Dear Patient:

We appreciate your choice of health care providers. Please be aware of the following process that is in place to help us better serve you.

- If you are a new patient, please arrive at least 30 minutes prior to your appointment time.
- If you are a return patient, please arrive at least 15 minutes prior to your appointment time.
- Patients who arrived 10 minutes after their appointment time are subject to cancellation.
- Co-pay is due at time of arrival.
- Please allow extra time for parking.

Thank you for your assistance in this matter. If you have questions, please contact our office at 205-934-5151 between the hours of 8:00am-4:00pm.

UAB Psychiatry
Sparks Center
UAB Department of Psychiatry

- Our office hours are Monday-Friday 8:00am-5:00pm, except holidays.

- If you have an emergency please contact the Crisis Center at 205-323-7777 or go to your nearest emergency room.

- Any call to the office received after 4:00pm may not be returned until the following business day. Your call is very important to us and will be returned as quickly as possible and in the order it was received. Please leave only one message. If your call is not returned within one business day, please call again.

- Please arrive to your scheduled appointment 15-30 minutes early to allow for checking-in, paying co-pays, and completing any needed paperwork. If you are more than 10 minutes late your appointment will be rescheduled for a later date.

- If you have not been seen within a 6 month period, or have failed to arrive for 2 appointments, no medications will be phoned in until you are scheduled to see your provider.

- We will only discuss patient issues with the patient, unless the patient has signed a release of information. There will be no exceptions. Please understand that these are federally mandated laws and are not just the policy of our clinic.
UAB Department of Psychiatry

NO-SHOW POLICY

This form is intended to notify you as a patient of the Department of Psychiatry, at UAB that a 24 hour cancellation notice is required.

Please be aware that you will be charged a $50.00 no-show fee when you fail to arrive for your appointment or if you cancel your appointment without providing a 24 hour notice.

Your insurance does not pay for no-show charges.

You agree to be financially responsible for this fee should you fail to keep your scheduled appointment.

Patient Name ______________________  Medical Record Number ______________________

Signature of Patient or Guardian ______________________

Date Signed ______________________
UAB Department of Psychiatry

CO-PAYS & BALANCES POLICY

This policy is for patients who choose to have services performed at the UAB Department of Psychiatry.

It is the policy of our department, to collect any copayments and/or balances, at the time of service.

By signing this, you acknowledge that you understand this policy and will be responsible for any copayments required by your insurance, or any balances on your account.

If you are choosing to be seen without insurance coverage, you agree to pay the full cost of the appointment at the time of your visit.

__________________________________________  _______________________________________
Patient Name                                      Medical Record Number

_____________________________________________
Signature of Patient or Guardian

___________________________________________
Date Signed
The clinic door to check in on the 7th floor and walk through the 7th floor, you will take a
right when exiting the elevator.
If you have an appointment on the 7th floor, go to 2nd or 3rd floor.
Look for elevators on right and go up to 9th floor.

To get to CPM 2nd or 3rd floor.

Going to CPM 2nd or 3rd floor.

Wheelchair accessible to Sparks is available through CPM 2nd fl.

Located at: 1720 7th Ave S, Birmingham, AL 35233.

If parking lot is full, you can park in the CPM parking lot.
Payment options: Cash or coins.
Parking hours: 6:00 AM to 6:00 PM, daily.
Parking is $2.00 per hour, $7.00 for each additional hour.
To exit the parking lot, you will cost $2.00.
**If your parking ticket is not validated, it will cost $2.00.

Going to Sparks Building?

Take elevators to the 9th floor.
The Sparks building will be on the left.
You will be walking parallel on 7th Ave South.
Take a left toward 18th St. South.
Walk out of new Psychiatry Parking lot and go to 18th Ave South.

Sparks Building, 1812 7th Ave S, Birmingham, AL 35233.

Walking from Psychiatry Outpatient Clinic lot.

Center for Psychiatric Medicine (CPM) - 2nd or 3rd floor, 1713 6th Ave S.
UAB PSYCHIATRY

Demographic Information

Last Name: ___________________________ First Name: ___________________________ MI
Maiden Name ________________________ DOB ___________________________ SSN ___________________________
City/ST of Birth ______________________ Race/Ethnic Group ___________________________
Address: ___________________________ City/ST/ZIP: ___________________________
Phone: ___________________________ Work: ___________________________ Cell: ___________________________

Current Gender Identity (Check all that apply)
Male ___________________________
Female ___________________________
Transgender Male __________________
Transgender Female __________________
Genderqueer __________________
Additional Category __________________ (please specify) __________________

Sex assigned at Birth (Check One)
Male ___________________________
Female ___________________________
Decline to Answer __________________

Preferred Name & Pronouns
Preferred Name: ___________________________

Pronouns: He/Him __________________
She/Her __________________
They __________________
Ze __________________

General Information

Email Address: ___________________________

Referred By ___________________________

Military Status (Active, Veteran, None) ___________________________
U.S Citizen: (Please Circle) Yes No ___________________________

Have you been seen at UAB before: ___________________________

Emergency Contact

Name: ___________________________ Relationship: ___________________________
Address: ___________________________ City/ST/ZIP: ___________________________
Primary Phone: ___________________________ Secondary Phone: ___________________________

Is this visit covered under workman's compensation? (please circle) Yes No ___________________________
UAB DEPARTMENT OF PSYCHIATRY
OUTPATIENT CLINICS
Brief History Questionnaire

This questionnaire covers health and developmental history which is important information we need for our new patient evaluations. The information you provide will help our staff provide you with the very best care possible. This form will become part of your clinic record, and as such, your responses will be held in confidence to the degree specified by law. Please answer all questions to the best of your knowledge.

WHAT BRINGS YOU TO OUR CLINIC?

________________________________________________________________________

________________________________________________________________________

OCCUPATIONAL INFORMATION

Current Occupation: ___________________________ Former Occupation: ___________________________

What disability are you receiving benefits for? _____________________________________________

________________________________________________________________________

RELIGIOUS INFORMATION

Do you have any spiritual beliefs you would like your clinician to know about? ___________________________________________________________________________________

________________________________________________________________________

MILITARY INFORMATION

Have you served in the armed forces? (please circle) Yes No

If so, did you have any combat exposure? ____________________________________________

________________________________________________________________________

LEGAL INFORMATION

Do you have any past or present legal issues? _____________________________________________

________________________________________________________________________
MEDICAL/PSYCHIATRIC INFORMATION

Are you currently receiving or have you ever received treatment for a mental health condition? (please circle)

Yes  No

Name and address of past mental health providers:

________________________________________

________________________________________

________________________________________

Approximate dates of treatment:

________________________________________

________________________________________

________________________________________

Are you currently being treated or have you ever been treated with a psychiatric medication?
(for example: an anti-depressant or anti-anxiety medication)

<table>
<thead>
<tr>
<th>Medication Name</th>
<th>Daily Dosage</th>
<th>Year Prescribed</th>
<th>Length Taken</th>
<th>Medication Helpful?</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>(Yes, Somewhat, No)</td>
</tr>
<tr>
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</tr>
</tbody>
</table>

Have you ever been hospitalized in a psychiatric facility? If so, please provide the following:

Name of Hospital:

________________________________________

________________________________________

________________________________________

Dates of Treatment:

________________________________________

________________________________________

________________________________________

Please list all major medical illness, surgical operations, or other medical hospitalizations you have had:

Medical Condition:

________________________________________

________________________________________

________________________________________

Physician:

________________________________________

________________________________________

________________________________________

Date:

________________________________________

________________________________________

________________________________________
Have you ever had an allergic reaction to any medication?

Drug: ____________________________  Reaction: ____________________________  Date: ____________________________

________________________________________

________________________________________

________________________________________

Do you have any other allergies? _______________________________________________________

What non-psychiatric medications are you taking at this time? (Please include all over-the-counter medications as well.)

Name: ____________________________  Does: ____________________________  How Often: ____________________________

________________________________________

________________________________________

________________________________________

Who is your primary care physician? _____________________________________________________

Where do they practice? ________________________________________________________________

Please mark any of the following that pertain to you. Please place a check in the row to indicate your typical use during the past year.

<table>
<thead>
<tr>
<th>Substance</th>
<th>Never</th>
<th>Monthly Or Less</th>
<th>2-4 Times Weekly</th>
<th>1-3 Times Weekly</th>
<th>Greater than 3 Times Weekly</th>
</tr>
</thead>
<tbody>
<tr>
<td>Caffeinated Beverages</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alcohol</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Cocaine/Crack/Free-Base</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Marijuana/Hash/Pot/Weed</td>
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<td></td>
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<tr>
<td>Heroin/Opiates/Pain Pills</td>
<td></td>
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<tr>
<td>Stimulants/Amphetamines/Crystal/Ice/Uppers</td>
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<tr>
<td>Steroids/Androgens</td>
<td></td>
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<tr>
<td>Tranquilizers/Sleeping Pills/Downers</td>
<td></td>
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<tr>
<td>Tobacco Products</td>
<td></td>
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<tr>
<td>Other Drug: ___________________________</td>
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</tbody>
</table>
FAMILY INFORMATION

Your Children: Age:

  
  
  
  
  
  
  
  
  
  
  
  

  

Your Brothers/Sisters: Age:

  
  
  
  
  
  
  
  

Mother’s Age—or if deceased, age at her death: Occupation:

How would you describe your mother?

How would others describe your mother?

Father’s Age—or if deceased, age at his death: Occupation:

How would you describe your father?

How would others describe your father?

To your knowledge, have you, or any of your relatives had any of the following:

<table>
<thead>
<tr>
<th></th>
<th>Self</th>
<th>Mother</th>
<th>Father</th>
<th>Siblings</th>
<th>Children</th>
<th>Grandparents</th>
<th>Other</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADD/ADHD</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
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<tr>
<td>Anxiety Disorder</td>
<td></td>
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<tr>
<td>Bipolar Disorder</td>
<td></td>
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<tr>
<td>Depression</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Schizophrenia/psychosis</td>
<td></td>
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</tr>
<tr>
<td>Substance Abuse</td>
<td></td>
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</tr>
<tr>
<td>Suicide Attempts</td>
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<tr>
<td>Thyroid Disease</td>
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</tbody>
</table>

Please add anything not covered in this questionnaire that you feel could help us understand your problem: