



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
Callahan Eye Foundation

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

Parking at Eye Foundation Hospital

Parking is available in the Callahan Eye Foundation Parking Deck on levels 1-4. Please park on one of these levels and enter the building from the parking deck. Upon check-in please have your parking ticket validated in order to receive the validated parking rate. The validated rate is based upon time parked in the deck and will not be free parking.

Without validation you will be charged \$15.00.

VALIDATED PARKING RATES

First Hour	\$2.00
Each Additional Hour	\$1.00
Max Daily Rate	\$6.00

Valet parking will be an additional \$2.00 to the timed rate.

\$5.00 required to exit after 8:30pm.

\$6.00 required for lost ticket.

Parking spaces are limited in our parking deck. We ask that you do not bring large vehicles into our deck due to height restrictions (6'8") and size of our parking spaces. We also have handicapped spaces spread over levels 2-4. There are handicapped ramps on the 1st & 2nd levels with access directly into the building.

We hope this information is helpful and that you have a safe visit to our facility.

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:
