Allyson Witters Cundiff, M.D.
30 Burton Hills Blvd., Suite 375
Nashville, TN 37215
Phone 615-327-4877 Fax 615-327-4881
http::/healthymindsnashville.com

Patient Information:

Last Name:_____ First:_____ MI:_____

Prefers to be called (if different from legal name):_____

Address:_____

City:_____ State:_____ Zip code:_____

Home Phone:_____Cell Phone:_____

Email: _____

Date of Birth:_____/_____/_____Age:_____ Gender:_____

Social Security#:_____-_____-_____

Spouse's/Partner's Name:_____Phone:_____

Patient Employer/Occupation:_____Phone:_____

Preferred Pharmacy: _____Phone:_____

Pharmacy Address/Neighborhood:_____

Who referred you to Dr Cundiff?: _____

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Emergency Contact Information:

Name:_____

Relationship to patient: _____Phone:_____

Email: _____

Electronic Mail (EMAIL) Policy:

By agreeing to communicate via email, you are assuming a certain degree of risk of breach of privacy beyond that inherent in other modes of traditional communication (such as telephone, written, or face-to-face). We cannot ensure the confidentiality of our electronic communications against purposeful or accidental network interception. Due to this inherent vulnerability, we will save email correspondence with you and these communications should be considered part of the medical record; therefore, you should consider that our electronic communications may not be confidential and will be included in your medical chart. Never send emails of an urgent or emergent nature and please contact the office if you have not received a reply within 24 hours.

*I have read and agree to the terms of the email policy:

Signature: _____ Date: _____

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Insurance Policy:

As an out-of-network provider, Allyson Witters Cundiff, M.D. is not contracted with nor will accept payment from insurance companies. You can request a statement of service and payment to file insurance for yourself (aka "superbill"). Additionally, Allyson Witters Cundiff, M.D. opted out of Medicare. Please notify the office if you have Medicare Insurance; you will need to sign an additional form, as Dr. Cundiff or the patient cannot file this insurance.

Payment Policy:

Payment is required in full at the time of service we accept credit/debit/checks/cash (please note we do not keep change in the office for cash payments but are happy to put a credit on your account if you do not have exact cash).

*For your convenience we will keep a credit card on file to charge at your appointments. If you change cards or payment type, please update with us in order to avoid cancellation of appointment if card is not valid.

Credit/Debit Card Payment for appointments:

I/we authorize Allyson Witters Cundiff, M.D. to bill the above credit/debit card for professional services at the time of service. I will notify Allyson Witters Cundiff, M.D. if I do not want my credit card billed. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

Signature: _____ Date:_____

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Credit/Debit Card Payment for Missed or Cancelled Appointments:

We do not overbook appointments and appointments made are explicitly reserved for each patient. We require a 24-hour cancellation notice. Patients will be charged the full session rate if they do not cancel an appointment within the 24-hour time frame or if they fail to keep their appointment on the day it is scheduled. If you need to change or reschedule an appointment, please call our office as soon as you can so we can accommodate other patients who wish to be seen.

I/we authorize Allyson Witters Cundiff, M.D. to charge the above credit/debit card when the patient/guardian does not give advanced notice for a late cancellation or no-show, as per the policies. I understand that if I do not want my credit card billed for this purpose, I am still responsible for these fees and will be billed accordingly.

Signature: _____Date: _____

☐ Visa ☐ Mastercard ☐ Discover ☐ Amex

Name on card:_____

Card Number: _____

Security Code:_____ Billing Zip code: _____

Exp. Date: _____

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Paperwork Policy:

Requests to complete forms or other paperwork (such as FMLA or disability) may result in additional charges that reflect hourly rates. The fee will depend on the time needed to complete forms appropriately, and this may include writing, chart review for supporting clinical documentation, preparing/sending faxes, emails and other administrative tasks. Some of this may occur during appointments.

Office Hours:

Dr. Cundiff schedules patients by appointment only. The front office is open:
Monday to Thursday: 9:00am-12:00pm & 1:00pm-4:00pm
Friday: 9:00am-2:00pma
Closed Saturday and Sunday and Holidays

If you need to contact the office regarding an appointment, billing questions or general needs, please call during these hours.

After Hours Emergencies:

To reach Dr. Cundiff after office hours, call the main office at 615-327-4877 and press "0" to be connected to our answering service. You may hear silence while the line connects. Please wait on the line. The answering service will page your doctor or the on-call doctor for any urgent needs. <u>If you are experiencing an emergency and cannot wait, please call 911.</u>

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Medication Refill Policy:

Medication refill requests require 72-hour notice. If medication refills are required between appointments, please have your pharmacy send us a refill request. If you need to call for a refill, you can do so during posted business hours. Refills will be communicated to your pharmacy within 24 hours during regular business hours. After-hours, holiday, or weekend requests may not be called in until the next business day. Please call with your prescription information and dosage and your pharmacy name, location and phone number. We will need this information in order to complete your refill request.

Patient Medication Agreement:

Prescription fraud, diversion and misuse are known challenges facing the healthcare industry. As a result, some clinics refuse to write certain controlled medications or those carrying some abuse potential.

While this effort may be helpful in some instances, we feel that omitting certain medications outright could limit the overall effectiveness of the care we aim to provide. To provide optimal care while prioritizing patient safety, we will take many measures detailed below.

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Please read, review and sign to demonstrate understanding of the Patient Medication Agreement.

- I understand that prescriptions for controlled medications will always include database monitoring and may include urine drug testing as appropriate and at the discretion of the treating physician.

- I agree to receive any prescribed or controlled substances from Allyson Witters Cundiff, M.D., and will not seek duplicate prescriptions from other providers.

- I understand that it is a felony to obtain medications by fraudulent means, possess medications without a legitimate prescription, or buy/sell/give/distribute medication to others.

- I understand that lost or stolen medications will not be refilled early.

- If appointments are not kept or scheduled, I understand that certain prescriptions will not be refilled.

We hope there is a limited negative impact from the above measures and that you understand the actions taken to safeguard against fraud and misuse.

Signature:_____ Date:_____

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Consent to Treatment and Patient Financial Responsibility

- The first appointment is solely for the purpose of consultation and it does not establish physician-patient relationship. If both parties are agreeable to continue working together beyond the initial appointment, we will proceed with patient and physician established relationship.

- I have read the above policies, and I understand and agree to follow them. I agree to be treated by Allyson Witters Cundiff, M.D., and when necessary, any doctors covering in her absence.

I, the undersigned, regardless of any insurance coverage, am financially responsible for all charges for services rendered. Office policy requires payment at the time of service. I understand that unpaid balances over 30 days may be subject to a late fee. I understand that outstanding balances over 90 days are past due and may be referred to a collection agency. If payment is still unable to be collected after that, I understand that I may be subject to dismissal from this office/termination of treatment. If a credit card is used, I understand there will be an additional credit processing fee.

Person Responsible for Payment
(complete only if the patient is NOT paying the bill):

Name of person responsible for bill: _____

Date of Birth: _____/_____/_____

Preferred Phone Number:_____Email:_____

Address:_____

City:_____State:_____Zip Code:_____

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Termination of Treatment:

Patients are not obligated to continue treatment. If you decide to terminate at any time, you are encouraged to discuss your decision with your doctor.

Signature: _____Date:_____

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HIPAA Privacy Rule
Receipt of Notice of Privacy Practices
Written Acknowledgement Form

Acknowledgement of receipt of Information Practices Notice (§ 164.520(a))

I, _____, (patients name) understand that this facility originates and maintains health records describing my health history, symptoms, examination and test results, diagnosis/diagnoses, treatment and any plans for future care or treatment. I acknowledge that I have been provided with and understand that this facility's Notice of Privacy Practices provides a complete description of the uses and disclosures of my health information.

I understand that:

- I have the right to review this facility's Notice of Privacy Practices before signing this acknowledgement.

- This facility reserves the right to change its Notice of Privacy Practices, and before implementation of this, will mail a copy of any revised notice to the address I've provided if requested.

Signature of Individual or Legal Representative Witness:_____

Printed Name of Individual or Legal Representative:_____

Date: _____

FOR OFFICE USE ONLY
We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but it could not be obtained because:
Individual refused to sign
Communication barriers prohibited obtaining the acknowledgment
An emergency situation prevented us from obtaining acknowledgement
Others (please specify)

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Treatment Overview

Have you ever seen a psychiatrist? If yes, who provided treatment/what was your diagnosis?

Are you currently or have you previously been in therapy? If yes, with who and for how long?

Current medication regimen (including supplements):

Previous psychiatric medication trials:

Previous psychiatric hospitalizations (which hospital and when and for what reason)?

Current medical providers (please include primary care, specialists, other relevant info):

Provider	Role	Phone

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Private Contract - Provider Opt-Out of Medicare

Beneficiary Name: _____ Beneficiary Medicare Number: _____

Legal Representative (if applicable) _____

This private contract agreement is between the physician and beneficiary noted above. The beneficiary is a Medicare Part B beneficiary and is seeking services covered under Medicare Part B. The physician above has informed the beneficiary or his/her legal representative they have opted-out of the Medicare Program. The current Medicare opt-out period will automatically renew every two years. The physician noted above is not excluded from participating in Medicare Part B under §§1128, 1156 or 1892 of the Act.

The beneficiary or his/her legal representative has read and agree to the following terms of the private contract by placing their initials by the items below:

___ I, or my legal representative, accept full responsibility for payment of the physician's or practitioner's charge for all services furnished by this physician/practitioner.

___ I, or my legal representative, understands that Medicare limits do not apply to what the physician/practitioner may charge for items or services furnished by the physician/practitioner.

___ I, or my legal representative, agree not to submit a claim to Medicare or to ask the physician/practitioner to submit a claim to Medicare.

___ I, or my legal representative, have been informed of the expected or known expiration date of the opt-out period.

___ I, or my legal representative, understand that Medicare payment will not be made for any items or services furnished by the physician/practitioner that would have otherwise been covered by Medicare if there was no private contract and a proper Medicare claim had been submitted.

___ I, or my legal representative, enter the contract with the knowledge that the beneficiary has the right to obtain Medicare covered items and services from physicians and practitioners who have not opted out of Medicare, and that the beneficiary is not compelled to enter into private contracts that apply to other Medicare covered services furnished by other physicians or practitioners who have not opted out.

___ I, or my legal representative, understand that Medigap plans do not, and that other supplemental plans may elect not to, make payments for items and services not paid for by Medicare.

___ I, or my legal representative, agree this contract was not entered into during a time when the beneficiary required emergency care services or urgent care services.

Beneficiary/Legal Representative's Signature: _____

Date: _____

THE MOOD DISORDER QUESTIONNAIRE

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

	YES	NO
1. Has there ever been a period of time when you were not your usual self and...	☐	☐
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found you didn't really miss it?	☐	☐
...you were much more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had much more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family into trouble?	☐	☐
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please check one response only.*

☐ No Problem ☐ Minor Problem ☐ Moderate Problem ☐ Serious Problem

4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	☐	☐
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	☐	☐

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.				
2. Feeling down, depressed, or hopeless.				
3. Trouble falling or staying asleep, or sleeping too much.				
4. Feeling tired or having little energy.				
5. Poor appetite or overeating.				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.				
7. Trouble concentrating on things, such as reading the newspaper or watching television.				
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.				
9. Thoughts that you would be better off dead, or of hurting yourself in some way.				
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.				
2. Not being able to stop or control worrying.				
3. Worrying too much about different things.				
4. Trouble relaxing.				
5. Being so restless that it's hard to sit still.				
6. Becoming easily annoyed or irritable.				
7. Feeling afraid as if something awful might happen.				
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

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

Patient Name		Today's Date	

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

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

Part A

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

Part B