Lauren Schwartz, M.D., PLLC
Psychiatry
Diplomate of the American Board of
Psychiatry and Neurology
Fellow of the American Psychiatric Association

Informed Consent for Assessment and Treatment

Please Print Patient's Name: _____

I understand that as a patient of Lauren H. Schwartz, M.D., I may receive a range of mental health and wellness services. The type and extent of services that I will receive will be determined following an initial assessment. The goal of the assessment process is to determine the best course of treatment for me. I understand that after the initial assessment process it may be determined that this clinic is the not the appropriate treatment center for me, and if so, this will be communicated to me directly.

I understand that while psychotherapy and/or medication may provide significant benefits, they may also pose risks. If I have any questions regarding the services offered by Dr. Schwartz about treatment plan, purpose, potential risks and benefits, I have the right to discuss them with Dr. Schwartz. I acknowledge that there is no guarantee that I will have full remission of all my symptoms, or that a given treatment will be effective for me personally.

It is my understanding that this consent form is to cover the entire course of treatment by Dr. Schwartz. I also understand that either Dr. Schwartz or I may discontinue treatment at any time. This consent will remain fully effective until it is revoked in writing.

By signing this form, I understand the following:

1. I understand that the laws that protect privacy and the confidentiality of medical information include my psychiatric care, and that no information obtained in assessment or treatment, which identifies me, will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to treatment in the course of my care at any time.
3. I understand that it is my duty to inform Dr. Schwartz of any other healthcare providers that are involved in my medical/psychiatric care and what their recommended treatments have been.
4. I understand that, although Dr. Schwartz does not prescribe opioids, if I am identified as a "qualifying opioid patient" this consent form fulfills the required written policy and agreement as per Oklahoma Statutes.
5. I understand that I may expect the anticipated benefits from psychiatric care, but that no results can be guaranteed or assured.
6. I understand that I have the right to refuse any treatment and have the right to discuss all medical treatments with Dr. Schwartz.

I have read and understand this consent form. I consent to participate in the evaluation and treatment offered to me by Dr. Schwartz. A copy of this consent form will be provided at my request.

Signature _____ Date _____ Patient's Date of Birth _____
(Patient, Guardian or Patient Representative)

If signed by guardian or patient representative, please print name, relationship to patient and date of birth.

_____ _____ _____
Representative's Printed Name Relationship to Patient Representative's Date of Birth

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Office policies and payment agreement

Dr. Schwartz would like to take this opportunity to welcome you. Carefully read the following information and sign in the space provided. If you have any questions regarding your account or the policies this form explains, please feel free to ask the office manager or Dr. Schwartz for assistance. If you would like, the office manager will provide you with a copy of this form.

It is expected that full payment will be made when services are rendered.

For all insurance policyholders: In order to optimize quality patient care and reduce billing confusion, Dr. Schwartz has opted out of insurance networks, Medicaid, and Medicare. Remember, your insurance policy is an agreement between you and/or your employer and your insurance company. As a courtesy, we are happy to provide you with the information you need to file your insurance claims so that you can receive all the benefits that you deserve as a policyholder. If there is a balance due on your monthly statement, payment needs to be received from you or your insurance provider in order to prevent your account from becoming past due. If other arrangements are needed, please discuss them with Dr. Schwartz.

Due to "exclusions" that may be part of your insurance policy, certain treatment services or medical procedures may not be covered. Regardless of such exclusions, all services rendered by Dr. Schwartz are considered medically or psychiatrically necessary. You are responsible for the entirety of your bill at the time of service.

For Medicare patients: Dr. Schwartz has "opted out" of Medicare. If you are insured by Medicare, or you anticipate you will be covered by Medicare in the near future, please ask the office manager for the "Medicare Private Contract" to review. If you have any questions, Dr. Schwartz will be happy to answer them. This contract must be signed before Dr. Schwartz is able to provide psychiatric treatment for you.

Missed appointments: Please understand that, out of respect for your time, our clinic does not double-book appointment times. If you need to cancel or reschedule an appointment, please let the office know ***at least 24 hours in advance***. When you have a scheduled appointment, the time is solely yours. If appointments are missed without at least a twenty-four hour notice, you will be charged for the full session. If there are unusual circumstances as to why you could not provide twenty-four hour notice, please discuss this with Dr. Schwartz at your next appointment.

Inpatient Psychiatric Services: Dr. Schwartz does not provide inpatient psychiatric care. If inpatient treatment is indicated, Dr. Schwartz or one of her associates will assist you in seeking the help you require.

In conclusion, Dr. Schwartz is an independent medical provider and therefore is not a member of any HMO or PPO. She does not participate under any provider contract with hospitals, insurance companies or other provider programs including workers compensation. She does not "accept assignment" on services rendered. Please contact your insurance company regarding exclusions or other questions you may have regarding "going out of network."

_____ _____

Patient or Guardian's Signature Date

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Patient Information

Name_____

Address _____

City _____State_____Zip_____

Home Phone _____ Work Phone _____ Ext_____

Cell Phone _____

Email Address _____Date of Birth ____/____/_____

SSN # _____ Gender ☐ Male ☐ Female

Employer or School_____ How Long _____

Marital Status _____ Spouse's Name_____

Spouse SSN# _____ Spouse's Date of Birth____/____/_____

Employer _____Work Phone _____

Section II - Billing Information

Who is responsible for charges for this patient. ☐ Patient ☐ Other - Please complete the following information.

Name_____ Relationship to Patient _____

Address_____

City_____ State_____Zip_____

Home Phone_____ Work Phone_____Ext_____

Cell Phone_____

Date of Birth_____/_____/_____ SSN#_____ Gender ☐ Male ☐ Female

Employer or School_____ How Long_____

Marital Status_____ Spouse's Name_____ Spouse's SSN#_____

Section III – Emergency Contact Information

In case of an Emergency, please list at least two contacts and contact information you would like this office to utilize:

Name_____ Relationship to Patient: _____

Address _____

Phone 1_____ Phone 2_____

Name_____ Relationship to Patient: _____

Address _____

Phone 1_____ Phone 2_____

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Section IV – Insured Information

(Please complete if you are requesting that we provide documentation for you to file with your insurance)

Is the patient covered by insurance? ☐ Yes ☐ No Patient Relationship to Insured: ☐ Self ☐ Spouse ☐ Child

If "Patient Relationship to Insured" is OTHER than "Self" please complete the following. If patient is the insured go directly to Section V.

Insured's Name _____

Address _____ City _____ State_____Zip_____

Home Phone _____ Cell Phone_____

Date of Birth _____/_____/_____ SSN#_____ Gender ☐ Male ☐ Female

Employer or School _____ How Long _____

Marital Status_____ Spouse's Name _____ Spouse's SSN# _____

Section V - Insurance Policy Information

Insurance Company _____

Address _____City _____ State _____ Zip _____

Plan Name _____ Policy Number _____ Group Number_____

Is the patient covered by more than one insurance? ☐ Yes-Please complete section IV ☐ No- Please complete section VI

Section VI - Secondary Insurance Policy Information

Insurance Company_____

Address_____City_____State_____Zip_____

Plan Name_____

Policy Number_____ Group Number_____

Section VII - Insurance Release and Payment Agreement

Medical and Insurance Release (Please sign if you are requesting that we provide documentation for you to file with your insurance.)

I authorize the release of any information necessary, including the diagnosis, to be made available to my insurance company for processing claims.

Signature of patient or responsible party:

_____ Date:_____

Insurance and Payment Agreement

I authorize payments of insurance benefits to be made directly to my physician, Lauren H. Schwartz, M.D. I understand that documentation for my insurance is provided as a courtesy and does not guarentee reimbursment for services rendered.

Signature of patient or responsible party:

_____ Date_____

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Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name:_____ Birth Date:_____

I acknowledge that I have received a copy of the Notice of Privacy Practices of Lauren H. Schwartz, M.D. effective from April 14, 2003 (see NOTICE OF PRIVACY PRACTICES).

Signature (patient or authorized representative):_____

Date: _____

Relationship/authority (if signed by authorized representative):_____

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Patient HIPAA Acknowledgment and Consent Form
Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications

OPTIONAL

Patients of Lauren Schwartz, M.D. may be contacted via email and/or text messaging to remind them of an appointment and/or to provide general health reminders/information. These communications are generated through a patient portal that is HIPAA compliant, secure and password protected. If you choose to participate, you will be invited to access your patient portal via the email you provide below.

I acknowledge that, by providing an email or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from Lauren Schwartz, M.D.

I, _____(patient or guardian name), approve receiving phone calls, voice messages or email messages from Lauren Schwartz, M.D. related to appointment reminders, service information and billing matters. I authorize the use of the following mobile phone: _____ and/or my email:_____.
I also **do** / **do not** (circle one) approve the use of text messaging to my mobile phone listed above. I realize that I can opt-out of texting at any time by replying STOP to any text I receive.

_____ (patient or guardian initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

Dr. Schwartz does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Name (Print)_____

Patient Signature _____ Date _____

Revocation: I hereby revoke my request for future communications via email and/or text.
__I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages.
__ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.
NOTE: This revocation only applies to communications from this Practice.
Patient Name: _____
Patient/Patient Representative Signature: _____
Date: _____ Time: _____

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Evaluation Questionnaire

At OKC Psychiatry, our goal is to provide you with the most comprehensive and highest quality of care. To help us do so, we would appreciate you taking the time to complete the following paperwork to the best of your ability. If you have or can obtain any past medical/psychiatric records or lab work, please bring them to your appointment. Please bring bottles of all medications or supplements you are currently taking to your initial appointment. Thank you.

Name: _____ Age: _____ Date: _____

Reason for this appointment (please check all that apply):

☐ Diagnostic Evaluation
☐ Psychotherapy/Counseling Services
☐ Pharmacological Evaluation/Medication Management
☐ Establish psychiatric care as recommended after psychiatric hospitalization
☐ Continuation of current psychiatric or psychotherapeutic care
☐ Transition of care from out of state
☐ One-time consultation
☐ Family Consultation

☐ Other: (please specify:)

_____
_____

Please list the primary symptoms/problems for which you are seeking care today. If none, please write N/A:

_____
_____
_____
_____
_____
_____
_____

What treatments have you tried in the past for these symptoms? (medications, therapy, supplements, alternative etc):

_____
_____
_____
_____

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Past Psychiatric History and Treatment

Has a doctor, therapist, or psychiatrist ever diagnosed you with (check all that apply):

- ☐ Major Depressive Disorder
- ☐ Dysthymia
- ☐ Anxiety Disorder with/without Panic Attacks
- ☐ Bipolar Disorder, type 1 or 2
- ☐ Attention Deficit/Hyperactivity Disorder
- ☐ Schizophrenia or Schizoaffective Disorder
- ☐ Obsessive Compulsive Disorder
- ☐ Post Traumatic Stress Disorder
- ☐ Personality Disorder (please specify if known_____)
- ☐ Drug or Alcohol Abuse/Dependence
- ☐ Postpartum Mood Disruption (depression, anxiety, OCD, panic disorder)
- ☐ Autism Spectrum Disorder
- ☐ Adjustment Disorder
- ☐ Other (please be specific) _____
- ☐ Other (please be specific) _____
- ☐ Other (please be specific) _____
- ☐ Other (please be specific) _____

Have you received psychiatric or mental health treatment in the past? ☐ yes ☐ no

- ☐ Medication Management
- ☐ Individual Therapy
- ☐ Intensive Outpatient
- ☐ Acute Inpatient
- ☐ Extended Stay Inpatient/Residential
- ☐ Self Help Group Attendance (12 Step Program, etc)
- ☐ Other _____

Have you previously been prescribed psychiatric medication from your primary care physician or other health care provider to treat mental health symptoms? ☐ yes ☐ no

Have you ever been hospitalized for a psychiatric or mental health condition? ☐ yes ☐ no
If yes, please include reason(s) for hospitalization(s). Please include date(s) and location(s).

_____
_____
_____
_____
_____

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Are you currently in psychotherapy/counseling? ☐ yes ☐ no
If yes, who is your therapist? How often do you see your therapist and how long have you seen him/her?

_____
_____
_____

Have you experienced any assaults or traumas, including physical, emotional, verbal or sexual abuse: ☐ yes ☐ no
Please specify all that apply:
☐ Physical ☐ Sexual ☐ Emotional ☐ Verbal
Please list the ages which the traumas occurred:

_____
_____
_____

Do you believe these traumas are related to the symptoms you are presenting with today? ☐ yes ☐ no
Has there been any past history of suicidal thoughts or attempts? ☐ yes ☐ no
Do you own a firearm? ☐ yes ☐ no
Has there been any past history of self-harming or self-mutilation behaviors? ☐ yes ☐ no
Has there been any past history or risky/dangerous/impulsive behaviors? ☐ yes ☐ no

If yes, please specify about the attempts or behaviors:

_____
_____
_____
_____

Substance Use History

Do you use alcohol? ☐ yes ☐ no
If yes, how many drinks per night, and how many nights per week? _____
In the last 12 months, have you consumed more than you intended or felt your drinking patterns were excessive or out of control for you? ☐ yes ☐ no
Have you wanted to cut down on your drinking patterns? ☐ yes ☐ no

Do you use nicotine? ☐ yes ☐ no
If yes, please specify route of administration, how much/often?

_____

Do you use any recreational drugs? ☐ yes ☐ no
If yes, which ones and how often?

_____
_____

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Do you have a history of illicit drug use or abuse? ☐ yes ☐ no
If yes, which substances and for how long did you use them?

Do you have a history of taking a larger amount (higher dose) or more frequent use of a medication than was originally prescribed by your provider? ☐ yes ☐ no
If yes, which substances and for how long did you use them?

Have you ever been treated for substance abuse in the past? ☐ yes ☐ no
Had to attend detox or rehab program? ☐ yes ☐ no
If yes, when and what type of treatment did you receive?

Family Psychiatric History

Does anyone in your family struggle with psychiatric symptoms or illness? ☐ yes ☐ no
If yes, please specify which family member(s) and diagnoses (if known):

Are any of your relatives on psychiatric medications? ☐ yes ☐ no
If yes, which medications? Are these medications helpful?

Do any relatives have a history of problems with alcohol or drug abuse? ☐ yes ☐ no
If yes, which relative(s) and which substances?

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Family/Childhood History

Where were your raised?

_____

While being raised, my parental figures were:
☐ Married ☐ Never Married ☐ Living as Married/Cohabitating ☐ Separated ☐ Divorced ☐ Widowed

If parents divorced, how old were you when this occurred? _____

Were you adopted? ☐ yes ☐ no

What was your overall experience of being raised in your family?
☐ Excellent ☐ Good ☐ Fair ☐ Poor (Please describe):

_____
_____
_____
_____

Developmental History:

Are you aware of any complications related to your mother's pregnancy or your birth? ☐ yes ☐ no

_____
_____

Did you participate in any special education programs/classes/tutoring for learning disabilities or processing differences in school (grades K- 12)? ☐ yes ☐ no

_____
_____

Family Information:

Mother:
Age_____ ☐ Living ☐ Deceased
If deceased, when _____
Cause of Death _____

Father:
Age_____ ☐ Living ☐ Deceased
If deceased, when _____
Cause of Death _____

List all siblings, their dates of birth, and any relevant health/mental health challenges:

_____
_____
_____

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Medical History

In general, would you say that your overall health is: ☐Good ☐Average ☐Fair ☐Poor

Do you see a physician on a regular basis regarding any medical need? ☐ Yes ☐ No

Physician's Name(s) & Specialties

_____
_____

If so, please explain:

_____
_____
_____

Are you experiencing any physical symptoms that concern you?: ☐ Yes ☐ No
If yes, please specify:

_____
_____
_____

Have you been hospitalized for any medical reasons (not psychiatric)?☐ Yes☐ No
If yes, please specify why and when (not including birth of children)

_____
_____
_____

Have you had any surgeries?☐ Yes☐ No
If yes, please specify why and when

_____
_____
_____

When was your most recent physical exam and labwork/bloodwork? Are you aware of any abnormal results?

_____
_____

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Allergies to Medications:

☐ No known allergies or adverse reactions

OR

Please list all medications you are allergic to and describe the reaction:

_____
_____
_____

Current medications: (PLEASE: List any prescription & non-prescription medications, vitamins, supplements or herbs. If you need additional space, please use the back of this form.

	Medication	Dose	Frequency	Prescribing Physician
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

Below are a list of gender-specific questions. We attempt to be as sensitive to gender specifications as possible. However, to ensure the most comprehensive care, it is necessary to obtain the medical information below. Please answer the following questions to the best of your ability.

Female Patients:

Are you pregnant or may be currently pregnant? ☐ Yes ☐ No
Are you trying to become pregnant? ☐ Yes ☐ No
If you are not planning to become pregnant, what is your primary form of birth control?
_____
Menses: ☐ Regular ☐ Irregular ☐ Amenorrhea
First Date of Last Period _____
Are you taking contraceptives or hormone supplement(s)? ☐ Yes ☐ No
Do you have any perimenopausal/menopausal symptoms? ☐ Yes ☐ No
Menopausal? ☐ Yes ☐ No
Postmenopausal? ☐ Yes ☐ No

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☐ Menopause Approximate date _____

Do you have any Premenstrual Syndrome (PMS)/Premenstrual Dysphoric (PMDD) symptoms? ☐ Yes ☐ No

Do you believe your moods have been negatively affected by:
☐ Puberty ☐ Menstrual Cycles ☐ Pregnancy(s) ☐ Menopause

Have you ever been evaluated for any hormonal dysfunctions, such as thyroid and/or adrenal gland dysfunctions?
☐ Yes ☐ No

If yes, please describe?

_____
_____
_____

Male Patients:

Have you ever been evaluated for any hormonal dysfunctions, such as testosterone deficiencies or thyroid gland dysfunctions? ☐ Yes ☐ No
If yes, please describe? Please include treatment.

_____
_____
_____

Diet/Nutrition History
How would you describe your diet/nutrition?

_____
_____
_____

Are you currently on a restricted diet (vegan, high protein only, etc)? ☐ Yes ☐ No
If yes, please describe:

_____
_____

Do you have any Food Allergies/Sensitivities? ☐ Yes ☐ No
If yes, please describe:

_____
_____
_____

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Do you suffer or have your suffered from anorexia, bulimia or any other eating disorder? ☐ Yes ☐ No
If yes, please specify diagnosis, approximate date of diagnosis. Please include any treatment received:

_____
_____
_____

Do you regularly consume caffeine? ☐ Yes ☐ No
If so, how much consumption daily, what types? (energy drinks, coffee, tea):

_____
_____

Sleep Pattern History

Do you have any sleep disturbances (falling asleep, staying asleep)? ☐ Yes ☐ No
If yes, how long does it take you to fall asleep or fall back asleep?
On average, how many hours do you sleep per night? _____

Have you ever had a sleep study? ☐ Yes ☐ No

If yes, when and what were the results?

_____
_____
_____

Do you have history of: ☐ Sleep Apnea ☐ Heavy Snoring ☐ Sleepwalking ☐ Grinding Teeth

Do you take medications, herbals, OTC treatments for sleep disturbances? ☐ Yes ☐ No
If yes, please list and for how long?

_____
_____
_____

Social/Background History

Marital Status:
☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Single ☐ In a Relationship
Do you consider yourself: ☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Other: _____
Are you currently involved in a significant relationship? ☐ Yes ☐ No
Are you sexually active? ☐ Yes ☐ No

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List all of your children and their dates of birth.

_____ _____

_____ _____

_____ _____

Current living situation (relationship of person(s) with whom patient resides)?
☐ Self ☐ Spouse/family ☐ Roommate(s) ☐ Dormitory ☐ Group Home or Assisted Living Facility
☐ Other (please specify)

_____

_____

Have you been previously married? ☐ Yes ☐ No
If yes, please provide
dates:_____

What is highest level of education/degree you have received?
☐ None ☐ High School Diploma ☐ GED (General Equivalency Degree for HS) ☐ Associate Degree/Technical Degree ☐ Some College ☐ College Degree (Bachelors Degree) ☐ Masters Degree ☐ Doctorate or Professional Degree (MD, JD, PhD)

Are you currently employed?
☐ Yes, full time ☐ No, Unemployed ☐ Yes, part time ☐ Retired ☐ Student ☐ Disabled

If working, current occupation:
_____

If not working, former occupation:
_____

Have you ever had any legal problems including jail, prison, lawsuits, probation, etc.? ☐ Yes ☐ No
If yes, please explain:

_____

_____

Have you ever served in the military? ☐ Yes ☐ No
If yes, what branch of the military? When did you serve? What type of discharge did you receive?

_____

_____

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Do you have any spiritual or religious or affiliation that you identify with?
☐ Yes (please specify): _____
☐ Spiritual but not religious
☐ Seeking/Undecided
☐ None
☐ Other

How important is spirituality/religious practice in your life?
☐ Very Important ☐ Important ☐ Not Very Important

Are there any cultural or spiritual or religious beliefs or affiliations that you would like to tell us about?

_____
_____
_____

Do you exercise regularly? ☐ Yes ☐ No

_____
_____

What hobbies or activities do you enjoy? How often do you get to do these activities?

_____
_____

If you were to need help with your current difficulties, who are the people you could rely on the most to help/support you?
☐ Family ☐ Friends ☐ Coworkers ☐ Therapist/Counselor ☐ Other: _____

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Current Medical Providers and Pharmacy Information (phone and fax are most important)

PHARMACY: _____
Address: _____
City, State, Zip: _____
Phone #: _____
Fax: _____

PRIMARY CARE PROVIDER (PCP):_____
Address: _____
City, State, Zip: _____
Phone #: _____
Fax: _____

THERAPIST/COUNSELOR:_____
Address: _____
City, State, Zip: _____
Phone #: _____
Fax: _____

OTHER (previous Psychiatrist, Nutritionist, other Specialist, etc): _____
Address: _____
City, State, Zip: _____
Phone #: _____
Fax: _____

OTHER (previous Psychiatrist, Nutritionist, other Specialist, etc): _____
Address: _____
City, State, Zip: _____
Phone #: _____
Fax: _____

OTHER (previous Psychiatrist, Nutritionist, other Specialist, etc): _____
Address: _____
City, State, Zip: _____
Phone #: _____
Fax: _____