THE FLORIDA PSYCHIATRIC CENTER

ERIC WEINSTOCK, M.D.
Diplomate of the American Board of Psychiatry and Neurology

1300 N WEST SHORE BLVD STE 240
TAMPA, FL 33607

PHONE (813) 636-8300 FAX (813) 636-8301

Patient Information
Please print

Last Name _____ First name _____ M.I._____ M/F ____

Home Address _____ Apt. # _____

City _____ State _____ Zip _____

Home Phone _____ Birthdate _____SSN_____

Cell Phone_____ Email: _____

Primary Care Physician Name _____ Phone _____

Employer Name_____Work Phone _____

Person to notify in case of emergency _____

Relationship to patient _____ Home phone_____

Referred by _____Date_____

Patient Consent To Treatment

I hereby authorize ERIC WEINSTOCK, M.D., P.A. its employees and agents to administer treatment. This in no way constitutes a warranty or guarantee that my present condition will be cured. ERIC WEINSTOCK, M.D., P.A. its staff and employees will provide me with the best possible care available but no assurance of cure is to be assumed. I sign this willingly and voluntarily in full understanding of the above, and in so doing I release ERIC WEINSTOCK , M.D., P.A., its directors and officers, staff employees, agents and physicians from any and all liability which may arise from this action, whether or not foreseen at present.

_____ _____

Signature of Patient or Legal Guardian **Date**

THE FLORIDA PSYCHIATRIC CENTER

RESPONSIBLE PARTY INFORMATION (if different than patient)

Last Name_____First Name _____M.I._____ M/F_____

Home Address _____ Apt. #_____

City_____ State_____ Zip_____

Home Phone _____Birth Date_____ SSN_____

Employer Name _____Work Phone _____

Relationship to Patient _____

Agreement To Guarantee Payment

I understand that the above named MD is providing professional services to and on behalf of the above mentioned patient and I hereby agree to assume full responsibility for payment of reasonable charges by the MD and staff on rendering such services. I understand that any appointments not cancelled at least 24 hours in advance will be charged to me as the responsible party. I have read, and I understand, the conditions attached to this agreement and agree to abide by those conditions.

_____ _____

Signature of Parent or Legal Guardian **Date**

WORKER'S COMPENSATION

Name of Carrier _____ Phone Number _____

Contact Person _____ Employer Claim Number_____

Auto Y/N _____ Date of Accident/Injury_____

THE FLORIDA PSYCHIATRIC CENTER

PRIMARY INSURANCE

Name of Carrier _____ Phone Number_____

Address _____ Group # _____

Insured: Last Name _____ First _____ M.I._____M/F_____

Home Address _____ Phone _____

City_____State _____ Zip _____

Relationship to patient _____ ID# _____

Date of Birth_____ SSN_____

SECONDARY INSURANCE

Name of Carrier _____ Phone Number_____

Address _____ Group # _____

Insured: Last Name _____ First _____ M.I._____M/F_____

Home Address _____ Phone _____

City_____State _____ Zip _____

Relationship to patient _____ ID# _____

Date of Birth_____ SSN_____

Release and Assignment of Benefits

I authorize ERIC WEINSTOCK, M.D, P.A. to release any medical information necessary to process my insurance claim(s). I hereby assign all medical, including major medical benefits to which I am entitled, private insurance and any other insurance programs to ERIC WEINSTOCK, M.D., P.A. This assignment will remain in effect until revoked by me in writing. I understand that I am financially responsible for all my charges whether or not paid by said insurance. If said insurance company has not made payments withing 60 days I understand that I will be responsible for any outstanding charges. This assignment will not apply when the balance has been paid as noted on claim form. If patient defaults in payment, patient agrees to pay collection costs and responsible attorney fees associated with the collection of outstanding balance.

_____ _____

Signature of Patient or Legal Guardian **Date**

Office Policies

Office Hours:

- 9:00 a.m. to 4:00 p.m. Monday through Friday

Waiting Room Policies:

- All patients must sign in and notify us of your presence.
- New patients must fill out necessary paper work and present any insurance card information.
- Patients with a change of address or insurance information should notify the staff when signing in.
- No food or drinks are allowed in the waiting room.
- Children may not be left unattended at any time unless prior arrangements are made.
- Please keep conversation at a low volume so as not to disturb other patients while they are in session.

Appointments:

- Please make all appointments as far in advance as possible to ensure availability of your desired time.

Cancellation of Appointments:

- Please help us to serve you better by keeping your regularly scheduled appointment.
- All cancellations must be made 24 hours in advance. This will allow us time to schedule that appointment for someone else**.**
- Any missed appointment not cancelled 24 hours in advance is subject to a **$75.00 reschedule charge**.
- We understand that emergencies arise, please call the office as soon as possible.

Paper Work:

- There will be a minimum $50.00 per page fee for the physician to complete any required paperwork such as disability, return to work, or letters to specific individuals. Please allow 7-10 business days for it to be completed.

Prescriptions and refills:

- Please obtain your prescription from your provider at the time of your appointment.
- Phone refills will be done on an emergent basis only.
- Please make sure that you have enough medication to last until your next appointment.
- Medication over-rides will result in a $75 charge for any required paperwork.
- No refill requests will be processed after 12 noon on Fridays.

Paging:

- Please reserve paging of providers for emergencies only.
- Specifically, appointment changes or prescription refills are not considered emergencies.
- Please discuss with your doctor or practitioner when paging is appropriate.

Payment for services:

- Insurance or co-payment or co-insurance (including deductible) is due at the time of service. There is a service charge of $50 for all returned checks.
- Except where required by insurance contracts, we are filing your insurance as a courtesy to you. <u>You are required to obtain the authorization for your initial visit</u> and you are responsible for verifying on each subsequent visit that each visit has been authorized.
- We will verify your insurance coverage, but you are responsible if your insurance pays for the claim differently than we are informed.
- If there are any delays on the part of your insurance company in the processing of the claim, it is your responsibility to contact the insurance carrier.
- We will expect payment in full from you if the insurance does not pay within 90 days of the service date. Any balance remaining after your insurance pays will be due and payable upon receipt of bill.
- <u>You, the patient, have full financial responsibility when utilizing mental health insurance. When using insurance, the patient will be fully financially responsible for payment if the insurance company does not pay, or does not pay in full, for any reason.</u>

Typical Reasons for Insurance Partial or Denied Payment

- *Contractual Exclusions:* The health insurance company may deny payment for services provided due to contractual exclusions such as: pre-existing conditions; uncovered/excluded diagnoses, or lifetime/annual deductible.

- *Non-Approved Provider or Services Not Authorized:* It is the responsibility of the patient to ensure both that Dr. Eric Weinstock is an approved participating provider with the insurance company and that the specific services, including dates of service are authorized by the insurance company. This applies for such situations as: changing insurance companies or plans in the midst of ongoing care with Dr. Weinstock; starting a new treatment episode with Dr. Weinstock after a previous treatment episode was completed or terminated with the same or different insurance company; employment change with insurance change; initiation of COBRA insurance coverage during job transition. If Dr. Weinstock is not a provider or services are not authorized or approved, then the patient will be held 100% responsible for paying for the services provided.

- *"Approved Provider" & "Carve Out" in Mental Health Insurance:* For mental health services, insurance companies frequently sub-contract out the management, pricing and payment of those services to other insurance companies. The primary insurance company - like Blue Cross, Cigna, Aetna, Humana, United, Medicare, or TriCare, etc. - may "carve-out" or sub-contract out the administration of mental health insurance benefits to secondary insurance companies - like Magellan, Value Options, MHNet, MHN, CompCare, PsycCare, EverCare, CitrusCare, Bradman/UniPsych, etc. Therefore the primary insurance company may have no role in authorizing or paying the mental health benefits of your insurance plan. Even though Dr. Weinstock may be a participating provider with the primary insurance company, he may NOT be a participating provider for the secondary insurance company managing the mental health benefits. If you have any questions about this, please call the number on the back of your insurance card and speak to member services for more information.
- Change of Insurance Notification: It is the patient's responsibility to notify this office immediately of any changes to your insurance information. It is the patient's responsibility to always keep this office up-to-date with the most current insurance information prior to each office visit.
- Insurance Company Errors: It is the patient's responsibility to rectify errors by the health insurance company, such as rectifying incorrect patient identification or group numbers, or disputes in contractual benefits, which result in partial or total denial of payment to Dr. Weinstock.

THE BOTTOM LINE:

THE PATIENT IS ULTIMATELY RESPONSIBLE FOR PAYING ALL FEES IF FOR ANY REASON THE INSURANCE COMPANY DENIES PAYMENT , FOR ANY REASON.

Fee Schedule:

Type of visit:	Cost
Initial Evaluation / or 60 minute session	$400
40 minutes	$240
20 minutes	$120

I have read and agreed to abide by the above stated office policies and understand that the doctor or practitioner reserves the right to discharge patients at their discretion, including non-compliance with treatment plan or office policies.

I HAVE READ AND UNDERSTAND THE CANCELLATION POLICY AND I WILL BE RESPONSIBLE FOR THE $75.00 "RESCHEDULE" FEE FOR ANY MISSED APPOINTMENTS NOT CANCELLED 24 HOURS IN ADVANCE. NOT RECEIVING A REMINDER CALL DOES NOT EXCUSE YOU FROM THIS FEE. IT IS YOUR RESPONSIBILITY TO KEEP TRACK OF YOUR APPOINTMENTS.

_____ _____

Signature of Patient or Guardian **Date**

TREATMENT CONSENT FORM:

I consent to psychiatric evaluation and treatment with Eric Weinstock, M.D., P.A. and/or his associates. I further consent that if initiate email contact with Dr. Weinstock or his staff, then that shall serve as my consent for Dr. Weinstock and his staff to communicate back to me via email, including the transmission of any confidential information regarding my case, via email. With this consent, I agree to not hold Dr. Weinstock nor any of his staff liable if there is a security breach or leak of any of my confidential information sent via email in this aforementioned manner.

I give my permission to release any medical or psychological information regarding my treatment to my insurance company via phone, fax, email or correspondence.

This authorization will not be used for any purpose other than stated. I may revoke this authorization in writing at any time.

I have read and understand the above consent form.

[Patient] / [Legal Guardian] Name: [Print] _____

[Patient] / [Legal Guardian] Signature: _____ Date: _____

NOTICE OF PRIVACY PRACTICE:

Please be advised that all information regarding our patients remains confidential. We do not disclose any patient information without a signed authorization of release.

Excluded are the following:

1) **To show compliance with the privacy rule, to appropriate agency.**
2) **We will disclose medical information about you, when required by federal, state or local law.**
3) **In response to a court order, subpoena, warrant summons or similar process.**
4) **To report child abuse or neglect.**
5) **To prevent serious threat to your health and safety or the health and safety of others.**
6) **For health oversight activities with the patients treating physician.**
7) **To a coroner or medical examiner for identification, cause of death, or other duties authorized by law.**

Please be advised that under the Privacy Rule, patients have the federal right to access their own medical record, except Psychiatric Notes. The patient can authorize the release of Psychiatric Notes to other parties, such as attorneys, or other treating physicians.

[Patient] / [Legal Guardian] Signature: _____ Date: _____

The Florida Psychiatric Center's UPDATED HIPAA OMNIBUS RULE POLICY

Purpose - This Notice describes the privacy practices of **Florida Psychiatric Center** in accordance with the Health Insurance Portability and Accountability Act (HIPAA) Omnibus Final Rule. It applies to all services carried out by the physicians of this facility. All physicians are required to redistribute this new policy to all patients. That is why you are receiving this today.

Privacy Obligations - By law, we must maintain the privacy of your Protected Health Information (PHI). In the event that we use or disclose your PHI, our practice must operate under the terms of this Notice. Additionally, in the event that we share your PHI with a third party, we will disclose only the minimum amount necessary. We reserve the right to change the terms of our notice, at any time.

Your Rights Under The Privacy Rule - Following is a statement of your rights under the Privacy Rule, in reference to your PHI. Please feel free to discuss any questions with our staff. You have the right to receive, and we are required to provide you with a copy of the Notice of Privacy Practices - We are required to follow the terms of the notice. We reserve the right to change the terms of our notice, at any time. Upon your request, we will provide you with a revised Notice of Privacy Practices if you call our office and request that a revised copy be sent to you in the mail or ask for one at the time of your next appointment.

You have the right to authorize other use and disclosure - This means you have the right to authorize any use or disclosure of PHI that is not specified within this notice. For example, we would need your written authorization to use or disclose your PHI for marketing purposes, for most uses or disclosures of psychotherapy notes, or if we intended to sell your PHI. You may revoke an authorization, at any time, in writing, except to the extent that your healthcare provider or our practice has taken an action in reliance on the use or disclosure indicated in the authorization.

You have the right to request an alternative means of confidential communication – This means you have the right to ask us to contact you about medical matters using an alternative method (i.e., email, telephone), and to a destination (i.e., cell phone number, alternative address, etc.) designated by you. You must inform us in writing, using a form provided by our practice, how you wish to be contacted if by other than the address/phone number that we have on file. We will follow all reasonable requests.

You have the right to inspect and copy your PHI - This means you may inspect, and obtain a copy of your complete health record. If your health record is maintained electronically, you will also have the right to request a copy in electronic format. We have the right to charge a reasonable fee for paper or electronic copies as established by professional, state, or federal guidelines.

You have the right to request a restriction of your PHI - This means you may ask us, in writing, not to use or disclose any part of your protected health information for the purposes of treatment, payment or healthcare operations. If we agree to the requested restriction, we will abide by it, except in emergency circumstances when the information is needed for your treatment. In certain cases, we may deny your request for a restriction. You will have the right to request, in writing, that we restrict communication to your health plan regarding a specific treatment or service that you, or someone on your behalf, has paid for in full, out-of-pocket. We are not permitted to deny this specific type of requested restriction.

You may have the right to request an amendment to your protected health information - This means you may request an amendment of your PHI for as long as we maintain this information. In certain cases, we may deny your request.

You have the right to request a disclosure accountability - This means that you may request a listing of disclosures that we have made of your PHI to entities or persons outside of our office.

You have the right to receive a privacy breach notice - You have the right to receive written notification if the practice discovers a breach of your unsecured PHI and determines through a risk assessment that notification is required. If you have questions regarding your privacy rights, please feel free to contact our Privacy Manager, Eric Weinstock, MD.

How We May Use or Disclose Protected Health Information

The following are examples of uses and disclosures of your protected health information that we are permitted to make. These examples are not meant to be exhaustive, but to describe the possible types of uses and disclosures.

Treatment - We may use and disclose your PHI to provide, coordinate, or manage your healthcare and any related services. This includes the coordination or management of your healthcare with a third party that is involved in your care and treatment. For example, we would disclose your PHI, as necessary, to a pharmacy that would fill your prescriptions. We will also disclose PHI to other Healthcare Providers who may be involved in your care and treatment.

Special Notices - We may use or disclose your PHI, as necessary, to contact you to remind you of your appointment. We may contact you by phone or other means to provide results from exams or tests and to provide information that describes or recommends treatment alternatives regarding your care. Also, we may contact you to provide information about health-related benefits and services offered by our office, for fund-raising activities, or with respect to a group health plan, to disclose information to the health plan sponsor. You will have the right to opt out of such special notices and each such notice will include instructions for opting out.

Payment - Your PHI will be used, as needed, to obtain payment for your healthcare services. This may include certain activities that your health insurance plan may undertake before it approves or pays for the healthcare services we recommend for you such as, making a determination of eligibility or coverage for insurance benefits. If you pay out of pocket, you can elect that we do not share your PHI with a third party.

Research – We may combine conditioned and unconditioned authorizations for research participation as long as you can opt-in to the unconditioned authorizations activities. The authorizations extend to future research.

Marketing – We need written consent to provide marketing entities with your information.

Healthcare Operations - We may use or disclose, as needed, your PHI in order to support the business activities of our practice. This includes, but is not limited to business planning and development, quality assessment and improvement, medical review, legal services, auditing functions and patient safety activities.

Health Information Organization – Florida Psychiatric Center may elect to use a health information organization or other such organization to facilitate the electronic exchange of information for the purposes of treatment, payment, or healthcare operations.

To Others Involved in Your Healthcare - Unless you object, we may disclose to a member of your family, a relative, a close friend or any other person that you identify

your PHI that directly relates to that person's involvement in your healthcare. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment. We may use or disclose PHI to notify or assist in notifying a family member, personal representative or any other person that is responsible for your care of your general condition or death. If you are not present or able to agree or object to the use or disclosure of the PHI, then your healthcare provider may, using professional judgment, determine whether the disclosure is in your best interest. In this case, only the PHI that is necessary will be disclosed.

Other Permitted and Required Uses and Disclosures - We are also permitted to use or disclose your PHI without your written authorization for the following purposes: as required by law; for public health activities; health oversight activities; in cases of abuse or neglect; to comply with Food and Drug Administration requirements; research purposes; legal proceedings; law enforcement purposes; coroners; funeral directors; organ donation; criminal activity; military activity; national security; worker's compensation; when an inmate in a correctional facility; and if requested by the Department of Health and Human Services in order to investigate or determine our compliance with the requirements of the Privacy Rule.

Privacy Complaints

You have the right to complain to us or directly to the Secretary of the Department of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying Eric Weinstock, MD.

We will not retaliate against you for filing a complaint.

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Notice about Medication Prior Authorizations

Dear Patients:

I have tried to avoid doing this for as long as possible, but health insurance companies continue to burden health care providers with more and more time consuming paperwork, and I have no choice now but to deal with this problem. With ever increasing frequency, health insurance companies are now "requiring" what is called a "prior authorization" before they will approve certain medications. This problem goes back at least 10 years, but back then they only did this in rare circumstances with very expensive medications.

Now it seems they are doing this with almost every medication, even inexpensive generic medication. It's nothing more than time consuming extra red tape to discourage doctors from prescribing any medication except for the ones on the health insurance company's list of "approved" or "formulary" medications. There is absolutely no medical justification for these requirements, they are simply cost cutting measures used by the insurance companies to put more money in their pocket. I find this to be morally wrong and I have always refused to allow insurance companies to influence my treatment decisions. I feel that only a patient's doctor should be the person making decisions about their medical treatment, not insurance companies.

To that end, Marsha and I have always spent additional time completing the "prior authorization" paperwork, and if necessary calling insurance companies directly so that you, the patient, can continue to receive the medication that is best suited to treat your symptoms.

Unfortunately, the number of prior authorizations has now grown so high, that we routinely must now complete anywhere from 5-10 auths per day. Each auth can take anywhere from 10-20 minutes for us to complete, depending on the complexity of the case. That translates to up to 2 hours per day that we spend on this unnecessary burden. This uses up significant time that could be spent seeing other patients. Therefore, in order to continue to provide this valuable service to all of you, I am left with no choice but to pass on the costs of this burden to my patients. Perhaps, one day, if enough consumers complain to their insurance companies and to the government about this problem, they may change their ways.

Therefore, in order to continue to provide this valuable service to all of you, if your insurance company requires any prior authorizations for one or more of your medications, there will be a one time annual fee of $75, to help reduce the time and cost burden placed on me and my staff. Rest assured, this fee will cover you for the entire calendar year, regardless of how many or how few auths you end up needing during the calendar year. As mentioned above, I really have tried my best to avoid taking this measure, but insurance companies have gotten so bad now that I am left with no other choice. I sincerely hope all of you understand that I am only doing what I believe is necessary for the best interests of all my patients. If you have any additional questions or concerns, please feel free to call or email me directly at the email addresses listed below.

Sincerely,

Eric Weinstock, MD
ericweinstockmd@gmail.com
floridamentalhealth@gmail.com

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Important Notice about Medication Refills

Dear Patients:

Please be aware that when you call your pharmacy and use their automated phone or website service to refill a prescription, you will often be incorrectly informed that your prescription is out of refills and requires the doctor's authorization. Unless you missed your last appointment with the doctor, you should never run out refills. If the automated system tells you that you are out of refills, please hang up and call the pharmacy back and ask to speak to a human being and ask them to look in the system to see if you have any additional prescriptions that are "on hold", which they can activate for you. The automated system does not recognize prescriptions that are "on hold", so you have to speak to an actual person to check for this.

If you are still informed that you are out of refills, then please DO NOT have the pharmacy fax the office for a refill request. Instead, please call us directly or even better, you can send us an email requesting the refill (floridamentalhealth@gmail.com).

Thanks for your cooperation.

Sincerely,

Eric Weinstock, MD

ericweinstockmd@gmail.com

floridamentalhealth@gmail.com

THE FLORIDA PSYCHIATRIC CENTER

ERIC WEINSTOCK, M.D.
Diplomate of the American Board of Psychiatry and Neurology

New Patient Questionnaire (CONFIDENTIAL) Name/Date: _____

For each item below, please think about how you have been feeling recently, in the PAST 2 to 4 WEEKS ONLY (CIRCLE ANSWERS).

Sleep:	Increased	Decreased	Okay
Daytime Energy Levels:	Increased	Decreased	Okay
Motivation:	Increased	Decreased	Okay
Appetite:	Increased	Decreased	Okay

Are you having crying spells for no specific reason? Yes No

If Yes, how often? ___ per day ___ per week ___per month

Are you having any happiness or joy? None Some Normal

Are you feeling very hopeless?	Always	Sometimes	Never
Are you feeling very helpless?	Always	Sometimes	Never
Are you feeling very worthless?	Always	Sometimes	Never

Are you isolating yourself and avoiding social interactions? Yes No

How is your self-esteem? Low High/Normal

How is your concentration? Bad So-So Normal

Do you experience racing thoughts, where it feels like your mind is going a million miles per hour and you can't get your mind to turn off? Yes No Night time only

If you are having racing thoughts, are they more focused on worrying about real problems or are the thoughts more random? Random Real Problems N/A

Are you getting easily irritated by things that shouldn't be irritating?	Yes	No
Are you getting easily frustrated by things that shouldn't frustrate you?	Yes	No
Are you getting overwhelmed by things that shouldn't overwhelm you?	Yes	No

Do you get easily distracted? Yes No

If yes, have you been easily distracted your whole life? Yes No

Have you been getting physically violent? Yes No

Are you verbally abusive to others? Daily Weekly None

Are you experiencing a lot of worrying? Yes Somewhat No

Are you having physical sensations of nervousness in your body? Yes No
If yes, where in your body? _____

Has your anxiety ever been so bad that you thought you might be dying or having a heart attack? Yes No

If yes, how often? ___ per day ___ per week ___per month

Have you ever in your life had a seizure? Yes No

Are you having frequent nightmares? Yes No

Do you have any history in your life of an eating disorder? Yes No

If yes, what behaviors did you exhibit (circle all that apply)?

Binge eating Restricting Purging Laxatives

Do you have any history in your life of self-harm? Yes No
If yes, please briefly describe:

Do you have any history of being abused, physically, sexually or mentally? Yes No
If yes, please describe:

FAMILY HISTORY: Please list all biological family members that have been diagnosed with mental illness (depression, anxiety, ADHD, Bipolar, Schizophrenia, OCD, Drug Addiction, Alcoholism, etc.)?

Are you allergic to any medication? Please list…

Are you currently seeing a therapist? If yes, please provide name and number.

Would you like to give your consent for Dr. Weinstock to contact your therapist for coordination of care?

Do you currently take St. John's Wort?

Please list all the prescription medications you are currently taking, including strength and number of pills per day, please include all meds, not just psychiatric ones:

Prior Medications: Please circle any of the following medications if you have **ever** tried them. If you have never tried it, then leave it blank.

Next to the meds you have tried, please list the most significant positive and negative effects of the medication.

Prozac (fluoxetine)_____
Paxil (paroxetine) _____
Zoloft (sertraline) _____
Celexa (citalopram) _____
Lexapro (escitalopram)_____
Luvox (fluvoxamine) _____
Wellbutrin (bupropion) _____
Remeron (mirtazapine) _____
Trazodone_(oleptro)_____
Effexor (venlafaxine) _____
Cymbalta_(Duloxetine) _____
Pristiq_(desvenlafaxine)_____
Depakote_(Divalproex / Valproate)_____ _____
Lithium_____
Tegretol (carbamazapine) _____
Trileptal (oxcarbazapine) _____
Lamictal (lamotrigine) _____
Neurontin (Gabapentin)_____
Zyprexa_(olanzapine)_____
Geodon (ziprasidone)_____
Abilify_(aripiprazole)_____
Seroquel (quetiapine)_____
Risperdal (risperidone) _____

Haldol (haloperidol) _____
Invega (paliperidone)_____
Fanapt_(iloperidone)_____
Saphris(asenapine)_____
Latuda_(lurasidone)_____
Valium (diazepam) _____
Ativan (lorazepam) _____
Klonopin (clonazepam) _____
Xanax (alprazolam) _____
Ambien (zolpidem) _____
Lunesta(eszopiclone)_____
Sonata (zaleplon) _____
Temazepam (Restoril)_____
Belsomra_(suvorexant)_____
Provigil_(modafinil)_____
Nuvigil_(armodafinil)_____
Adderall (detroamphetamine) _____
Ritalin (methylphenidate) _____
Vyvanse__(lisdexamfetamine)_____
Strattera_(atomoxetine)_____
Amitriptylene (Elavil)_____
Viibryd (vilazodone)_____
Suboxone / Subutex_____
Buspar_(buspirone)_____
Brintellix / Trintellix (vortioxetine)_____
Rexulti_(brexpiprazole)_____
Vraylar_(cariprazine)_____
Pamelor (nortriptyline)_____
Antabuse (disulfiram)_____
Contrave (bupropin/naltrexone)_____
Naltrexone_____
Campral (Acamprosate)_____
Belviq (lorcaserin)_____
Topamax (topiramate)_____
Chantix (carenicline)_____
Methadone_____
Doxepin_____
Nardil (phenelzine)_____
Rozerem (ramelteon)_____
Deplin (L-methylfolate)_____

Office use only		PHQ-9		GAD-7		Global	

Name _____ Date _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?

PHQ-9	Use "✔" to indicate your answer in the box	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
GAD-7	Use "✔" to indicate your answer in the box	Not at all	Several days	More than 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 is 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

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

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

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 circle 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?	○	○

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KETAMINE FOR DEPRESSION AND ANXIETY

What is Ketamine?

Multiple studies over the last decade have shown that ketamine can rapidly alleviate symptoms of treatment resistant depression, within hours of treatment. (References below)

This "off-label" psychiatric use appears to offer several advantages over traditional anti-depressant therapy. Rapid response is the primary benefit. Depression can improve within minutes or hours, compared to 4-6 weeks for a trial of anti-depressants. And unlike most anti-depressants, ketamine does not cause sexual side effects or weight gain. The medication is so promising (70% rapid response rate in most studies) and it is so different from existing anti-depressants, that it can now be offered to carefully selected patients in an office setting.

Ketamine was first synthesized in 1962 and received FDA approval in 1970 for use as an anesthetic for general anesthesia induction and maintenance. It is classified by the DEA as a schedule 3 controlled substance. It is also used off-label for the treatment of chronic pain conditions such as fibromyalgia and complex regional pain syndrome (CRPS).

What are the side effects?

Ketamine is a "fast-in, fast-out" drug that can be given as an injection in the arm or hip muscle with 90% absorption and elimination in 4-6 hours, or by monitored IV infusion, 100% absorption and elimination in minutes. The side effects are rare but include allergic reaction, elevation of blood pressure, and a weird "spaced out" dreamy state that quickly wears off. These risks require a companion to drive the patient home after the first treatment (Uber is okay too). Normal activities can be resumed after 2 hours. For follow-up treatments, patients are usually able to drive themselves home once they have been cleared by Dr. Weinstock.

What are the benefits?

Ultra-rapid relief of depression and anxiety symptoms. Symptoms can improve within minutes or hours, compared to 4-6 weeks for a trial of anti-depressants. And unlike most anti-depressants, ketamine does not cause sexual side effects or weight gain.

When starting ketamine, it is not necessary to stop your current medication, however; after demonstrating a positive response, patients may be able to gradually wean off of their other depression medication under the careful guidance and supervision of Dr. Weinstock.

Patients commonly describe the treatment experience as a feeling of complete calmness, peaceful, light, tranquil, relaxed, and mildly euphoric. The residual after-effects, which can last several days to several weeks after your treatment, include a general sense of well being and a much greater ability to cope with the daily stresses in your life.

Recent research has also discovered that ketamine increases the production and release of BDNF (brain derived neurotrophic factor) in the brain. BDNF acts as a kind of "fertilizer" for neurons and other brain cells, leading to increased synaptic connections between neurons and the formation of new neuronal pathways.

Ketamine IV Infusion Therapy vs. Ketamine Injection Therapy

Dr. Weinstock offers both Ketamine IV Infusion Therapy and Ketamine Injection Therapy.

The Ketamine IV Infusion Therapy requires placement of a peripheral IV in the arm or hand. A carefully titrated Ketamine / Saline sterile solution is then slowly infused into the blood stream over the course of 60-75 minutes in a private room with continuous monitoring. Once the patient has completed the infusion, the peripheral IV is removed and the patient is re-evaluated by Dr. Weinstock and then cleared for discharge. Routine blood pressure and pulse oximetry readings are measured both before and after the procedure.

The Ketamine Injection Therapy is a little less invasive. It consists of a very fine needle intramuscular injection of ketamine into the deltoid (shoulder) muscle. The patient will then relax in a private room for approximately one hour with periodic monitoring. The patient is then re-evaluated by Dr. Weinstock and then cleared for discharge. Routine blood pressure and pulse oximetry readings are measured both before and after the procedure.

Patients often ask what is the difference between infusions and injections, is one better than the other?

Most studies of ketamine therapy for depression have utilized infusions. Therefore, we have more data on efficacy for infusions. It is probably fair to say that injections can be anywhere from 50-75% as effective as infusions. Fast metabolizers will get better results from infusions, because the infusions can maintain a steady concentration of ketamine in the blood stream.

The specific treatment regimen will be **individually tailored** to each patient but it usually consists of 6-8 initial treatments, given once or twice per week. Once patients are experiencing sustained relief, the treatments can then be spaced farther apart. Eventually once per month or longer is sufficient to maintain stability.

Dr. Weinstock may also give you a prescription for daily sublingual (under the tongue) ketamine tablets to extend the beneficial effects of the treatments. This prescription can be filled at most compounding pharmacies and usually costs around $60 per month. Using the sublingual tablets is optional and can usually help extend the time between treatments, but it is not required.

What is the cost?

You are responsible for paying your normal insurance co-pay plus deductible (if applicable) for the office visit plus an additional amount for the ketamine treatment because ketamine therapy is not a covered service by any insurance.

You may use a health savings account (HSA) or flexible savings account (FSA) to pay for the treatment cost.

The Ketamine Injection Therapy cost is $250 per treatment.
The Ketamine IV Infusion Therapy cost is $500 per treatment.

How do I get started?

Call or email our office to schedule a new patient visit to determine if ketamine is right for you.

Office phone: 813-636-8300
Office email: floridamentalhealth@gmail.com

References:

From the U.S. Psychiatric and Mental Health Congress:
Novel Therapeutics for Major Depression

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