

# UAB Department of Psychiatry

Dear Patient:

We appreciate your choice of health care providers. In order to better serve you, it has become necessary to change our clinic procedure.

- 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 10 minutes prior to your appointment time.
- Patients who arrive 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 help in this matter. If you have questions, please contact our office at 205-934-5151 between the hours of 8:00am-4:00pm.

UAB Department of Psychiatry

Eye Foundation Hospital

# UAB Department of Psychiatry

## NO-SHOW POLICY

Due to time-oriented appointments, 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.

If you fail to keep an appointment and do not cancel within 24 hours prior to that appointment, a \$50 no-show fee may be charged to you. Insurance does not cover/pay for no-show charges. You agree to be financially responsible for this fee should you fail to keep your scheduled appointment as required herein.

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Patient Name

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Medical Record Number

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Signature of Patient or Guardian

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Date Signed

## UAB DEPARTMENT OF PSYCHIATRY

- Our office hours are Monday-Friday 8:00am—5:00pm except holidays. We will post in the clinic lobby a calendar of holidays on which the clinic is closed.
- If you have an emergency or need to talk with someone after hours or on holidays, please contact the UAB Psychiatric Emergency Services at 205-996-5033 or you may also contact the Crisis Center at 205-323-7777, or page the psychiatry resident on call through UAB Paging at 205-934-3411. Please note that the residents are not allowed to phone in any prescriptions. If you need a prescription refill; you must call the office on the next clinic day.
- 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 handled as quickly as possible. Please understand that due to the large volume of calls we receive, we will return them in the order in which they were received. Please leave only one message. If your call has not been returned within one business day, please call again.
- You must give a 24 hour notice of appointment cancellation or you will be charged a **\$50.00 fee**. If you call after hours, you may leave a voice message at **934-7685 or 996-7431**.
- If you fail to show for 2 appointments or have not been seen in a 6 month time period, no medications will be phoned in until you schedule an appointment to see your doctor.
- 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 need any forms or letters, we will assist on 2 occasions. After that, there will be a \$25.00 fee for completing forms such as medical leave, disability or insurance forms.
- Due to HIPPA laws, we will be allowed to discuss patient issues only with the person who is the patient, unless the patient signs 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.

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DOCTOR

APPOINTMENT DATE

TIME

# Parking at Eye Foundation Hospital

Parking is available in the Callahan Eye Foundation Parking Deck for clinic patients. You may enter the parking deck from the main deck entrance off University Boulevard. Please have your ticket validated when you are seen in the clinic and present it to the parking attendant as you exit on 7<sup>th</sup> Avenue. This will give you the validated rate for parking. The validated rate will be based upon time parked and will **not** be free parking.

Parking is available in our deck on levels 1 through 4. Please park on one of these levels and enter the building from the parking deck. Entrance to the building is available on each level of our deck. When you enter the building, you may then access the elevators that will take you to our office on Level 3.

Upon entering the check-in area, please have your parking ticket validated for the validated parking rate. The validated rate is based upon time parked in the deck.

## **Without validation you will be charged \$15.00.**

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.

Upon entering our deck please continue in one direction. On our lower 1<sup>st</sup> level we have 12 handicapped spaces and an area for dropping off disabled patients.

We also have several handicapped spaces spread over levels 2 through 4. There are handicapped ramps on the 1<sup>st</sup> and 2<sup>nd</sup> levels with access directly into the building. Level 3 has a flat entrance into the building and there are three steps entering off the 4<sup>th</sup> floor level.

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

### **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.**

# **Directions to the Eye Foundation Hospital – EFH**

**Parking is available at the EFH on 8<sup>th</sup> Avenue South also called University Boulevard**

## **Directions from Birmingham International Airport:**

Follow I-20/59 West/South toward downtown Birmingham. Exit at Highway 31/280 (Exit 126A). Proceed south and exit at 8th Avenue South (University Boulevard). Turn right onto 8th Avenue South. The EFH is on the corner of 18<sup>th</sup> and 8<sup>th</sup> Ave. also known as University Boulevard. The parking deck is on the right. Airport transportation for international patients may be arranged by calling International Patient Services at 205.934.2096.

## **Directions Heading Southbound on I-65:**

Exit 4th Avenue South (Exit 259B). Proceed to 18th Street South and turn right. Proceed to 8<sup>th</sup> Avenue South and turn right. The entrance to the EFH will be on the right.

## **Directions Heading Northbound On I-65:**

Exit at 8th Avenue South (University Boulevard/Exit 259). The EFH is on the corner of 18<sup>th</sup> and University Boulevard on the left.

## **Directions Heading East / Northbound On I-20/59:**

Follow I-20/59 to the junction of I-65. Take I-65 South to 4th Avenue South (Exit 259B). Proceed to 18th Street South and turn right. Proceed to 8<sup>th</sup> Avenue South and turn right. The entrance to the EFH will be on the right.

## **Directions Heading Westbound On I-20:**

Follow I-20 to the junction of I-65. Take I-65 South to 4th Avenue South (Exit 259B). Proceed to 18th Street South and turn right. Proceed to 8<sup>th</sup> Avenue South and turn right. The entrance to the EFH will be on the right.

## **Directions Heading Southbound On I-59:**

Follow I-59 to the junction of I-65. Take I-65 South to 4th Avenue South (Exit 259B). Proceed to 18th Street South and turn right. Proceed to 6th Avenue South and turn right. The entrance to the Center For Psychiatric Medicine will be midway down the block on your left.

## **Directions Heading Westbound On U.S. 280:**

Follow Highway 280 until it merges with Highway 31 North and becomes the Red Mountain Expressway. Proceed north and exit at 8th Avenue South (University Boulevard). Turn right onto 8th Avenue South. The EFH is on the corner of 18<sup>th</sup> and 8<sup>th</sup> Ave. also known as University Boulevard. The parking deck is on the right

## **Directions Heading Southbound On U.S. 31:**

Follow Highway 31 through North Birmingham until it becomes the Red Mountain Expressway. Proceed south and exit at 8th Avenue South (University Boulevard). Turn right onto 8th Avenue South. The EFH is on the corner of 18<sup>th</sup> and University Boulevard on the right.

## **Directions Heading Northbound On U.S. 31:**

Follow Highway 31 through Homewood until it becomes the Red Mountain Expressway. Proceed north and exit at 8th Avenue South (University Boulevard). Turn right onto 8th Avenue South. The EFH is on the corner of 18<sup>th</sup> and University Boulevard on the right.

Medical Record # \_\_\_\_\_

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**DEPARTMENT OF PSYCHIATRY**  
**Registration Information**

Last Name \_\_\_\_\_ First Name \_\_\_\_\_ MI \_\_\_\_\_

Date \_\_\_\_\_ SSN \_\_\_\_\_ Maiden Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

County \_\_\_\_\_ Phone (Home) ( ) \_\_\_\_\_ (Work) ( ) \_\_\_\_\_

Marital Status \_\_\_\_\_ Sex \_\_\_\_\_ Race/Ethnic Group \_\_\_\_\_

Date of Birth \_\_\_\_\_ Mother's Maiden Name \_\_\_\_\_

City of Birth \_\_\_\_\_ State of Birth \_\_\_\_\_ U.S. Citizen - YES NO

**General Information**

Referred by? \_\_\_\_\_ Phone # \_\_\_\_\_

Address \_\_\_\_\_

Military Status (veteran, non-veteran, in-service) \_\_\_\_\_

Have you been seen at UAB before? \_\_\_\_\_

Usual living situation (spouse, children, parents, etc.) \_\_\_\_\_

Source of Support:

- \_\_\_\_\_ Wages/Salary
- \_\_\_\_\_ Retirement/Pension
- \_\_\_\_\_ Disability
- \_\_\_\_\_ Public Assistance
- \_\_\_\_\_ Other
- \_\_\_\_\_ None

Employment Status:

- \_\_\_\_\_ Full-time
- \_\_\_\_\_ Part-time
- \_\_\_\_\_ Unemployed
- \_\_\_\_\_ Not in labor force
- \_\_\_\_\_ Volunteer

Education Status:

- Current Grade \_\_\_\_\_
- Highest Grade \_\_\_\_\_

Average family income (optional) \_\_\_\_\_ Occupation: \_\_\_\_\_

**Employer Information**

Employer \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Phone \_\_\_\_\_

**Financial Responsibility**

Responsible Party Name \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_ Occupation \_\_\_\_\_

Employer \_\_\_\_\_ Phone \_\_\_\_\_

Employer Address \_\_\_\_\_

**Please continue on back**

Is this visit covered under Workman's Compensation? (please circle) YES NO

**Insurance Coverage**

Primary Insurance:

Insurance Company Name: \_\_\_\_\_

Contract No. \_\_\_\_\_ Group No. \_\_\_\_\_

Group Name \_\_\_\_\_

Subscriber's Name D.O.B \_\_\_\_\_ Relationship to you \_\_\_\_\_

Type of Coverage: Single \_\_\_\_\_ Family \_\_\_\_\_

Mail Claim Forms To: \_\_\_\_\_

Phone No. \_\_\_\_\_

Secondary Insurance:

Insurance Company Name: \_\_\_\_\_

Contract No. \_\_\_\_\_ Group No. \_\_\_\_\_

Group Name \_\_\_\_\_

Subscriber's Name \_\_\_\_\_ Relationship to you \_\_\_\_\_

Mail Claim Forms To: \_\_\_\_\_

Phone No. \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Address \_\_\_\_\_

City/State/Zip \_\_\_\_\_

Phone #1 \_\_\_\_\_ Phone #2 \_\_\_\_\_

UAB DEPARTMENT OF PSYCHIATRY  
OUTPATIENT CLINICS  
Brief History Questionnaire

This questionnaire covers health and developmental history items which are important parts of 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. It should take about 30 minutes to fill out the questionnaire completely.

Please answer all the following questions to the best of your knowledge.

GENERAL INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Gender:     M     F

Occupation: \_\_\_\_\_ Marital Status: \_\_\_\_\_ Length of marriage: \_\_\_\_\_

If married, age of spouse: \_\_\_\_\_ Spouse's occupation: \_\_\_\_\_

Prior marriages: Yes   No     If so, how many? \_\_\_\_\_ Length of each: \_\_\_\_\_

Person or agency who referred you to UAB Neuropsychiatry Clinic:

\_\_\_\_\_

Primary Care Physician: \_\_\_\_\_

EDUCATIONAL/OCCUPATIONAL INFORMATION

Highest educational level completed:

- \_\_\_\_\_ Grade School
- \_\_\_\_\_ GED
- \_\_\_\_\_ High School
- \_\_\_\_\_ Trade School
- \_\_\_\_\_ Some College
- \_\_\_\_\_ College Graduate
- \_\_\_\_\_ Graduate/Professional School

Adjustment to school situations:

- \_\_\_\_\_ Poor
- \_\_\_\_\_ Fair
- \_\_\_\_\_ Good
- \_\_\_\_\_ Excellent

<u>Name of School</u>	<u>Location</u>	<u>Dates</u>
College: _____	_____	_____
Postgraduate: _____	_____	_____

Type(s) of work you have done (occupations): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

If you are disabled, please give date of onset of disability: \_\_\_\_\_

If you are being seen in reference to an injury, please give date of injury: \_\_\_\_\_

Was it work related? Yes No

Past ambitions: \_\_\_\_\_

Present ambitions: \_\_\_\_\_

**RELIGIOUS INFORMATION**

Current Religion: \_\_\_\_\_ Religion in which you were raised: \_\_\_\_\_

Do you presently engage in any religious activity? Yes No

Rate the strength of your religious beliefs. Circle the appropriate response.

0 1 2 3 4 5  
none very strong

**MILITARY HISTORY**

Have you served in the armed forces? Yes No

If so, branch of service? \_\_\_\_\_

Years: from \_\_\_\_\_ to \_\_\_\_\_ Rank: \_\_\_\_\_

How did you adjust to military life? \_\_\_\_\_

\_\_\_\_\_

**LEGAL HISTORY**

Are you currently, or have you previously been involved in any civil or criminal legal proceedings? If so, please provide details. \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

### MEDICAL/PSYCHIATRIC HISTORY

Please describe briefly the main problem or condition for which you are currently seeking help:

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How long have you been bothered by this condition? \_\_\_\_\_

Are you currently receiving or have you ever received treatment for your condition? Yes No

Name and location of provider:

Dates of treatment:

_____	_____
_____	_____
_____	_____

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

Medication Name	Daily Dosage (mg)	When Prescribed (year)	Taken how long	Medication helpful? (yes/somewhat/no)
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

If you have ever been psychiatrically hospitalized, please give the following.

Name of Hospital:

Date of Treatment:

_____	_____
_____	_____
_____	_____

Describe your current state of general health: (circle) poor fair good excellent

What is your approximate weight now? \_\_\_\_\_ 3 months ago? \_\_\_\_\_ 1 year ago? \_\_\_\_\_

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

<u>Event:</u>	<u>Date:</u>
_____	_____
_____	_____
_____	_____

If you have ever had an allergy or reaction to any drug or medicine:

<u>Drug:</u>	<u>Reaction:</u>	<u>Date:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

What non-psychiatric medications are you taking at the present time? Please include all non-prescriptions that you take on a regular basis.

Medication:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please mark any of the following that pertain to your lifestyle habits:

<u>Habit:</u>	<u>Yes</u>	<u>Average Number Per Day</u>
Cigarettes	_____	_____
Cigars	_____	_____
Pipe	_____	_____
Chewing tobacco/snuff	_____	_____
Coffee (8 oz)	_____	_____
Tea (8 oz)	_____	_____
Caffienated soft drinks (12 oz)	_____	_____
Alcohol	_____	_____

Have you ever used alcohol or drugs (e.g. marijuana, cocaine) to help cope with your current condition?

(circle)      YES              NO





Please place a check in the row after each substance to indicate your typical use during the past year.

SUBSTANCE	NEVER	MONTHLY OR LESS	2-4 TIMES WEEK	1-3 TIMES WEEK	MORE THAN 3 TIMES/WEEK
Alcohol					
Marijuana/Hash/TCH/Pot/Weed					
Cocaine/Crack/Free-Base					
Heroin					
Other Opiates/Pain Pills					
Tranquilizers/Sleeping Pills/Downers					
Stimulants/Amphetamines/Crystal/Meth/Ice/Crank/Uppers					
Amyl Nitrate/Poppers					
Other Inhalants/Glue/Solvents/Aerosols					
Steroids/Androgens/Roids/Juice					
Over-The-Counter Medications					