information you have on file with us. If you send us unencrypted emails or texts, you understand there are security risks in doing so and you accept those risks.

For Payment We may use and share your health information with others to bill and collect payment for the services we provide to you, such as with billing departments, insurance companies, health plans and their agents, and consumer reporting agencies. We may also contact payors before you receive scheduled services, such as for pre-approval from your health plan or to confirm you qualify for coverage.

Treatment Alternatives We may use and share your health information to tell you about possible treatment options or alternatives that may be of interest. Note you are responsible for reviewing any additional terms of use may apply to apps or other tools that you use.

Business Associates Sometimes, we hire other people and companies known as business associates to help us perform services and manage operations. We may need to share your health information with these business associates so that they can perform their job for us. For example, we may hire healthcare monitoring companies, collection agencies, or medical directors. We require them to protect your health information and keep it confidential.

Individuals Involved in Your Care or Payment We may share your health information with a family member, personal representative, friend or other person you identify or who is involved in your care or payment. For example, if you bring a sibling to your appointment or have a friend pick you up from a procedure and you do not object to them hearing your medical information, then we can share relevant information with them. We could also tell your family how to care for you at home or share billing information if they are helping with your bills or covering your services. We may also share information to notify people involved in your care about your location, general condition or death. If you are unable to make decisions for yourself or it is an emergency, we will use our professional judgment to decide if it is in your best interest to share your health information with those involved in your care.

Authorization for Other Uses of Health Information Before we use or share your health information in a manner not covered by this Notice or required or permitted by applicable laws, we will ask for your written permission. For example, we will ask for your written permission to use or share psychotherapy notes, to use your health information for marketing purposes, or to share your information in a way that constitutes sale of health information. Note that we can remove or aggregate identifiers, so the information becomes anonymous and then use or share it without written permission.

Right to a Copy of Your Health Records You can ask for a copy of all or part of your medical record, though certain exceptions may apply. For example, if your doctor decides something in your record might endanger you or someone else, your request may be denied in whole or in part. To request a copy of your record, go to the HIM website and submit the Patient Request for Access form. In most cases, you will receive the information within 30 days of when we receive your request, unless we let you know we need another 30 days, such as if the are in storage.

Special Situations In certain situations, we may use or share your health information without your permission or without giving you a chance to object, including:

When Required by Law, such as to report gunshot wounds, communicable diseases, child abuse, or to make certain reports to state or federal agencies.

For Public Health Activities, such as to prevent or control disease, injury, or disability; report reactions or problems with medical products; report births or deaths; work with the CDC.

For Health Oversight Activities, such as to the state health regulators or the Center for Medicare/Medicaid Services.

For a Legal Proceeding, such as in response a court order, a warrant, or a legal proceeding.

To Law Enforcement and Correctional Institutions, such as in the event of certain crimes, missing persons, or other situations involving law enforcement or prisoners.

To Avoid a Serious Threat to Health or Safety, such as if there is an imminent danger to someone or the public.

For Medical Research, such as for studies that have been approved by special institutional review boards; we will follow the relevant research regulations to protect your information.

For Workers' Compensation, such as to an employer under state law.

Your Rights Regarding Your Health Information You have certain rights regarding the health information we maintain about you, which are outlined below. Our Health Information Management Department (HIM) oversees many of these rights. If you have any questions, please call HIM at 828-608-0892 and they will be happy to help you.

Zen Psychiatric Services, PLLC complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Last Updated September 2022

Zen Psychiatric Services, PLLC

Acknowledgment of Receipt of Notice of Privacy Practices

Zen Psychiatric Services, PLLC is providing you a copy of our Notices of Privacy Practices. The notice provides information about your rights as a patient of our practice and whom you may contact at our office to ask questions about our privacy practices. By signing this form, you agree that you have had the opportunity to read our Notice of Privacy Practices. I have received a copy of the Notice of Privacy Practices for Zen Psychiatric Services, PLLF

Name (Please Print): _____

Signature of patient (or representative) Date: _____ ___/___/___

No Show/Late Cancellation Policy

This policy has been established to help us serve you better.

It is necessary for us to make appointments in order to see our patients as efficiently as possible. No-shows and late-cancellations cause problems that go beyond a financial impact on our practice. When an appointment is made, it takes an available time slot away from another patient. No-shows and late-cancellations delay the delivery of healthcare to other patients.

A "no-show" is missing a scheduled appointment. A "late-cancellation" is canceling an appointment without calling us to cancel within 24 hours of an office appointment or 72 hours in advance of a procedure.

We understand that situations such as medical emergencies occasionally arise. These situations will be considered on a case by case basis.

A charge of $30.00 will be assessed for each no show or late cancellation office visit appointment if less than 24 hours notice is given.

Please understand that insurance companies consider this charge to be entirely the patient's responsibility.

To cancel or reschedule an appointment please call Zen Psychiatric Services, PLLC 828-608-0892. This policy is in effect to ensure that all of our patients have the opportunity to be seen in a timely manner.

It is my understanding that my credit card on file will be charged $30.00 for each no show or late cancellation appointment. If no credit card is on file, I agree to be billed for the no show or late cancellation appointment. I am also aware that three no show or late cancellation events may constitute dismissal from this clinic.

_____ _____

Patient Acknowledgment (Please sign) (Date)

Recurring Credit Card Payment Authorization

You authorize regularly scheduled charges to your credit card. You will be charged the amount indicated below each billing period. A receipt for each payment will be provided to you and the charge will appear on your credit card statement. You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least 10 days prior to the payment being collected.

I _____ authorize __Zen Psychiatric Services, PLLC to
(Cardholder's Name) (Merchant's Name)

charge my Credit Card indicated below for $___30.00_____for _no show per signed agreement.

Billing Information

Billing Address _____ Phone # _____

City, State, Zip _____ Email _____

Card Details

☐ Visa ☐ MasterCard ☐ Discover ☐ American Express

Cardholder Name _____

Account/CC Number _____

Expiration Date ____ /____

CVV ____

Zip Code _____

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify _Zen Psychiatric Services, PLLC__ in writing of any changes in my account information or termination of this authorization at least 15 days prior to the next billing date. If the above noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these

scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

SIGNATURE _____ DATE _____

(Cardholder's Signature)

Janssen Patient Support Program
Patient Authorization Form

Patients should read the Patient Authorization, check the desired permission boxes, sign, and return both pages of the Form to the Janssen Patient Support Program.

- Completed Form may be faxed to 844-577-7282 or mailed to Partner withMe, 680 Century Point, Lake Mary, FL 32746.
- Patients may also read, eSign, and submit a digital version of this form at **SpravatowithMePatientAuth.com**

Patient Name _____ **Email Address** _____

I give permission for each of my "Healthcare Providers" (eg, my physicians, pharmacists, specialty pharmacies, other healthcare providers, and their staff) and "Insurers" (eg, my health insurance plans) to share my Protected Health Information as described on this Form.

My "Protected Health Information" includes any and all information related to my medical condition, treatment, prescriptions, and health insurance coverage.

The following person(s) or class of person(s) are given permission to receive and use my Protected Health Information (collectively "Janssen"):

- Johnson & Johnson Health Care Systems Inc., its affiliated companies, agents, and representatives
- Providers of other sources of funding, including foundations and co-pay assistance providers
- Service providers for the patient support programs, including subcontractors or Healthcare Providers helping Janssen run the programs
- Service providers maintaining, transmitting, de-identifying, aggregating, or analyzing data from Janssen patient support programs

Also, I give permission to Janssen to receive, use, and share my Protected Health Information in order to:

- see if I qualify for, sign me up for, contact me about, and provide services relating to Janssen patient support programs, including in-home services
- manage the Janssen patient support programs
- give me educational and adherence materials, information, and resources related to my Janssen medication in connection with Janssen patient support programs
- communicate with my Healthcare Providers regarding access to, reimbursement for and fulfillment of my Janssen medication, and to tell my Healthcare Provider that I am participating in Janssen patient support programs
- verify, assist with, and coordinate my coverage for my Janssen medication with my Insurers and Healthcare Providers
- coordinate prescription or treatment location and associated scheduling
- conduct analysis to help Janssen evaluate, create, and improve its products, services, and customer support for patients prescribed Janssen medications
- share and give access to information created by the Janssen patient support programs that may be useful for my care

I understand that my Protected Health Information may be shared by Janssen for the uses written in this Form to:

- My Insurers
- My Healthcare Providers
- Any of the persons given permission to receive and use my Protected Health Information as mentioned above
- Any individual I give permission as an additional contact

Janssen and the other data recipients listed on this Form may share information about me as permitted on this Form or if any information that specifically identifies me is removed. I understand that Janssen will use reasonable efforts to keep my information private but once my Protected Health Information is disclosed as allowed on this Form, it may no longer be protected by federal privacy laws.

Clear Form Print Form

Janssen Patient Support Program
Patient Authorization Form

I understand that I am not required to sign this Form. My choice about whether to sign will not change how my Healthcare Providers or Insurers treat me. If I do not sign this Form, or cancel or remove my permission later, I understand I will not be able to participate or receive assistance from Janssen's patient support programs.

I understand that pharmacies that dispense and ship my medication and service providers for the patient support programs may be paid by Janssen for their services and data. This may include payment for sharing Protected Health Information and other data in connection with these programs, as allowed on this Form.

This Form will remain in effect 10 years from the date of signature, except where state law requires a shorter time, or until I am no longer participating in any Janssen patient support programs. Information collected before that date may continue to be used for the purposes set forth in this Form.

I understand that I may cancel the permissions given by this Form at any time by letting Janssen know in writing at: Partner withMe, 680 Century Point, Lake Mary, FL 32746.

I can also cancel my permission by letting my Healthcare Providers and Insurers know in writing that I do not want them to share any information with Janssen.

I further understand that if I cancel my permission it will not affect how Janssen uses and shares my Protected Health Information received by Janssen prior to my cancellation.

I understand I may request a copy of this Form.

Permission for communications outside of Janssen patient support programs:

☐ Yes, I would like to receive communications relating to my Janssen medication.

☐ Yes, I would like to receive communications relating to other Janssen products and services.

For privacy rights and choices specific to California residents, please see Janssen's California privacy notice available at **https://www.janssen.com/us/privacy-policy#california**

Permission for text communications:

☐ Yes, I would like to receive text messages. By selecting this option, I agree to receive text messages as allowed by this Form to the cell phone number provided below. Message and data rates may apply. Message frequency varies. I understand I am not required to provide my permission to receive text messages to participate in the Janssen patient support programs or to receive any other communications I have selected.

Cell phone number: _____

Patient name (print): _____

Patient sign here: _____ **Date:** _____

If the patient cannot sign, patient's legally authorized representative must sign below:

By: _____ **Print Name:** _____ **Date:** _____

(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient:

_____

janssen

Clear Form Print Form

Spravato withMe

Spravato® (esketamine) C III
28 mg nasal spray

SPRAVATO withMe Savings Program
Patient Assignment of Benefits

1. **OPTIONAL:** This form is optional. Signing this form is not required for a patient to receive medical treatment, to start or stay on therapy, or to be enrolled in SPRAVATO withMe.
2. **AUTHORIZATION:** By signing this form, the patient authorizes SPRAVATO withMe to issue payment directly to their provider for any reimbursement amounts attributable to the costs of SPRAVATO® administered in their provider's office. This form's authorization is not limited to one provider, but grants patient authorization for all of the patient's treatment providers who submit a rebate request to SPRAVATO withMe Savings Program.
3. **BENEFITS:** This form is limited to repayment of the costs of medication that are administered in the provider's office. It does not cover the cost of the office visit or your treatment's administration.
4. **INSTRUCTIONS:** Patient must read this form, complete all fields, sign, and return this form to their provider if the patient is in agreement with the assignment of the above benefits to all providers from whom the patient receives medical services related to SPRAVATO®. Providers should fax the completed form to SPRAVATO withMe at 844-584-1453, or mail to SPRAVATO withMe, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.
5. **CANCELLATION:** Patient can, at any time, call SPRAVATO withMe and elect for the rebate check(s) (payment) to be sent directly to them.

Patient Information:

Patient Name: _____ Date of Birth (mm/dd/yyyy): _____

SPRAVATO withMe Savings Program Member #: _____
(from the front of your Savings Program card)

Patient Address: _____

City: _____ State: _____ ZIP Code: _____

Patient Authorization:

My signature on this Patient Assignment of Benefits Form confirms that I authorize that each of my SPRAVATO withMe Savings Program out-of-pocket payment(s) be sent on my behalf to all provider(s) for payment of my out-of-pocket SPRAVATO® medication cost(s). I also understand that I may, at any time, call SPRAVATO withMe and elect for the rebate check(s) to be sent directly to me.

Patient Signature: _____ Date: _____

If the patient cannot sign, patient's legally authorized representative must sign below.

By: _____ Date: _____
(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient:

_____

Please read the full Prescribing Information, including Boxed WARNINGS, and Medication Guide for SPRAVATO® and discuss any questions you may have with your healthcare provider.

Patient Assistance Enrollment Form

I understand that JJHCS and third parties associated with administrating the Program on behalf of JJHCS (collectively, the "Program Administrators"):

- Reserve the right without notice to change the application form, change the Program or Program criteria, or to terminate my enrollment at any time;
- May request and obtain information about my or my family's income, including verification of my income, or my insurance coverage, including documentation of any insurance denials, and that the information may be requested from me, others acting on my behalf or third-party sources;
- May request that I re-verify my eligibility to receive medicines under the Program

I certify that:

- All the information on this form and all the documentation submitted are complete and correct, and to the best of my knowledge, I meet the eligibility requirements for the submission of the application
- I am completing this application voluntarily. I have not been directed by my insurance company or by a non-medical professional to complete this application. I have not been offered any financial or other benefit by any third party in order to seek assistance from Johnson & Johnson Patient Healthcare Systems, Inc. (JJHCS) and I have not been told that any benefit will be denied or withheld (such as insurance coverage) if I do not complete this application
- I have completed this application myself or with the assistance of a legally authorized representative (such as a guardian), family member, caregiver, friend, healthcare provider or representative of a patient organization. If such assistance was provided, I have reviewed the application before submission to JJHCS to ensure all information is accurate and true. No other third party has assisted with the completion of this application
- The product(s) provided under this patient assistance program will not be sold or traded
- I will notify the Janssen Support Program within thirty (30) days if there is any change in my income or health insurance coverage. This includes a change in my eligibility to participate in the Medicare program due to changes in my age or disability status or my enrollment in Medicare Part D
- I will not attempt to claim or submit any costs associated with the medicine(s) I receive under the Janssen Support Program to any person or entity, including my Medicare Part D plan
- I will not seek true out-of-pocket (TrOOP) credit under the Medicare Part D program for the cost of the medicine(s) I receive under this program

SIGN & DATE:

Patient Name (*print*): _____

Patient Sign Here: _____ Date (*mm/dd/yyyy*): _____

If patient cannot sign, patient's legally authorized representative must sign below:

By: _____ Print Name: _____ Date (*mm/dd/yyyy*): _____
(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient:

_____

Clear Form Print Form

Patient Authorization Form

I understand that I am not required to sign this Form. My choice about whether to sign will not change how my HCPs or Insurers treat me. If I do not sign this Form, or cancel or remove my permission later, I understand I will not be able to participate or receive assistance from Janssen's patient support programs.

I understand that pharmacies that dispense and ship my medication and service providers for the patient support programs may be paid by Janssen for their services and data. This may include payment for sharing Protected Health Information and other data in connection with these programs, as allowed on this Form.

This Form will remain in effect 10 years from the date of signature, except where state law requires a shorter time, or until I am no longer participating in any Janssen patient support programs. Information collected before that date may continue to be used for the purposes set forth in this Form.

I understand that I may cancel the permissions given by this Form at any time by letting Janssen know in writing at: Janssen CarePath, 2250 Perimeter Park Drive, Suite 300, Morrisville, NC 27560.

I can also cancel my permission by letting my HCPs and Insurers know in writing that I do not want them to share any information with Janssen.

I further understand that if I cancel my permission it will not affect how Janssen uses and shares my Protected Health Information received by Janssen prior to my cancellation.

I understand I may request a copy of this Form.

Permission for communications outside of Janssen patient support programs:

☐ Yes, I would like to receive communications relating to my Janssen medication.

☐ Yes, I would like to receive communications relating to other Janssen products and services.

For privacy rights and choices specific to California residents, please see Janssen's California privacy notice available at **janssen.com/us/privacy-policy#california**

Permission for text communications:

☐ Yes, I would like to receive text messages. By selecting this option, I agree to receive text messages as allowed by this Form to the cell phone number provided below. Message and data rates may apply. Message frequency varies. I understand I am not required to provide my permission to receive text messages to participate in the Janssen patient support programs or to receive any other communications I have selected.

Cell Phone Number: _____

SIGN & DATE:

Patient Name (*print*): _____

Patient Sign Here: _____ Date (*mm/dd/yyyy*): _____

If patient cannot sign, patient's legally authorized representative must sign below:

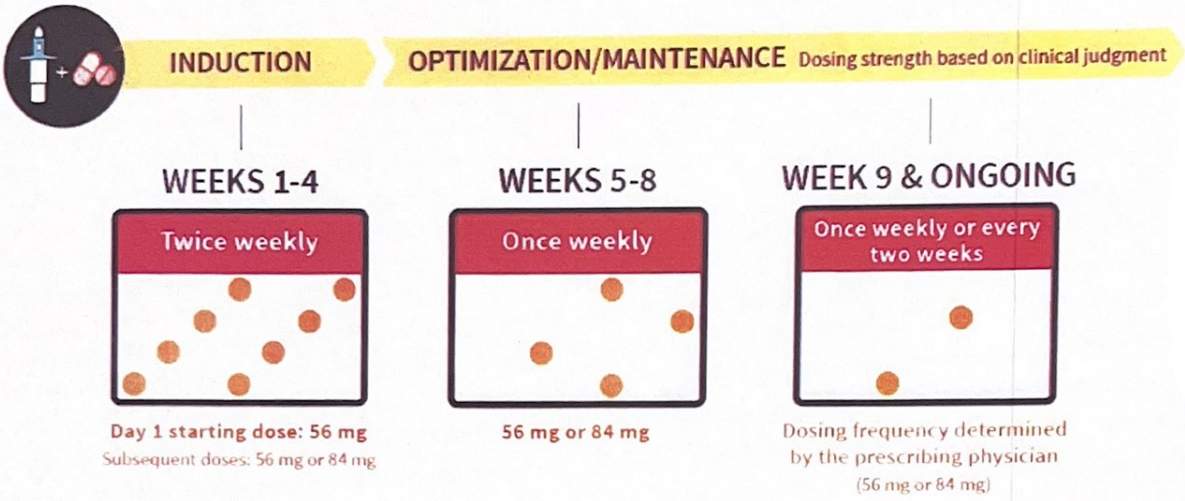
By: _____ Print Name: _____ Date (*mm/dd/yyyy*): _____
(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient:

_____

Clear Form Print Form

Dosing SPRAVATO®



- SPRAVATO® must be taken with an oral AD
- SPRAVATO® is self-administered only under the supervision of a healthcare provider
- Evidence of therapeutic benefit should be evaluated at the end of the induction phase to determine need for continued treatment. This will be discussed on the day of your 8th treatment.
- Dosing frequency should be individualized to the lowest frequency required to maintain remission/response

* After week 8 or your 12th treatment, you will have a 30 minute schedule re-evaluation with Dr. Frasca. This will be scheduled on a different day than your Spravato treatment.