Ahava Healthcare
Jody Amazon, DSc APRN
2160 Fountain Drive #220, Snellville, GA 30078

(P)678-336-9102 (F) 770-674-8563
Kristina Thompson - Practice Manager
info@ahavahealthcare.org

LEGAL NAME: _____ _____ ____
Last **First** **MI**

DOB: _____ **Social Security:** _____-_____-_____

Telephone Number: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Email: _____

Marital Status: Single ☐ Married ☐ Divorced ☐ Widow/Widower ☐ Partner ☐

Employment Status: Retired ☐ Disabled ☐ Employed ☐

required for billing purposes

Primary Insurance: _____ **ID#:** _____

Group #: _____

Secondary Insurance: _____ **ID#:** _____

Group #: _____

Name of physician/person that referred you: _____

Address: _____Phone: _____

Is patient in an assisted living facility, personal care home or nursing home? _____

If yes, what is the name of the facility? _____

Telephone Number _____

If other than patient, to whom should all correspondence be mailed?

Name: _____

Address: _____

City_____ State ____ Zip _____ Phone: _____

Relationship to patient: _____

Power of Attorney? Yes No
(Please provide a copy of the power of attorney for the chart)

****The power of attorney will be contacted first for all matters. If there is no power of attorney we will contact the person named above for all matters. In the event the patient, primary contact named above, or power of attorney cannot be reached, please provide the name of another person that we may contact in case of an emergency.***

EMERGENCY CONTACT

Name: _____ Relationship to patient: _____

Home phone_____ Work phone _____ Cell _____

AHAVA HEALTHCARE

2160 Fountain Drive, Suite 220
Snellville, GA 30078
Ph (678)336-9102 Fax (770)674-8563

PHARMACY INFORMATION

FOR LOCAL PHARMACIES –

Pharmacy Name _____

Pharmacy Address _____

_____

Pharmacy Phone Number (_____) _____

FOR MAIL ORDER PHARMACIES –

Pharmacy Name _____

Pharmacy Address _____

_____

Pharmacy Phone Number (_____) _____

AHAVA HEALTHCARE

2160 Fountain Drive, Suite 220
Snellville, GA 30078
Ph (678) 336-9102 Fax (770) 674-8563

PRE-VISIT FORM

Last Name	**First Name**	**MI**	**AGE**	**DOB**

Referred by:	**Name & phone number of Primary Care Physician:**
Spouse's Name:	**Years Married:**
# of Children:	**# of Grandchildren:**
Child Name:	**Phone #:**
Child Name:	**Phone #:**
Where were you born and raised?	**Where do you currently reside?**
Highest level of education completed: □ Primary School □ Secondary School □ High School □ College □ Advanced degree	
Occupation:	**Retired: Y or N Year retired:**
Do you have special living needs? Y or N If yes, please explain: **Are you disabled? Y or N If yes, please describe:**	
Individual / Group / IOP/ PHP Therapy? **If Yes, Please list Therapist name(s), _____** **Dates:**	

AHAVA HEALTHCARE

2160 Fountain Drive, Suite 220
Snellville, GA 30078
Ph (678)336-9102 Fax (770)674-8563

HEALTH HISTORY

Reason for visit:	**Allergies:**
Do you have a memory problem? Y or N? **If yes, please explain:**	**Do you smoke? Y or N?** **Packs per day?** **If you quit, when did you stop?**
Do you have a Psychiatric History? Y or N? **If yes, please describe:**	**Do you drink alcohol? Y or N?** **If yes, how often?** **If you quit, when did you stop?**
Does your family have any psychiatric history? Y or N? If yes, please explain:	

AHAVA HEALTHCARE

2160 Fountain Drive, Suite 220
Snellville, GA 30078
Ph (678)336-9102 Fax (770)674-8563

PAST MEDICAL HISTORY

□ Rheumatic Fever
□ Heart Attack
□ Congestive Heart Failure
□ Irregular Heartbeat
□ Dizziness
□ Ankle Swelling Disease
□ Shortness of Breath
□ Stroke
□ TIA's (mini stroke)
□ Cancer

□ Diabetes
□ High Blood Pressure
□ Cataracts
□ Glasses
□ Hearing difficulty
□ Ulcer

□ Anemia
□ Urinary Tract Infection
□ Prostate Problems
□ Loss of Consciousness

□ Diarrhea
□ Kidney Disease
□ Asthma/COPD
□ Seasonal Allergies
□ Thyroid Disease
□ Liver

□ Arthritis
□ Constipation
□ Head Injury
□ Other

FAMILY HISTORY					
Pathology	Relationship	Pathology	Relationship	Pathology	Relationship
Alcoholism		Cancer		Glaucoma	
Asthma		Diabetes		Heart Dz	
Bleeding Dz		Seizures		Hypertension	
Kidney Dz		Mental Illness		Migraine	
Osteoporosis		Stroke		Thyroid Dz	

Year of most recent					
Tetanus Shot		Cholesterol √		Pneumovax	
Flu Vaccine		Rectal Exam		TB Test	
PSA (Prostate problems)		Mammogram		Colonoscopy	
DXA Scan for women (Osteoporosis)					

AHAVA HEALTHCARE

2160 Fountain Drive, Suite 220
Snellville, GA 30078
Ph (678)336-9102 Fax (770)674-8563

PAST MEDICAL HISTORY

Past Hospitalizations	
Year	Reason

Past Surgical History	
Year	Surgery

Current Medications

Ahava Healthcare
Jody Amazon, DSc APRN
2160 Fountain Drive #220, Snellville, GA 30078
(P)678-336-9102 (F) 770-674-8563
Kristina Thompson - Practice Manager
info@ahavahealthcare.org

Jae Pak, MD – Geriatric Psychiatrist
Collaborating Physician

HIPAA Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSEDAND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice of Privacy Practices described how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and relates to your past, present or future physical or mental health or condition and related health care services.

Uses and Disclosure of Protected Health Information

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the physician's practice, and any other use required by law.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with a third party. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you.

Payment: Your protected health information will be used, as needed, to obtain payment for your health care services. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Healthcare Operations: We may use or disclose, as-needed, your protected health information in order to support the business activities, employee review of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, and conducting or arranging for other business activities. For example, we may disclose your protected health information to medical school students that see patients in out office. In addition, we may use a sign-in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room when your physician is ready for you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointment. We may use or disclosure your protected health information in the following situations without your authorization. These situations include: as required by Law, Public Health issues as required by law, Communicable Diseases; Health Oversight; Abuse or Neglect; Food and Drug Administration requirements; Legal Proceedings; Law Enforcement; Coroners, Funeral Directors. And Organ Donation; Research; Criminal Activity; Military Activity and National Security; Workers Compensation; Inmates; Required uses and disclosures; under the law, we must make disclosures to you and when required by the Secretary of the

Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500.

Other Permitted and Required Uses and Disclosures will be made only with your consent, Authorization or Opportunity to object unless required by law.

You may revoke this authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

Your rights

Following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purpose of treatment, payment or healthcare operations. You may also request that any part of your protected health information not to be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply. Your physician is not required to agree to a restriction that you may request. If physician believes it is in your best interest to permit use and disclosure of your protected health information, your protected health information will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request to receive confidential communication from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us,
upon request, even if you have agreed to accept this notice alternatively i.e. electronically.

You may have the right to have your physician amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosure we have made, if any, or your protected health information.

We reserve the right to change the terms of this notice and will inform you by mail of any changes. You then have the right to object or withdraw as provided in this notice.

Complaints

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint.

We will not retaliate against you for filing a complaint.

This notice was published and become effective on/or before **April 14, 2003.** We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. If you have any objections to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

Signature below is only acknowledgement that you have received this Notice of our Privacy Practices:

_____

Signature of Patient/Power of Attorney/Guardian

_____ _____

Printed Name of Patient **Date**

Ahava Healthcare

Jody Amazon, DSc APRN
Jae Pak, MD Collaborating Physician

HIPAA Privacy Notice & Consent for Services Signature Form

I have received my Notice of Privacy Practices which informs me how my medical information may be used and released. This form also grants permission to Dr. Jae H. Pak, MD (Geriatric Psychiatrist) or Jody Amazon, DSc, APRN (Geriatric Nurse Practitioner) to see the patient for initial and/or follow up visits and medication management. I understand that we are under no obligation and may revoke services at any time.

_____

Signature of Patient/Power of Attorney/Guardian

_____ _____

Printed Name of Patient **Date**

Release for Billing

By signing below you grant us authority to release any medical information deemed necessary to the appropriate insurance company in order to bill for your medical services. You also agree to accept full responsibility for any balances or co-pays that are not covered by your primary and/or secondary insurance company.

Signature: _____

(Patient or Power of Attorney)

Printed Name of Patient: _____

DATE: _____/_____/_____

Ahava Healthcare

Ahava Healthcare
Jody Amazon, DSc APRN
2160 Fountain Drive #220, Snellville, GA 30078
(P)678-336-9102 (F) 770-674-8563
Kristina Thompson - Practice Manager
info@ahavahealthcare.org

Office Policies

No-Show Policy: A no show is an appointment that was not canceled in advance. A no show for a scheduled appointment will result in a fee of **$50** for every appointment missed. After three no-shows in a row you will be discharged from the practice. **By not properly canceling your appointment you are prohibiting other patients from receiving timely treatment.** To avoid a cancellation fee, please provide cancellation notice at least (24 hours) prior to your appointment. Same day cancellation will result **$50** fee. You can cancel or reschedule an appointment by calling us at **678 336 9102**.

Late Policy: If you are more than **15 minutes** late to your scheduled appointment time you will be asked to reschedule.

Financial Policy: Our office is happy to submit insurance claims for your visits. Please remember that your health insurance is a contract between you and your insurance company; therefore, you are responsible for knowing the details of your insurance coverage. We will file your claim for you; however we ask that you are aware of your coverage and whether your plan included deductibles, co-pays, and/or co-insurance fees. Any and all account balances are ultimately your responsibility.

Please contact us immediately if you make any changes to your health plan coverage so we may keep accurate and current records of your account and expedite reimbursement for the services provided to you.

For your convenience, we accept cash, personal checks, Visa, Discover, MasterCard, and American Express. All returned person checks will be subject to a $25 fee.

Printed Patient Name: _____

Patient/POA Signature: _____

Date: _____/_____/_____

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

TO REQUEST RELEASE OF MEDICAL INFORMATION PLEASE COMPLETE AND SIGN THIS FORM

* I, _____hereby voluntarily authorize the disclosure of information from my health record. (Name of Patient)

Patient Information:

* Patient Name: _____Record Number: _____

Address: _____ Date of Birth: _____

Information Requested:

_____

_____

_____

Purpose of Release:

_____

_____

_____

The Information Is To Be Provided To:

Name of Person/Organization/Facility: _____

Address: _____

Phone Number: _____

* _____
Patient's Signature or Patient's Representative

* _____
Date

* _____
Printed Name of Patient's Representative

* _____
Relationship of Patient

This information is to be released for the purpose stated above and may not be used by recipient for any other purpose.

PLEASE MAKE A COPY OF THIS RELEASE FOR YOUR RECORDS HIPAA Authorization For Release of Medical Records

Ahava Healthcare
Jody Amazon, DSc APRN
2160 Fountain Drive #220, Snellville, GA 30078
(P)678-336-9102 (F) 770-674-8563
Kristina Thompson - Practice Manager
info@ahavahealthcare.org

Ahava Healthcare

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING *0* **+** _____ **+** _____ **+** _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Patient name _____

Date _____

1A: Patient consent form

GeneSight® testing is offered by Assurex Health, doing business as Myriad Neuroscience.

By signing below, you agree to the following:

Purpose and process

- I give consent for GeneSight testing. I understand the GeneSight panels will test for genetic variants related to the metabolism or action of various mental health medications.
- I understand this test is intended to be used by my clinician to assist in medication treatment decision-making. I will address with my clinician any concerns I have about medication changes as a result of this test.
- Once my test results are provided, Myriad Neuroscience removes all personal identifiers on my samples and may use the sample and information derived from the sample for purposes of test validation, education, and research and development of new products. Patient samples, including samples from New York, shall be destroyed at the end of the testing process or not more than 60 days after the sample collection date.
- By providing my email and mobile number below, I consent to receiving communication from Myriad Neuroscience (including SMS messages). I understand the risks of communication in this manner and that Myriad Neuroscience cannot guarantee the security and confidentiality of such communication. I understand I may revoke this consent by contacting Myriad Neuroscience.

Coverage and cost

- If I am covered by insurance, I authorize Myriad Neuroscience to give my designated insurance carrier, health plan, or third-party administrator the information necessary or reasonably requested for reimbursement. I understand Myriad Neuroscience can appeal to my health insurance plan if the service is either partially paid or denied, and release all relevant medical records, only for the purpose of health insurance plan coverage. I understand that my test may not be covered by my insurance if deemed medically unnecessary. In that event, I may receive a bill from Myriad Neuroscience.
- I understand that $330 is an estimate of a typical patient financial responsibility for the GeneSight test. I understand that Myriad Neuroscience will contact me prior to processing my test if my total financial responsibility could be more than $330.
- I authorize that direct benefits under this claim be paid directly to Myriad Neuroscience. If I receive payment directly from my health insurance plan, I will promptly send the payment to Myriad Neuroscience.
- I authorize Myriad Neuroscience to complete a soft credit inquiry on me, which will not impact my credit score, and agree that that information may be used to qualify me for financial assistance or other billing programs.

I agree that I have read and understand the terms listed above. I understand that Myriad Neuroscience will send me a statement for any balance due after my health insurance plan has processed the claim. I understand and agree that I will pay the full amount of this statement to Myriad Neuroscience within 30 days of receiving the statement. If there is a balance due, I understand that Myriad Neuroscience will provide applicable patient financial assistance program information. If I qualify for financial assistance, I agree to provide Myriad Neuroscience with any additional information or documentation that may be needed to confirm my qualification for the financial assistance program.

By signing below I attest that I am the patient or someone who is designated and authorized to sign and provide consent on behalf of the patient for healthcare and financial matters. If the healthcare provider/facility allows for a verbal consent for testing (including financial responsibility), please provide in the spaces below the printed name of the authorized person giving consent and the name of the representative verifying consent. Identify each name provided.

I hereby appoint _____ as my "Personal Representative," effective on this date. This appointment shall entitle my Personal Representative to all rights pursuant to HIPAA including the right to request, receive, and review any information regarding my GeneSight test.

GeneSight cannot process test(s) without signed consent form.

Patient, Legal Guardian, or Other Authorized Signature X _____

(signer must be 18 years or older)

Printed Name _____ Date _____

Printed Patient Name _____ Relationship to Patient _____

Email _____ Phone (mobile preferred) _____

When completed, place in FedEx® shipping envelope.

Myriad genetics

genesight

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety