THE FLORIDA PSYCHIATRIC CENTER

ERIC WEINSTOCK, M.D. P.A.
1300 N WEST SHORE BLVD STE 240
TAMPA, FL 33607
PHONE (813) 636-8300 FAX (813) 636-8301

Patient Legal Full Name: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

Date of Birth: _____

Cell Phone: _____

Home Phone: _____

Social Security Number: _____

Email: _____

Primary Physician Name and Number: _____

Employer Name and Work Number: _____

Emergency Contact Name and Number: _____

Relationship to Patient: _____

Patient Consent To Treatment

I hereby authorize ERIC WEINSTOCK, M.D., P.A. its employees, independent contractors 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, independent contractors 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**

THE FLORIDA PSYCHIATRIC CENTER

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 provider 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.
- **Medication Prior Authorizations: $35 per auth**

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 $35 charge for any required paperwork.**
- No refill requests will be processed after 12 noon on Fridays.

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. You are required to obtain the authorization for your initial visit 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.
- 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.

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 Eric Weinstock, MD PA.

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

1300 N West Shore Blvd. Ste 240
Tampa, FL 33607
Phone: (813)636-8300 Fax: (813)636-8301

Controlled Substances Policy

At The Florida Psychiatric Center we want to ensure that we are doing everything possible to provide the best, most innovative care, in a safe and caring environment. There may be times when medications that are classified as "controlled" (due to their potential of abuse) will be prescribed. For the purpose of safe prescribing by the MD/APRN, the patient and prescriber must have open, honest communication with the establishment of a mutually understood agreement for controlled substance prescriptions.

PRESCRIBER EXPECTATIONS/PATIENT RESPONSIBILITIES:

1. The patient will safeguard his/her medication.
2. The patient will refrain from use of any street drugs or medications not prescribed for them.
3. The patient understands that controlled medications can adversely affect his/her judgement and ability to safely drive.
4. Prescriptions will never be sold, shared or traded and will remain in the possession of the patient for which the medication was prescribed.
5. The patient understands that the MD/APRN will access their personal information regarding all controlled substances filled through the Prescription Drug Monitoring Program in compliance with Florida Law HB21.
6. The patient agrees to use one pharmacy to fill controlled medications and gives the MD/APRN permission to have discussions with pharmacy staff for the purposes of maintaining accountability.
7. The patient agrees to NEVER use multiple prescribers to obtain controlled substances for psychiatric conditions.
8. If the patient is receiving controlled medications from another prescriber for non-psychiatric conditions, he/she gives permission to the MD/APRN to have treatment collaboration for the purpose of reducing poly-pharmacy and in an effort to increase safe prescribing practices.
9. Early refills will generally not be given except in rare instances at the discretion of the MD/APRN.
10. Refills will be provided during regular scheduled office appointments. No refills on nights, holidays, or weekends.
11. Patients will NOT increase the dose or frequency of controlled medications without discussing with the MD/APRN in a scheduled office visit.
12. Changes to dose or frequency of controlled medications will ONLY be made during scheduled office visits and will not be done via phone or email. PLEASE DO NOT CONTACT your provider for this reason.
13. Medications may be denied if a patient fails to attend a scheduled appointment without sufficient notice until the next appointment is kept.
14. Per State and Federal Regulations, patient must be assessed at regular intervals to determine the continued necessity of controlled medications. Specifically, patients prescribed Schedule II controlled substances are REQUIRED to be assessed and monitored a minimum of every 3 months. Patients prescribed Schedule IV medications are REQUIRED to be assessed and monitored a minimum of every 6 months.
15. Any patient receiving a prescription for a controlled medication will submit to an initial drug screen, an annual drug screen and at any other time requested at the discretion of the prescriber. Cost of drug screens are the responsibility of the patient.

Discussion as to whether controlled medication is providing sufficient therapeutic benefit to justify continued use will be made at regular scheduled office visits. Your prescriber will balance risk vs benefit and ensure that you have an understanding of this information. By signing below you agree to these guidelines and understand that violation of these requirements may result in immediate discharge from the practice.

_____

Patient's signature and 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.

THE FLORIDA PSYCHIATRIC CENTER
ERIC WEINSTOCK, M.D.
Diplomate of the National Board of Physicians and Surgeons
1300 N WEST SHORE BLVD STE 240
TAMPA, FL 33607
PHONE (813) 636-8300 FAX (813) 636-8301

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, we 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 charge of $35 per medication, to help reduce the time and cost burden placed on me and my staff. 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
eric.weinstock@ericweinstockmd.com

THE FLORIDA PSYCHIATRIC CENTER
PHONE (813) 636-8300 FAX (813) 636-8301

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 send an email directly to your provider or send an email to the front desk (help@ericweinstockmd.com).

Thanks for your cooperation.

Sincerely,

Eric Weinstock, MD

ericweinstockmd@gmail.com

floridamentalhealth@gmail.com

THE FLORIDA PSYCHIATRIC CENTER

PROVIDER CONTACT INFORMATION

The fastest way to communicate with your provider is via our secure / encrypted, HIPPA compliant email system:

Dr. Eric Weinstock:	eric.weinstock@ericweinstockmd.com
Maryn Parham:	maryn.parham@ericweinstockmd.com
Jonathan Pope:	jonathan.pope@ericweinstockmd.com
Amanda Costello:	amanda.costello@ericweinstockmd.com
Paula DelValle:	paula.delvalle@ericweinstockmd.com
Jessica Sabo:	jessica.sabo@ericweinstockmd.com
Marsha Byers:	marsha.byers@ericweinstockmd.com
Front Desk:	help@ericweinstockmd.com

THERAPISTS

This is a brief list of some therapists that we have worked with and would recommend. Remember that each therapist has their own style and there are numerous types of therapy. It is important for you to find one that works well with your needs.

1. Erin Saintil – creator of neurolease therapy for PTSD - 813-951-7346
2. Debbie Dubickas – specializes in trauma resolution via hypnotherapy - 813-992-3330
3. Kelly Mulroy – sees children and adults 813-765-2748
4. Maria Estes – 813-205-0015
5. Delene Iacono – speaks Spanish – 813-857-6438
6. Kathy Dan Moore – self-pay only – 727-692-7440
7. Tampa Bay DBT – DBT, EMDR, ERP 443-621-0976
8. Family Psychology Assoc. – in Trinity area - 727-203-2770
9. Linda Peterman – 813-404-3174
10. Heidi Hanlon – 813-254-0109
11. Sharon Miller – 813-261-5069
12. Susan Posada – 813-438-4692
13. Ronald DeMao – 813-438-4221

Also, use the mental health number on the back of your insurance card for assistance in finding a therapist in your network. Medication is a tool and it is important for you to also engage in therapy for optimal treatment and to receive the best results.

THE FLORIDA PSYCHIATRIC CENTER

New Patient Intake

DATE: _____

NAME: _____

DOB: _____

AGE: _____

Grade Level and School (if under 18): _____

Marital Status: _____

Living Situation: _____

Number of Children and ages: _____

Highest Level of education / degrees held: _____

Current Occupation: _____

Medical History: Please list any current medical conditions that you are being treated for (example: high blood pressure, diabetes, hypothyroidism, chronic pain, asthma, etc) Write "None" if none.

Surgical History: Please list any previous surgical procedures and approximate date of procedure. Write "None" if none.

Family Psychiatric History: Please list any biological family members that have been diagnosed with a psychiatric condition. List if any blood relatives have committed suicide. (Example: maternal grandmother – depression; paternal uncle – anxiety and alcohol abuse; paternal grandfather committed suicide in his 40s – diagnosed with PTSD) Write "None" if none.

Trauma / Abuse History: Please list any previous emotional, physical and/or sexual abuse with approximate time frame / age. Write "None" if none.

Prenatal and Birth History (if under 18): Please list any prenatal complications or birth complications, noting if pregnancy was full-term and the type of delivery (Example: 37 weeks gestation, delivered via C-section due to maternal uncontrolled high blood pressure) Write "None" if none.

Educational History (if under 18): Please list current grade level and if child received any additional help in school or has accommodations. Also list if there has been a history of repeating a grade, academic or behavioral issues at school. List any suspensions / expulsions.

Psychiatric History: Please list any previous psychiatric treatments such as hospitalizations, medication management, therapy, residential programs or intensive outpatient programs. Write "None" if none.

History of Substance Abuse: Please indicate any history of substance abuse or substance abuse. List substance of concern, amount of substance used and if treatment has been sought. (Example: Alcohol – sober since 2015, previously treated in rehab, currently attending AA meetings weekly) Write "None" if none.

History of Self Injury or Suicide Attempts: Please list any occurrences of self-harm behaviors or suicide attempts and approximate date behaviors occurred. Write "None" if none.

REASON FOR TODAY'S VISIT: Please list your concerns that prompted today's visit, noting symptoms that you have been having for the past 2-4 weeks (example: continuing medication management since my recent move for symptoms of anxiety, panic attacks and increased racing thoughts).

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
How is your self-esteem? Low High/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

Are you having thoughts to hurt yourself or someone else? Always Sometimes Never

Do you feel like others are out to harm you? Always Sometimes Never

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

Have you ever heard or seen things that others in the room could not see or hear? If yes, please elaborate....

MEDICATION ALLERGIES: 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 us to contact your therapist for coordination of care?

Do you currently take St. John's Wort?

CURRENT MEDICATION LOG

Please list all current medications, both psychiatric and medical. Don't forget to include any supplements or over-the-counter medications.

Medication Name and Dose/Timing	Reason	Duration	Prescriber's Name
Example: Prozac 20mg in morning	*depression*	*2 yrs*	*Dr. Smith*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			
15.			
16.			
17.			
18.			
19.			
20.			

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 mixed salts)

Adderall – based ADHD medications (Vyvanse, Evekeo, Zenzedi, Aptensio XR, Adzenys XR, Dyanavel XR, Mydayis)

Ritalin (methylphenidate)

Ritalin – based ADHD medications (Concerta, Focalin, Methylin, Metadate, Daytrana patch, Quillivant XR, Cotempla XR)

Intuniv (Guanfacine ER)

Kapvay / Catapres (clonidine)

Strattera (atomoxetine)

Amitriptylene (Elavil)

Viibryd (vilazodone)

Suboxone / Subutex (buprenorphine)

Buspar (buspirone)

Brintellix / Trintellix (vortioxetine)

Rexulti (brexpiprazole)

Vraylar (cariprazine)

Pamelor (nortriptyline)

Anafranil (clomipramine)

Tofranil (imipramine)

Norpramin (desimipramine)

Antabuse (disulfiram)

Minipres (prazosin)

Contrave (bupropin/naltrexone)

Naltrexone

Campral (Acamprosate)

Belviq (lorcaserin)

Topamax (topiramate)

Chantix (carenicline)

Methadone

Doxepin

Nardil (phenelzine)

Rozerem (ramelteon)

Deplin (L-methylfolate)

Thorazine (chlorpromazine)

Inderal (propranolol)

Hetlioz (tasimelteon)

Vivitrol (injectable naltrexone)

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?	❍	❍

SUICIDE RISK ASSESSMENT SCALE

Adopted from the Columbia-Suicide Severity Rating Scale 2008

ANSWER QUESTIONS 1 AND 2 THINKING ABOUT YOUR FEELINGS OVER THE PAST MONTH:

1. Have you wished you were dead or wished you could go to sleep and not wake up? ___

2. Have you actually had any thoughts of killing yourself? _____

IF YOU ANSWERED YES TO 2, ANSWER QUESTIONS 3-6. IF NO TO 2, ONLY ANSWER QUESTION 6:

3. Have you been thinking about how you might kill yourself? _____

4. Have you had these thoughts with some intention to act on them? _____

5. Have you started to work out the details of how to kill yourself? _____

   Do you intend to carry out this plan? _____

6. Have you ever done anything, started to do anything, or prepared to do anything to end your life? _____

   If YES, how long ago did you do any of these things _____

IF YOU ARE CURRENTLY HAVING ANY SUICIDAL THOUGHTS WITH A PLAN AND INTENTION TO ACT UPON THEM, CALL 911 OR 211 IMMEDIATELY FOR CRISIS INTERVENTION.

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

Severity Measure for Panic Disorder—Adult

Name:_____ **Age:** _____ **Sex: Male** ❑ **Female** ❑ **Date:**_____

Instructions: The following questions ask about thoughts, feelings, and behaviors about panic attacks. A panic attack is an episode of intense fear that sometimes comes out of the blue (for no apparent reason). The symptoms of a panic attack include: a racing heart, shortness of breath, dizziness, sweating, and fear of losing control or dying. **Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
	During **the PAST 7 DAYS**, I have...	**Never**	**Occasionally**	**Half of the time**	**Most of the time**	**All of the time**	**Item score**
1.	felt moments of sudden terror, fear or fright, sometimes out of the blue (i.e., a panic attack)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
2.	felt anxious, worried, or nervous about having more panic attacks	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
3.	had thoughts of losing control, dying, going crazy, or other bad things happening because of panic attacks	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
4.	felt a racing heart, sweaty, trouble breathing, faint, or shaky	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
5.	felt tense muscles, felt on edge or restless, or had trouble relaxing or trouble sleeping	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
6.	avoided, or did not approach or enter, situations in which panic attacks might occur	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
7.	left situations early, or participated only minimally, because of panic attacks	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
8.	spent a lot of time preparing for, or procrastinating about (putting off), situations in which panic attacks might occur	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
9.	distracted myself to avoid thinking about panic attacks	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
10.	needed help to cope with panic attacks (e.g., alcohol or medication, superstitious objects, other people)	❑ 0	❑ 1	❑ 2	❑ 3	❑ 4	
						Total/Partial Raw Score:	
						Prorated Total Raw Score: (if 1-2 items left unanswered)	
						Average Total Score:	

Y-BOCS Symptom Checklist

Instructions: Generate *a Target Symptoms List from* the attached Y-BOCS Symptom Checklist by asking the patient about specific obsessions and compulsions. Chock all that apply. Distinguish between current and past symptoms. Mark principal symptoms with a "p". These will form the basis of the Target Symptoms *List*. Items marked may "*" or may not be an OCD phenomena.

Current Past

AGGRESSIVE OBSESSIONS

___ ___ Fear might harm self
___ ___ Fear might harm others
___ ___ Violent or horrific images
___ ___ Fear of blurting out obscenities or insults
___ ___ Fear of doing something else embarrassing*
___ ___ Fear will act on unwanted impulses (e.g., to stab friend)
___ ___ Fear will steal things
___ ___ Fear will harm others because not careful enough (e.g. hit/run motor vehicle accident)
___ ___ Fear will be responsible for something else terrible happening (e.g., fire, burglary

Other:

CONTAMINATION OBSESSIONS

___ ___ Concerns or disgust w\ with bodily waste or secretions (e.g., urine, feces, saliva Concern with dirt or germs
___ ___ Excessive concern with environmental contaminants (e.g. asbestos, radiation toxic waste)
___ ___ Excessive concern with household items (e.g., cleansers solvents)
___ ___ Excessive concern with animals (e.g., insects)
___ ___ Bothered by sticky substances or residues
___ ___ Concerned will get ill because of contaminant
___ ___ Concerned will get others ill by spreading contaminant (Aggressive)
___ ___ No concern with consequences of contamination other than how it might feel

SEXUAL OBSESSIONS

___ ___ Forbidden or perverse sexual thoughts. images. or impulses
___ ___ Content involves children or incest
___ ___ Content involves homosexuality*
___ ___ Sexual behavior towards others (Aggressive)*
___ ___ Other:

HOARDING/SAVING OBSESSIONS

(distinguish from hobbies and concern with objects of monetary or sentimental value)

___ ___ _____

RELIGIOUS OBSESSIONS (Scrupulosity)

___ ___ Concerned with sacrilege and blasphemy
___ ___ Excess concern with right/wrong, morality
___ ___ Other:

OBSESSION WITH NEED FOR SYMMETRY OR EXACTNESS

___ ___ Accompanied by magical thinking (e.g., concerned that another will have accident dent unless less things are in the right place)
___ ___ Not accompanied by magical thinking

MISCELLANEOUS OBSESSIONS

___ ___ Need to know or remember
___ ___ Fear of saying certain things
___ ___ Fear of not saying just the right thing
___ ___ Fear of losing things
___ ___ Intrusive (nonviolent) images
___ ___ Intrusive nonsense sounds, words, or music
___ ___ Bothered by certain sounds/noises*
___ ___ Lucky/unlucky numbers
___ ___ Colors with special significance
___ ___ 3 superstitious fears
___ ___ Other:

Current Past

SOMATIC OBSESSIONS

___ ___ Concern with illness or disease*
___ ___ Excessive concern with body part or aspect of Appearance (eg., dysmorphophobia)*
___ ___ Other

CLEANING/WASHING COMPULSIONS

___ ___ Excessive or ritualized handwashing
___ ___ Excessive or ritualized showering, bathing, toothbrushing grooming, or toilet routine Involves cleaning of household items or other inanimate objects
___ ___ Other measures to prevent or remove contact with contaminants
___ ___ Other

CHECKING COMPULSIONS

___ ___ Checking locks, stove, appliances etc.
___ ___ Checking that did rot/will not harm others
___ ___ Checking that did not/will not harm self
___ ___ Checking that nothing terrible did/will happen
___ ___ Checking that did not make mistake
___ ___ Checking tied to somatic obsessions
___ ___ Other:

REPEATING RITUALS

___ ___ Rereading or rewriting
___ ___ Need to repeat routine activities jog, in/out door, up/down from chair)
___ ___ Other _____

COUNTING COMPULSIONS

___ ___ _____

ORDERING/ARRANGING COMPULSIONS

___ ___ _____

HOARDING/COLLECTING COMPULSIONS

(distinguish from hobbies and concern with objects of monetary or sentimental value (e.g., carefully reads junk mail, piles up old newspapers, sorts through garbage, collects useless objects.)

___ _____

MISCELLANEOUS COMPULSIONS

___ ___ Mental rituals (other than checking/counting)
___ ___ Excessive listmaking
___ ___ Need to tell, ask, or confess
___ ___ Need to touch, tap, or rub*
___ ___ Rituals involving blinking or staring*
___ ___ Measures (not checking) to prevent: harm to self - harm to others terrible consequences
___ ___ Ritualized eating behaviors*
___ ___ Superstitious behaviors
___ ___ Trichotillomania *
___ ___ Other self-damaging or self-mutilating behaviors*
___ ___ Other

Adapted from Goodman, W.K., Price, L.H., Rasmussen, S.A. et al.:
"The Yale-Brown Obsessive Compulsive Scale."
Arch Gen Psychiatry 46:1006-1011,1989

IMPACT OF EVENTS SCALE-Revised (IES-R)

INSTRUCTIONS: Below is a list of difficulties people sometimes have after stressful life events. Please read each item, and then indicate how distressing each difficulty has been for you DURING THE PAST SEVEN DAYS with respect to (specify which traumatic life event) _____(event) that occurred on _____(date). How much have you been distressed or bothered by these difficulties?

	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Any reminder brought back feelings about it	0	1	2	3	4
2. I had trouble staying asleep	0	1	2	3	4
3. Other things kept making me think about it.	0	1	2	3	4
4. I felt irritable and angry	0	1	2	3	4
5. I avoided letting myself get upset when I thought about it or was reminded of it	0	1	2	3	4
6. I thought about it when I didn't mean to	0	1	2	3	4
7. I felt as if it hadn't happened or wasn't real.	0	1	2	3	4
8. I stayed away from reminders of it.	0	1	2	3	4
9. Pictures about it popped into my mind.	0	1	2	3	4
10. I was jumpy and easily startled.	0	1	2	3	4
11. I tried not to think about it.	0	1	2	3	4
12. I was aware that I still had a lot of feelings about it, but I didn't deal with them.	0	1	2	3	4
13. My feelings about it were kind of numb.	0	1	2	3	4
14. I found myself acting or feeling like I was back at that time.	0	1	2	3	4
15. I had trouble falling asleep.	0	1	2	3	4
16. I had waves of strong feelings about it.	0	1	2	3	4
17. I tried to remove it from my memory.	0	1	2	3	4
18. I had trouble concentrating.	0	1	2	3	4
19. Reminders of it caused me to have physical reactions, such as sweating, trouble breathing, nausea, or a pounding heart.	0	1	2	3	4
20. I had dreams about it.	0	1	2	3	4
21. I felt watchful and on-guard.	0	1	2	3	4
22. I tried not to talk about it.	0	1	2	3	4

Total IES-R Score:_____

INT: 1, 2, 3, 6, 9, 14, 16, 20
AVD: 5, 7, 8, 11, 12, 13, 17, 22
HYP: 4, 10, 15, 18, 19, 21

Weiss, D.S. (2007). The Impact of Event Scale-Revised. In J.P. Wilson, & T.M. Keane (Eds.) *Assessing psychological trauma and PTSD: a practitioner's handbook* (2nd ed., pp. 168-189). New York: Guilford Press.

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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 (Uber is okay too). Normal activities can be resumed after 2-4 hours.

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 there is a 60-90 minute recovery time during which 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. Heart rate and oxygen saturation are monitored throughout the entire infusion.

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 continuous 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. Heart rate and oxygen saturation are monitored throughout the entire treatment.

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 and brain.

The specific treatment regimen will be **individually tailored** to each patient but it usually consists of 6-10 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 $75 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: help@ericweinstockmd.com

References:

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

Journal Article References:
Rapid and longer-term antidepressant effects of repeated ketamine infusions in treatment-resistant major depression.
Ketamine's antidepressant effect: focus on ketamine mechanisms of action
The role of ketamine in treatment-resistant depression: a systematic review.
Effects of intravenous ketamine on explicit and implicit measures of suicidality in treatment-resistant depression.
Antidepressant mechanism of ketamine: perspective from preclinical studies.
Acute Antidepressant Effects of Intramuscular Versus Intravenous Ketamine

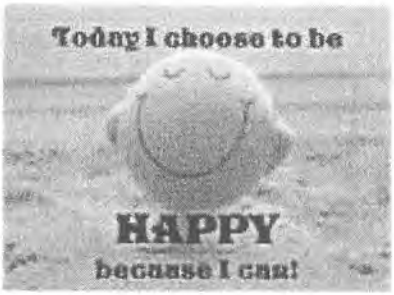
12 Steps to Positive Change

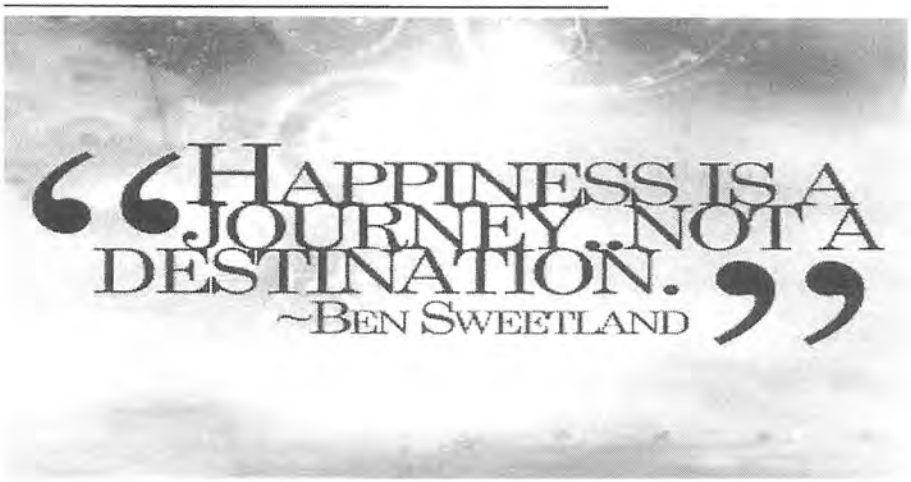
1. Avoid depressive thinking traps, cognitive distortions and negative self-talk.
2. Exercise at least 30 minutes per day.
3. Eat healthy.
4. Get adequate rest and sleep.
5. Use downtime constructively; an idle mind is easily overrun with worry, doubt and negative thoughts. The more time you spend in meaningful pursuits the less time you spend absorbed in depressive thoughts.
6. Maintain positive relationships.
7. Resolve conflicts quickly.
8. Get fresh air and sunshine daily.
9. Stick to priorities.
10. Each day do something novel.
11. Make a daily change in routine.
12. Persist

- Depression is time limited.
- Activity is a remedy for depression.
- Depressive thinking is a state of mind, not a concrete reality.

5 Things to Tell Yourself Daily

1. _Keep trying
2. Stay in touch spiritually (Keep praying)
3. Stay positive
4. Be awesome
5. Become better – not better than anyone else, but a better person than you were yesterday.





Don't Quit

by anonymous

When things go wrong, as they sometimes will,
When the road you're trudging seems all up hill,
When the funds are low and the debts are high,
And you want to smile, but you have to sigh,
When care is pressing you down a bit,
Rest! if you must; but don't you quit.

Life is queer with its twists and turns,
As everyone of us sometimes learns,
And many a failure turns about
When he might have won had he stuck it out;
Don't give up, though the pace seems slow;
You might succeed with another blow.

Often the goal is nearer than
It seems to a faint and faltering man,
Often the struggler has given up
When he might have captured the victor's cup.
And he learned too late, when the night slipped down,
How close he was to the golden crown.

Success is failure turned inside out;
The silver tint of the clouds of doubt;
And you never can tell how close you are,
It may be near when it seems afar;
So stick to the fight when you're hardest hit;
It's when things seem worst that you mustn't quit.

(Complete only if patient under the age of 18)

PHQ-9 modified for Adolescents (PHQ-A)

Name: _____ **Clinician:** _____ **Date:** _____

Instructions: How often have you been bothered by each of the following symptoms during the past **two weeks**? For each symptom put an **"X"** in the box beneath the answer that best describes how you have been feeling.

	(0) Not at all	(1) Several days	(2) More than half the days	(3) Nearly every day
1. Feeling down, depressed, irritable, or hopeless?				
2. Little interest or pleasure in doing things?				
3. Trouble falling asleep, staying asleep, or sleeping too much?				
4. Poor appetite, weight loss, or overeating?				
5. Feeling tired, or having little energy?				
6. Feeling bad about yourself – or feeling that you are a failure, or that you have let yourself or your family down?				
7. Trouble concentrating on things like school work, reading, or watching TV?				
8. Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you were moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself in some way?				

In the **past year** have you felt depressed or sad most days, even if you felt okay sometimes?

☐Yes ☐No

If you are experiencing any of the problems on this form, 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

Has there been a time in the **past month** when you have had serious thoughts about ending your life?

☐Yes ☐No

Have you **EVER**, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt?

☐Yes ☐No

***If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital emergency room or call 911.*

Office use only: **Severity score:** _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)