Adult ADHD and Anxiety Clinic

Phone: 202-802-6004
Fax: 703-637-1095

1234 19th street, NW Suite 600
Washington, DC 20036

E-mail: Office@AdultADHDandAnxietyClinic.com

Registration Information

(Please print)

Date: (Month, Day, Year) ____/____/_______

Client Name: (Last, First, Middle) ____

Date of Birth: ____/____/______ Age:______ Sex: Male ☐ Female ☐

Main Phone: (_____)______-___________ Is it Home ☐ Work ☐ or Cell ☐ ?

Can we leave a message? Yes ☐ No ☐ Can we text you? Yes ☐ No ☐

Client E-mail: ____

Client Address: ____________________________________ ______________________ ____ ______

Street City State ZIP

Employer: (Name, Phone) ____

Emergency Contact ___________________________ Relationship to Client ___________________

Cell Phone (____)____-__________

Primary Doctor: (Name, City, State) ________________________________ Phone (_____)____-_________

Referring Doctor: (Name, City, State) _______________________________ Phone (_____)____-_________

Therapist: (Name, City, State) _____________________________________ Phone (_____)____-_________

Client Pharmacy: Name: _______________ Address: ____

Phone (____)____-___________ Fax: (____)____-___________

Client Signature: __________________________________ Date: ____/____/_____

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List ALL current and previous medical conditions, including surgical procedures

Name	Date

List ALL allergies, including foods

Name	Reaction

List ALL current medications and supplements, including OTC (Over The Counter)

Name	Dosage	How often	Start Date

Client Signature: ____________________________________ Date: ____/____/_____

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Client Name: ____ Date ________________

Did you take any of the medications below? If so, what was your experience with them?

Antipsychotic Medication

Brand Name	Generic Name	Pt's experience with medication. Start and discontinuation dates.
Abilify	aripiprazole	
Clozaril	clozapine	
Fanapt	iloperidone	
fluphenazine	fluphenazine	
Geodon	ziprasidone	
Haldol	haloperidol	
Invega	paliperidone	
Loxitane	loxapine	
Navane	thiothixene	
Orap (for Tourette's syndrome)	pimozide	
perphenazine (generic only)	perphenazine	
Risperdal	risperidone	
Saphris	asenapine	
Seroquel	quetiapine	
Stelazine	trifluoperazine	
thioridazine (generic only)	thioridazine	
Thorazine	chlorpromazine	
Zyprexa	olanzapine	

Antidepressant Medications

Anafranil (tricyclic)	clomipramine	
Asendin	amoxapine	
Aventyl (tricyclic)	nortriptyline	
Celexa (SSRI)	citalopram	
Cymbalta (SNRI)	duloxetine	
Desyrel	trazodone	
Effexor (SNRI)	venlafaxine	
Elavil (tricyclic)	amitriptyline	
Emsam	selegiline	
Lexapro (SSRI)	escitalopram	
Ludiomil (tricyclic)	maprotiline	

Luvox (SSRI)	fluvoxamine	
Marplan (MAOI)	isocarboxazid	
Nardil (MAOI)	phenelzine	
Norpramin (tricyclic)	desipramine	
Pamelor (tricyclic)	nortriptyline	
Parnate (MAOI)	tranylcypromine	
Paxil (SSRI)	paroxetine	
Pexeva (SSRI)	paroxetine-mesylate	
Prozac (SSRI)	fluoxetine	
Pristiq (SNRI)	desvenlafaxin	
Remeron	mirtazapine	
Sarafem (SSRI)	fluoxetine	
Sinequan (tricyclic)	doxepin	
Surmontil (tricyclic)	trimipramine	
Tofranil (tricyclic)	imipramine	
Tofranil-PM (tricyclic)	imipramine pamoate	
Vivactil (tricyclic)	protriptyline	
Wellbutrin	bupropion	
Zoloft (SSRI)	sertraline	

Mood Stabilizing and Anticonvulsant Medications

Depakote	divalproex sodium (valproic acid)	
Eskalith	lithium carbonate	
Lamictal	lamotrigine	
lithium citrate (generic only)	lithium citrate	
Lithobid	lithium carbonate	
Neurontin	gabapentin	
Tegretol	carbamazepine	
Topamax	topiramate	
Trileptal	oxcarbazepine	

Anti-anxiety Medications

Ativan	lorazepam	
BuSpar	buspirone	
Klonopin	clonazepam	
Librium	chlordiazepoxide	
oxazepam (generic only)	oxazepam	
Tranxene	clorazepate	
Valium	diazepam	
Xanax	alprazolam	
Atarax, Vistaril.	hydroxyzine	

ADHD Medications/stimulants

Adderall	amphetamine	
Adderall XR	amphetamine (extended release)	
Concerta	methylphenidate (long acting)	
Daytrana	methylphenidate patch	
Desoxyn	methamphetamine	
Dexedrine	dextroamphetamine	
Dextrostat	dextroamphetamine	
Focalin	dexmethylphenidate	
Focalin XR	dexmethylphenidate (extended release)	
Metadate ER	methylphenidate (extended release)	
Metadate CD	methylphenidate (extended release)	
Methylin	methylphenidate (oral solution and chewable tablets)	
Ritalin	methylphenidate	
Ritalin SR	methylphenidate (extended release)	
Ritalin LA	methylphenidate (long-acting)	
Strattera	atomoxetine	
Vyvanse	lisdexamfetamine dimesylate	
Provigil	modafinil	
Nuvigil	armodafinil	

Medications for insomnia/ nightmares.

Ambien/ Ambien CR	Zolpidem	
Catapres	Clonidine	
Lunesta	Eszopiclone	
Minipress	Prazosin	
Rozerem	Rameltion	
Silenor	Doxepin	
Sonata	Zaleplon	

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Outpatient Services Contract
(Informed Consent)

Dr. Mira Khmurets, PSYCHIATRIST – ______________________________, CLIENT
First Name, Last Name

Welcome to our practice. This document contains important information about our professional services and business policies. Please read it with care and jot down any questions you might have so that we can discuss them at our next meeting. When you sign this document, it will represent an agreement between us.

Our services
Clinical assessment and pharmacological treatment of adult ADHD and related psychiatric disorders.

Initial meeting and follow up appointments
Our first few sessions will involve an evaluation and discussion of your needs. It might include rating scales and psychological tests if needed. By the end of the first (on some occasions second) meeting, I will present my initial diagnostic impression and treatment considerations. We will discuss risks versus benefits of medication management and side effects of medications. Frequency of follow-up appointments depends on the situation. Usually I schedule second appointment within 1-2 weeks of the initial evaluation. Subsequent follow-up visits are scheduled based on individual needs. The time between visits is extended once your condition begins to improve.

<u>You are expected to arrive for each appointment 20 minutes prior to the scheduled time.</u>

Referrals and Coordination of Care
Please be aware that medication management is a “trial and error” process and it may take some time before we find an effective medication or combination of medications for you. In some very rare cases none of the medications are effective. In this case we will discuss alternative options for treatment and you will be offered a referral to other specialist. I will be glad to talk to your PCP or other providers to help coordinate your care. I will not call any third parties without your written permission. A life threatening emergency is an exception to this rule.

Contact
I am not immediately available by telephone. We will call you back within 24 business hours after you leave a message. If necessary, we will schedule an emergency appointment at the earliest availability.

If I am unavailable for an extended period of time, I will make necessary arrangement for the continuation of your treatment.

If you are experiencing serious side effects or life threatening emergency please call 911 or go to the nearest emergency room immediately. <u>Do not wait until we return your call</u>.

Insurance and Payment
Our services may be partially covered by most of the health insurance plans as "out of network". It is client's responsibility to verify benefits before coming to the first appointment. We will provide an itemized statement (Superbill) which you can submit to your insurance company.

Payment is due in full at the time services are rendered. We accept all major credit cards and cash. No personal checks accepted.

Appointment Cancellation Policy
If you have to miss a session, please provide a 24-hour notice of cancellation. If you do not provide such notice your account may be charged the fees equal to missed session fees.

Prescription Refill Policy
The client is responsible for knowing when medication(s) will need to be refilled (please verify with the doctor during your office visit).

We require **3 business days** to process prescription renewal/pre-authorization requests. Please notify the office as soon as you learn that pre-authorization is required.

No prescriptions will be refilled on Fridays, Saturdays, Sundays or Holidays.

New symptoms and/or events require a clinic appointment. Provider is unable to diagnose via phone.

In some cases, prescriptions may be mailed to clients. Overnight delivery method will be used. Additional fees may apply.

Lost/damaged prescriptions will not be replaced. Please treat your prescriptions as money.

Confidentiality
In general, the law protects the privacy of all communications between a patient and a mental health professional. I can release your medical information to others only with your written permission. There are a few exceptions:

1. The situations in which I am legally obligated to take action to protect others from harm, even if I have to reveal some information about a client's treatment. For example, if I believe that a child, elderly person, or disabled person is being abused, I must file a report with the appropriate state agency. In some instances, I must also report past physical and sexual abuse of minors.
2. If I believe that a client is threatening serious bodily harm to others, I am required to take protective actions. These actions may include notifying the potential victim, contacting the police, and/or seeking hospitalization for the client. If the client threatens to harm himself or herself, I may be obligated to seek hospitalization for him or her and/or to contact family members or others who can help provide protection.
3. If you ever become involved in a divorce or custody dispute or any other legal proceedings I will not provide evaluations or expert testimony in court. You should hire a different mental health professional for any evaluations or testimony you require. When you sign this document it means that you will not attempt to use me in any legal matter or proceedings.
4. The terms of your health insurance contract may stipulate that I provide information about your treatment. I can disclose only the following information: diagnosis, treatment plan, reasons for continuing treatment, and estimate of the length of treatment. If the insurance company determines that more information is necessary, the insurance company must appoint an independent reviewer, and the additional information can be disclosed only to the reviewer.
5. If a client files a worker's compensation claim, I must, upon appropriate request, provide a copy of the record to the employer, and/or client's insurer.

If any of the above situations occur, I will make every effort to discuss them with you before I take action.

While this written summary of exceptions to confidentiality should help inform you about potential problems, it is important that we discuss any questions or concerns that you may have at our next meeting.

Termination

I reserve the rights to terminate our professional relationship with 30 days written notice in cases of non-compliance with office policies, failure to follow treatment instructions, failure to keep appointments (2 or more times) without appropriate notice, failure to pay or if in my professional opinion I cannot meet your needs.

Our professional relationship will be terminated at the time of the event due to the client's intolerable behavior including shouting, using profanities, verbal or physical threats, diversion of controlled substances, doctor shopping with the intent to obtain controlled substances.

Agreement to Terms

Your signature below indicates that you have read this statement describing my services, the risks and benefits of therapy, and policies about referrals and coordination of care, meetings, cancellations, contact outside of scheduled meetings, fees, insurance, billing and payment, professional records, and confidentiality, and that you agree to abide by its terms during our professional relationship. Please return one copy to me and retain one copy for your records.

Signature: ___________________________ Date: _____________

Name (printed): ____________________________________

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APPOINTMENT CANCELLATION POLICY

In order for us to deliver care in the most efficient and effective way, we ask that you inform us if you are unable to attend your scheduled appointment. Your notification allows us to better utilize available appointment time for other clients in need of prompt medical care.

If it is necessary to cancel your scheduled appointment, we require that you call or leave a message at least 24 hours before your appointment time. Appointments are in high demand, and your early cancellation will give another client the opportunity to have access to timely care.

We reserve the right to charge **a fee equal to missed session fee** for any scheduled appointment that is:

- **Cancelled with less than 24 hour notice**
- **Missed without calling to cancel (no-show)**
- **15 or more minutes late and the doctor is unable to see you**

You are required to pay the cancellation fee prior to the start of your next scheduled visit.

Signature: ___________________________ Date: _____________

Name (printed): ___________________________________

Regular Attendance is Critical for Optimal Outcomes

ADULT ADHD AND ANXIETY CLINIC

PATIENT AGREEMENT/CONSENT FOR CONTROLLED SUBSTANCE PRESCRIPTIONS.

I ______________________________ understand that medication(s) I was prescribed is potentially addictive and I agree to the following:

1. I will list ALL the medications I use now or used in the past and disclose full history of past or current drugs or alcohol use. I will take an initiative to notify Dr. Khmurets if there any changes in prescription or illicit drugs or alcohol use.
2. Dr. Khmurets will be the only physician who prescribes my ADHD or anxiety medications, and I will not attempt to get these medications from any other providers, or without telling the other provider that Dr. Khmurets already prescribes these medications for me.
3. I understand that I am responsible for taking this medication as prescribed and keeping track of the amount remaining. I will not increase the dose of my medications unless Dr. Khmurets has recommended that.
4. I am responsible for safeguarding the controlled substance medication prescribed to me, including from family members, roommates, etc.
5. I will not share, sell or trade my medications. I will let Dr. Khmurets know if I have excessive amounts of medications at home.
6. **Prescription for controlled substance medication will not be replaced, if it lost, stolen or used up sooner than expected.**
7. I agree to the toxicology test (urine or buccal swab) before medications are prescribed and randomly during the treatment course.
8. I will do my best to use one pharmacy to fill controlled substance medications. If this is not possible I will let Dr. Khmurets now the names and addresses of all pharmacies I am getting my medications from.
9. I agree that Dr. Khmurets could talk with the pharmacists regarding my obtaining of the controlled substance medications.
10. I understand that Dr. Khmurets will be monitoring my prescriptions history through Prescriptions Monitoring Program and she has a right to terminate our therapeutic relationship if records reveal suspicious behavior such as doctors shopping or using multiple pharmacy, without proper disclosure.
11. I understand that Dr. Khmurets will terminate our doctor – patient relationship if my behavior is inconsistent with responsibilities above.
12. I understand that if I misuse Benzodiazepines (Klonopin, Xanax, Ativan etc.) Dr. Khmurets will stop this medication immediately and it will become my responsibility to seek help/ treatment or prevention of withdrawal symptoms in emergency room. I understand that withdrawal from benzodiazepines is potentially life threatening.

Signature: __________________________ Date: ____________