ALLEN MELVIN, M.D., P.A.
3315 Springbank Ln., Ste. 302
Charlotte, NC 28226
Phone 704.644.7885 Fax 704.353.7275

Office Information

Office Hour Monday 7:40am to 4:00pm, Tuesday 7:40am to 4:00pm, Wednesday Closed, Thursday 7:40am to 4:00pm Friday Closed

Office Visits:

- **Scheduling – you must have a scheduled appointment to be seen.** Schedule appointments by contacting the office at 704.644.7885. You can also request an appointment by email at appointments@allenmelvinmd.com by providing preferred date and time of day and contact information.
- **Missed or late cancelled appointments**: Notify the office at least 24 hours before your appointment or you will be charged 50% of the appointment fee, even if you did not receive a reminder call. If you miss or late cancel your initial appointment you may not be rescheduled.
- **We do not participate in, and we do not file, any insurance.** Your office receipt will contain the necessary information for you to file your own insurance.
- **We do not participate in, and we do not file, Medicare.** Medicare requires that you sign a private contract with our office at the time of your first visit.
- **Full Payment is expected at time of service**. Cash, Check, Debit and Credit Cards (Visa, MasterCard and Discover) are accepted.

Prescription Refills:

- If you are prescribed medication, you will be provided with an initial prescription and refills to last until the recommended follow-up visit. **It is your responsibility** to schedule your follow-up appointment before the prescription runs out to ensure a continued supply of medication.
- Medication refill requests will be denied if you fail to keep follow-up appointments. To give good clinical care, patients must be seen on a regular basis.
- Only minor changes in your medication regimen can be made between appointments. If a major change in your medication regimen is needed you will need to have an appointment.
- W*e do not accept faxed refill requests from your pharmacist because the requests frequently do not match your current medication regimen.*
- It may take up to 24 hours for reviewing your medical history and deciding if the requested refill is appropriate.
- Please call your pharmacy to see if your request was processed before calling the office to request the same refill a second time.
- Routine prescriptions refills will not be provided on the weekends.

Services Subject to Charge:

- Telephone consultation, request for records, prescription refills, missed appointments and late cancellations.
- Completion of form letters and/or reports if not done **during** your appointment.

Emergency/After Office Hours:

- Should you experience a life threatening medical emergency please immediately call 911 or go to the nearest hospital emergency department.
- An on-call physician will be available for after office hours emergencies only.
- No routine prescription refills will be authorized by the on-call physician.

I have read and understand the information listed above and received a copy.

____ __________________

Signature Date

ALLEN MELVIN, M.D., P.A.

Patient Registration

Referred by: ____

Patient First Name:______________________**Middle**__________________**Last**________________________

Age ___________**Date of Birth** ___________________ **Gender** ____________

Single ( ) Married ( ) Separated ( ) Divorced ( ) Widowed ( ) Partnered ( )

Home Address _____________________________ **City** _____________________**State** _______________

Phone Numbers: Mobile______________________**Work**____________________ **Home**_________________

Preferred telephone number for your appointment reminder: Mobile ( ) Work ( ) Home ( )

Preferred e-mail address for your appointment reminder _______________________________________

Preferred method of contact for your appointment reminder: Text ( ) Phone ( ) E-mail ( )

Has any other family member been seen previously by Dr. Melvin? No ( ) Yes ( )

If yes, who and when ____

<u>Emergency Contact</u>

First Name:__________________ **Last Name:**_____________________ **Relationship:**________________

Address: __________________________ **City:**______________**State:**__________ **Zip Code**_____________

Best Phone Contact ____

Pharmacy Information

Local Pharmacy________________**Address**_____________________**City**________________**Zip**__________

Mail Order Pharmacy____

I UNDERSTAND THAT I AM RESPONSIBLE FOR FULL PAYMENT AT THE TIME OF SERVICE

Signature____**Date**____________________

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CONSENT FOR PURPOSES OF TREATMENT, PAYMENT AND HEALTHCARE OPERATIONS

Name ____ **Date of Birth** ________________________

Mailing Address ____

City________________________________**State** ___________________ **Zip Code**___________________

By signing this form, you grant Alien Melvin, MD, PA (the Practice) and Allen Melvin, MD consent to use and disclose your protected health information for the purposes of treatment, payment and healthcare operations as described in our Notice of Privacy Practices. Our Notice provides a description of our uses and disclosures regarding your protected health information and your health information rights.

With this consent, you are granting permission for Allen Melvin, MD, PA to contact you by telephone, voicemail, text message or email, in reference to any items that assist the practice in carrying out your treatment, payment activities or healthcare operations. This includes, but not be limited to, appointment reminders, prescription information or any matters pertaining to your clinical care.

You are also granting permission for us to talk with your designated emergency contact person when needed.

Allen Melvin, MD, PA may not be able to agree with every special restriction request regarding use or disclosure of your protected healthcare information. However, if granted we are bound by such agreement.

Allen Melvin, MD, PA reserves the right to revise our privacy practices as described in our Notice of Privacy Practices. If we change our privacy practices, we will issue a revised Notice of Privacy Practices, which will contain any changes.

Right to Revoke: You will have the right to revoke this Consent at any time, except to the extent that Allen Melvin, MD, PA has already made disclosures in reliance upon prior consent. A refusal to sign this Consent or a revocation may result in refusal or discontinuation of treatment.

I have been provided an opportunity to review the Notice of Privacy Practices and I understand that I will be provided a copy, upon request, before signing this consent.

Signature ____ **Date**______________________________

If, on behalf of the patient, a personal representative signs this Consent, please complete the following:

Representative's Name_____________________________Relationship to Patient ____________________________

Upon request you are entitled to a copy of this consent after you sign it.

The following statement is to be signed only if you decide to revoke your Consent agreed to by the signature above.

Revocation of Consent

I revoke my consent for your use and disclosure of my protected health information for treatment, payment activities and healthcare operations.

I understand the revocation of my Consent will not affect any action taken in reliance on my consent before you received my written Notice of Revocation. I also understand that I may be declined treatment as a result of my Revocation of Consent.

Signature ____________________________ ____________________ Date ______________________

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AllenMelvinMD.com

PERSONAL HISTORY

Personal History

Please **complete all information** **on this form prior to your initial visit**. It may seem long, but most of the questions require only a check, so it will go quickly. You may need to ask family members about the family history. Thank you!

Date				D.O.B.	
First Name		Middle Name		Last Name	
Primary Care Physician					
Current Therapist					

For what problems are you seeking help? Please describe symptoms and their duration.

What are your treatment goals?

What are your precipitating and/or current stressors?

Office Use Only

Personal History

All My Current Medications and Supplements

Medication Name	Current Strength	When med is taken	How long	Prescriber
Prescription Medications				
Nonprescription Medications				
Supplements				

CURRENT SYMPTOM CHECKLIST								
Check once for any current symptom. Check twice for severe current symptoms								
Depressed Mood	☐	☐	Decreased libido	☐	☐	Excessive worry	☐	☐
Unable to enjoy activities	☐	☐	Increased libido	☐	☐	Anxiety Attacks	☐	☐
Insomnia	☐	☐	Racing thoughts	☐	☐	Avoidance	☐	☐
Hypersomnia	☐	☐	Increased Impulsiveness	☐	☐	Hallucinations	☐	☐
Unable to concentrate	☐	☐	Increased risky behavior	☐	☐	Suspiciousness	☐	☐
Decreased appetite	☐	☐	Decreased need for sleep	☐	☐	Fatigue	☐	☐
Increased appetite	☐	☐	Excessive energy	☐	☐	Crying spells	☐	☐
Excessive guilt	☐	☐	Increased irritability	☐	☐		☐	☐

SUICIDE RISK ASSESSMENT		
Yes	No	
☐	☐	Do you feel hopeless and/or helpless?
☐	☐	Have you ever attempted suicide or intentional harmed yourself?
		When was the last time you had suicidal thoughts?
☐	☐	Do you have a suicidal plan?
☐	☐	Do you have means to carry out your plan?

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NonMental Health Medical History

Allergies:	Weight:	Height:

My Current Medical Conditions, Previous Hospitalizations and Previous Surgeries

Current Medical Conditions	Previous Nonpsychiatric Hospitalizations	Previous Surgeries

My Personal and Family NonMental Health Medical History

Illness	You	Family	Which Family Member Include blood related Aunts, Uncles, Grandparents, Parents, Siblings
Heart Disease	☐	☐	
Hypertension	☐	☐	
Cancer	☐	☐	
Thyroid Disease	☐	☐	
Liver Disease	☐	☐	
Diabetes	☐	☐	
Respiratory problems	☐	☐	
Seizures	☐	☐	
Head Trauma	☐	☐	
High Cholesterol	☐	☐	
Chronic Pain	☐	☐	
Chronic Fatigue	☐	☐	
Fibromyalgia	☐	☐	

Please describe below any additional relevant personal or family history not previously noted.

Date of last physical exam	

Exercise Level

Do you exercise regularly?	Yes ☐	No ☐
How many days per week do you exercise?		
How much time each day do you exercise?		

For Women Only

Date your last menstrual period started		N/A ☐
Are you pregnant or think you may be pregnant?	Yes ☐	No ☐
Do you want to become pregnant in the near future?	Yes ☐	No ☐
What is your birth control method?		

Mental Health Medical History

My Current and Previous Mental Health Treatment Providers

Name of Provider/ Hospital	When	Check if Currently Seeing
Outpatient Counselors/Therapist		
		☐
		☐
		☐
		☐
Psychiatrists/ Other Physicians		
		☐
``		☐
		☐
Hospitalizations		

My Family Mental Health and Substance Abuse History

Illness	Yes	No	Which Family Member(s) Include blood related Aunts, Uncles, Grandparents, Parents, Siblings
Major Depression	☐	☐	
Dysthymia	☐	☐	
Attempted Suicide	☐	☐	
Bipolar Disorder	☐	☐	
General Anxiety	☐	☐	
Panic Disorder	☐	☐	
Agoraphobia	☐	☐	
Anger	☐	☐	
Schizophrenia	☐	☐	
Post-traumatic Stress	☐	☐	
Alcohol Abuse	☐	☐	
Other Substance Abuse	☐	☐	
Violence	☐	☐	
	☐	☐	

Office Use Only

Personal History

Past Mental Health Related Medication Treatment

If you have ever taken any of the following medications please indicate the estimated dates taken, its effect, and any side effects.

Medication		Daily Dosage	Dates taken How long taken	Effect None, Positive or Negative	Side effects (if any)
Antidepressants					
Name Brand	***Generic Name***				
Anafranil	Clomipramine				
Celexa	Citalopram				
Cymbalta	Duloxetine				
Desyrel	Trazodone				
Effexor XR	Venlafaxine ER				
Elavil	Amitriptyline				
Emsam	Selegiline				
Lexapro	Escitalopram				
Luvox	Fluvoxamine				
Nardil	Phenelzine				
Pamelor	Nortriptyline				
Parnate	Tranylcypromine				
Paxil	Paroxetine				
Pristiq	Desvenlafaxine				
Prozac	Fluoxetine				
Remeron	Mirtazapine				
Serzone	Nefazodone				
Tofranil	Imipramine				
Viibryd	Vilazodone				
Wellbutrin	Buproprion				
Zoloft	Sertraline				
Other					
Mood Stabilizers					
Depakote ER	Valproate				
Lamictal	Lamotrigine				
Lithium	Lithium				
Tegretol	Carbamazepine				
Topamax	Topiramate				
Other					

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Personal History

Medication		Daily Dosage	Dates Taken	Effect None, Positive or Negative	Side effects (if any)
Antipsychotics/Mood Stabilizers					
Name Brand	***Generic Name***				
Abilify	*Aripiprazole*				
Clozaril	*Clozapine*				
Fanapt	*Iloperidone*				
Geodon	*Ziprasidone*				
Haldol	*Haloperidol*				
Invega	*Paliperidone*				
Latuda	*Lurasidone*				
Prolixin	*Fluphenazine*				
Risperdal	*Risperidone*				
Seroquel	*Quetiapine*				
Trilafon	*Perphenazine*				
Zyprexa	*Olanzapine*				
Other					
Sedative Hypnotics					
Ambien	*Zolpidem*				
Desyrel	*Trazodone*				
Halcion	*Triazolam*				
Restoril	*Temazepam*				
Rozerem	*ramelteon*				
Silenor	*Doxepin*				
Sonata	*Zaleplon*				
Other					
ADHD Medications					
Adderall	Amphetamine Salt				
Adderall XR	Amphetamine Salt				
Concerta	Methylphenidate				
Intuniv	Guanfacine				
Ritalin	Methylphenidate				
Stratterra	Atomoxetine				
Vyvanse	Lisdexamfetamine				
Other					
Antianxiety Medications					
Ativan	Lorazepam				
BuSpar	Buspirone				
Klonopin	Clonazepam				
Tranxene	Clorazepate				
Valium	Diazepam				
Xanax	Alprazolam				
Other					

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Substance Use

Alcohol		
		How many days per week do you drink any alcohol?
		What is the least number of drinks you will drink in a day?
		What is the most number of drinks you will drink in a day?
		In the last 3 months what are the most drinks you had in one day?
Yes ☐	No ☐	Have you ever felt you needed to cut down on your alcohol consumption?
Yes ☐	No ☐	Have people annoyed you by criticizing you drinking?
Yes ☐	No ☐	Have you ever felt guilty about your drinking?
Yes ☐	No ☐	Have you ever drunk alcohol in the morning to steady your nerves?
Yes ☐	No ☐	Have you ever had alcohol related withdrawal symptoms, legal problems, relationship problems or work problems?
Nicotine		
Yes ☐	No ☐	Do you smoke tobacco?
		If yes, how much do you smoke?
		What age did you start?
Yes ☐	No ☐	Do you use other nicotine products?
Marijuana		
Yes ☐	No ☐	Have you smoked marijuana in the last 3 months?
		How many days per week do you smoke marijuana?
Opiates		
Yes ☐	No ☐	Have you abused pain medication in last 3 months?
		If yes, which ones and how much were you taking daily?
Other illicit or legal drugs or prescription medications		
Yes ☐	No ☐	Have you misused any prescription or nonprescription drugs in the last 3 months?
		If yes, which ones and for how long?
Yes ☐	No ☐	Have you ever had or currently have a drug abuse problem?
		If yes, please describe.
Yes ☐	No ☐	Have you ever had drug related withdrawal symptoms, legal problems, relationship problems or work problems?
Substance Abuse Treatment		
Yes ☐	No ☐	Have you had any previous treatment for alcohol or drug use?
		If yes, please describe.

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Personal History

Family Background and Childhood History

Were you adopted?	Yes ☐	No ☐
Where did you grow up?		
How many brothers and sisters do you have?		
Father's Occupation		
Mother's Occupation		
Describe your relationship with your Father.		
Describe your relationship with your Mother		
What age did you leave home?		
List any deaths in your immediate family		

Trauma History

Any history of emotional, sexual, physical abuse or neglect?	Yes ☐	No ☐
If yes, by whom and at what ages		
Please describe any other trauma you have experienced		

Education

Did you attend college?	Yes ☐	No ☐
Where?		
Major?		
What is your highest educational level or degree obtained?		

Military Service

Have you served in the military?	Yes ☐	No ☐
What branch and how long?		
What type of discharge from the military?		

Current Working Status

Working	☐
Not working by choice	☐
Unemployed	☐
Disabled	☐
Retired	☐

Current Occupation

How long in present position?	
Your current occupation	
Where do you work?	

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Personal History

Relationship History and Current Family

Current Status	☐ Single	☐ Married	☐ Divorced	☐ Widow(er)
How long?				
If not married, are you currently in a relationship?	Yes ☐ No ☐	How long?		
Are you sexually active?				
What is your sexual orientation?				
What is your spouse or significant other's occupation?				
Describe your relationship with your spouse or significant other.				
Have you had any prior marriages? Yes ☐ No ☐	If yes, how many and duration of each			
Do you have children? Yes ☐ No ☐	If yes, list gender and age			
Describe your relationship with your children.				
List everyone that lives with you.				

Legal History

Have you ever been arrested?	Yes ☐	No ☐
Do you have any pending legal issues?	Yes ☐	No ☐

Spiritual Life

Do you belong to a particular religious or spiritual group?	Yes ☐	No ☐
If yes, what is your level of involvement?		
Do you find your involvement helpful or stressful?		

Is there anything else that you would like Dr. Melvin to know?

Signature ______________________________ Date ____________________

Reviewed by: ______________________________ Date ____________________