UAB PSYCHIATRY

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.

DOCTOR **APPOINTMENT DATE** **TIME**

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 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

_____

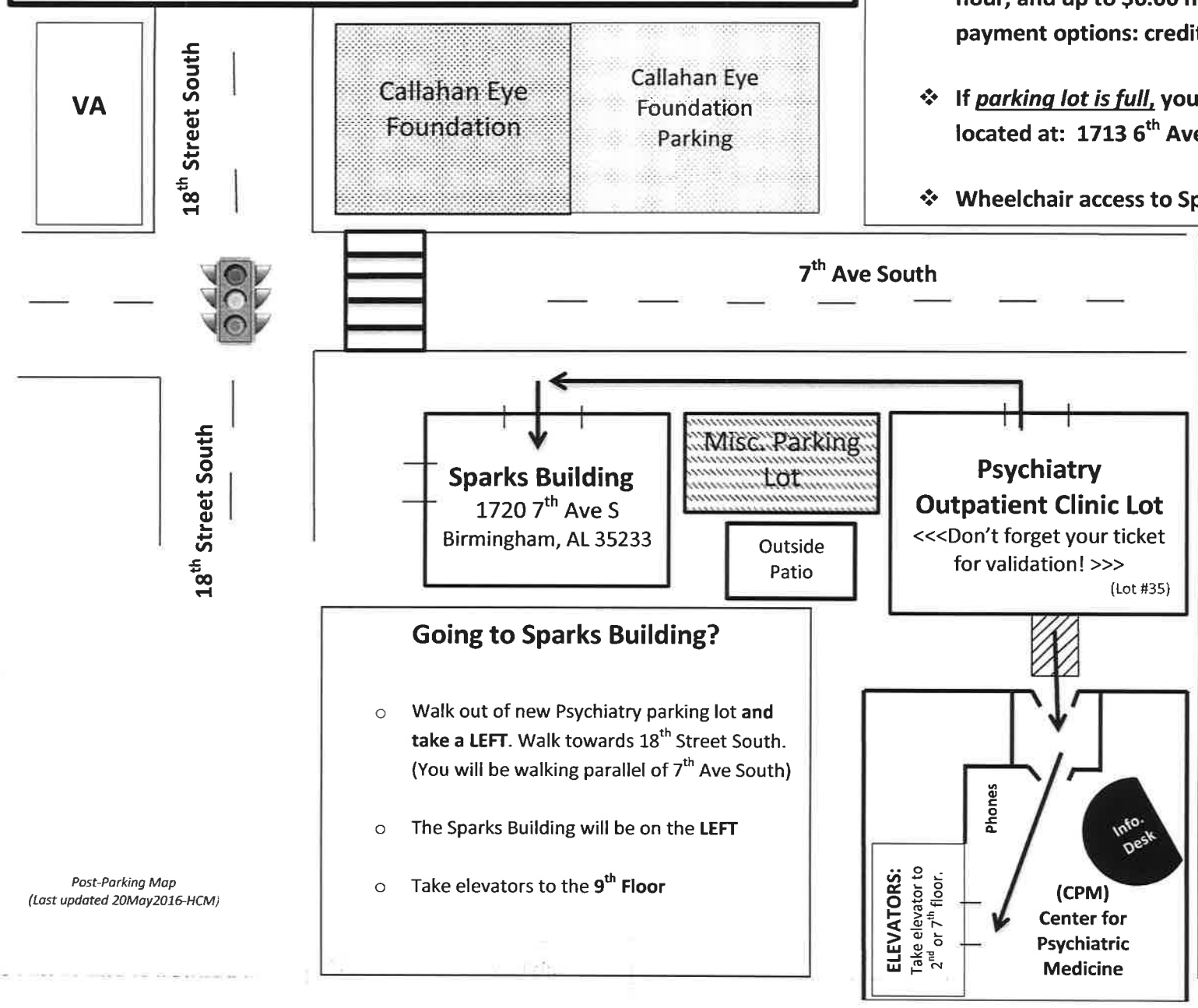
Signature of Patient or Guardian

_____

Date Signed

Walking from Psychiatry Outpatient Clinic Lot
to
Sparks Building - **9th floor**, 1720 7th Ave S, Birmingham, AL 35233
or
Center for Psychiatric Medicine (CPM) – 2nd or 7th floor, 1713 6th Ave S, Birmingham, AL 35294

- ☺ ***Don't Forget Your Parking Ticket So We Can Validate it!*** ****If your parking ticket is not validated, it will cost $25.00 to exit the parking lot. ****
- **Parking is $2.00 for the first hour, $1.00 for each additional hour, and up to $6.00 maximum daily rate. Parking payment options: credit cards, cash, or coins**
- **If *parking lot is full,* you can park in the CPM parking lot located at: 1713 6th Ave S. Birmingham, AL 35294.**
- **Wheelchair access to Sparks is available through CPM 2nd fl.**



Going to Sparks Building?

- Walk out of new Psychiatry parking lot **and take a LEFT**. Walk towards 18th Street South. (You will be walking parallel of 7th Ave South)
- The Sparks Building will be on the **LEFT**
- Take elevators to the **9th Floor**

Going to CPM 2nd or 7th floor?

- To enter the Center for Psychiatric Medicine (CPM) from the Psychiatry parking lot, you may access the building from the **back of the parking lot.**
- After entering the CPM building, go **through the double doors** to the lobby.
- Look for **elevators on RIGHT** and go to 2nd or 7th floor.
- If you have an appointment on the 7th floor, you will take a **RIGHT** when exiting the elevator on the 7th floor and walk through the clinic door to check in.

Post-Parking Map
(Last updated 20May2016-HCM)

Medical Record Number _____ Date _____

UAB PSYCHIATRY

Demographic Information

Last Name: _____ First Name: _____ MI ____

Maiden Name _____ DOB _____ SSN _____

City/ST of Birth _____

Marital Status _____ 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)

Medication Name:	Daily Dosage:	Year Prescribed:	Length Taken	Medication Helpful? *(Yes, Somewhat, No)*

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.

Substance	Never	Monthly Or Less	2-4 Times Weekly	1-3 Times Weekly	Greater than 3 Times Weekly
Caffeinated Beverages					
Alcohol					
Cocaine/Crack/Free-Base					
Marijuana/Hash/Pot/Weed					
Heroin/Opiates/Pain Pills					
Stimulants/Amphetamines/Crystal/Ice/ Uppers					
Steroids/Androgens					
Tranquilizers/Sleeping Pills/Downers					
Tobacco Products					
Other Drug:_____					

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:

	Self	Mother	Father	Siblings	Children	Grandparents	Other
ADD/ADHD							
Anxiety Disorder							
Bipolar Disorder							
Depression							
Schizophrenia/Psychosis							
Substance Abuse							
Suicide Attempts							
Thyroid Disease							

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

_____

_____

_____

_____