Patient Evaluation Packet

Welcome

NAD in Georgia
Dr. Krishna Doniparthi
13680 Hwy 9 N Suite 300/400 Bldg-F
Milton, GA 30004

Phone: 678-242-0204       Fax: 678-242-0406

Email: getbetter@NADinGA.com

Website: NADinGA.com

Thank you for choosing NAD in Georgia
## NAD in Georgia

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Patient Information Sheet

Patient’s Name: __________________________________________________________ Married __________

Street Address/ Apt. # ___________________________________________________________

City/State/Zip: __________________________________________________________________________________

Employee: ________________________________________________________________________________________

Home Phone Number: __________________________ Work Phone: __________________________

Cell Phone Number: __________________________ Driver’s Lic # __________________________

Social Security Number: __________________________ Date of Birth __________________________

E-mail Address: __________________________________________________________________________________

Spouse’s/Guardian: _______________________________________________________________________________

Address/City/State: _______________________________________________________________________________

Social Security Number: ___________________________________________________________________________

Relative/Friend Not Living with you:

Name: __________________________________________ Relationship ________________

Address: _________________________________________________________________________________________

Phone Number __________________________________________________________

We require PAYMENT IN FULL prior to treatment. Payment must be received before treatment can begin. We are a fee for service facility. We do not accept payments from insurance companies or file insurance claims. We will provide the necessary documentation in order for you to file or _______ we can refer you to the claims specialist.

Each treatment protocol is individualized. Product orders are made for each individual. We are not able to provide refunds.

I will NOT be filing claims with my insurance company.  YES_____ NO ___

I will be filing insurance claims myself.  YES_____ NO ___

I have read and understand the Payment Policy and agree to make payment in full prior to treatment.

Signature: of patient: __________________________________________ Date:_______/_______/_______

Spouse’s/Guardian signature: __________________________________________ Date:_______/_______/_______
NOTICE OF PRIVACY PRACTICES
NAD in Georgia

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU MAY GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

State and federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. This Notice will take effect on April 14, 2003 and will remain in effect until amended or replaced by us.

It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

You may request a copy of our Privacy Notice at any time. Information on contacting us can be found at the end of this Notice.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it for the following purposes:

Treatment: We may use your health information to provide you with our professional services. We have established “minimum necessary or need to know” standards that limit various staff members’ access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.

Disclosure: We may disclose and/or share your healthcare information with other healthcare professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.

Payment: We may use and disclose your health information to seek payment for services we provide for you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.

Emergencies: We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays, or other similar forms of health information and/or supplies unless you have advised us otherwise.

Healthcare Operations: We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.

Required by Law: We may use or disclose your health information when we are required to do so by law for lawful processes. We will use disclose your information when requested by national security, intelligence, and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.
Public Health Responsibility: We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.

Marketing Health-Related Services: We will not use your health information for marketing purposes unless we have your written authorization to do so.

National Security: The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.

Reminders: We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters. In addition, we may contact you to inform you of health screenings, wellness events or information about treatment alternatives or other health-related benefits and services that may be of interest to you. We may contact you about seminars or programs that we are providing.

YOUR PRIVACY RIGHTS AS OUR PATIENT

Access: Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian). There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Once approved, an appointment can be made to review your records. Copies, if requested, will be $1.00 per page for the first 25 pages and .25 cents per page for 26 and up. If you want the copies mailed to you, postage will be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee.

Amendment: You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.

Non-routine Disclosures: You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures; therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons other than treatment, payment or healthcare operations. You can request non-routine disclosures going back 6 years starting on April 14, 2003. Information prior to that date would not have to be released. Disclosures prior to April 14, 2003 do not have to be made available.

Restrictions: You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except emergencies.) This request must be submitted in writing. We can provide you with the following forms to make such requests:

A. Request to review health care information
B. Request to amend health care information
C. List of non-routine disclosures
D. Complaint form
E. Authorization for disclosure of protected health information
QUESTIONS AND COMPLAINTS

You have the right to file a complaint with us if you feel we have not complied with our Privacy Policies. If you feel we may have violated your privacy rights, or if you disagree with a decision we made regarding your access to your health information, you can complain to us in writing. (Request a complaint form.) We support your right to the privacy of your information and will not retaliate in any way if you choose to file a complaint with us or with the U.S. Department of Health and Human Services.

HOW TO CONTACT US

NAD in Georgia

ADDRESS: 13680 Hwy 9 N Suite 300/400-F Milton, GA 30004

TELEPHONE: 678-242-0204

Patient Name ______________________________________________________________________________________

Signature: _____________________________________________________________ Date:________/_______/________

HIPAA Notice of Privacy Practices
This form does not constitute legal advice.

ADDENDUM TO HIPPA NOTICE OF PRIVACY PRACTICES

CONSENT TO RELEASE PROTECTED HEALTH INFORMATION

I hereby consent to release information related to my care and treatment at NAD in Georgia to the following individuals:

1. ____________________________________________ Relationship ____________________________________________

2. ____________________________________________ Relationship ____________________________________________

3. ____________________________________________ Relationship ____________________________________________

Patient Name ______________________________________________________________________________________

Signature: _____________________________________________________________ Date:________/_______/________
Medical Information Release Form

(HIPAA Release Form)

Name: _______________________________________________________________    Date of Birth:________/_______/________

Release of Information

I authorize the release of information including the diagnosis, records; examination rendered to me and claims information. This infor-
mation may be released to:

[ ] Spouse________________________________________

[ ] Child(ren)______________________________________

[ ] Other__________________________________________

[ ] Information is not to be released to anyone.

This Release of Information will remain in effect until terminated by me in writing.

Messages

Please call:      [ ] my home      [ ] my work      [ ] my cell Number:____________________________

If unable to reach me:

[ ] you may leave a detailed message

[ ] please leave a message asking me to return your call

[ ] You may text or e-mail by phone

The best time to reach me is (day)_______________________  between (time)_____________________

Signature: ___________________________________________________________________   Date:________/_______/________

Witness: ____________________________________________________________________   Date:________/_______/________
Medical History

Name:_______________________________________________ Date of Birth:_____/_____/_______ Gender:_____ 

All Current Medication: (Please include dosage / frequency)
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________
_________________________________________________________________________________________________

Allergies:

Are you currently under the care of a Primary Physician?   [  ] Yes   [  ] No

Primary Physician:

Name: _________________________________________________________________________________
Address: ________________________________________________________________________________
Phone number: __________________________________________________________________________

Check all below that applies:

___ High blood pressure  ____ Low blood pressure  ____ Hepatitis/Liver disease

___ Respiratory Disease/COPD   ____ Seizures/Fainting Spells  ____ Cardiovascular Disease

___ Migraines  ____ Epilepsy  ____ Cancer

___ Stomach ulcers/Acid reflux  ____ Kidney Disease  ____ AIDS or HIV infection

___ Sexually Transmitted Disease  ____ Mental Illness  ____ Tuberculosis

___ Thyroid Problems  ____ Diabetes  ____ Immune System Problems

___ Alcohol Dependent  ____ Bleeding Problems  ____ Asthma/Chronic Bronchitis

___ Do you think you may be pregnant?

Signature: _________________________________________________________________________________ Date:_____/_____/_______
## Chemical Use History

<table>
<thead>
<tr>
<th>CHEMICAL TYPE</th>
<th>AGE AT START</th>
<th>AGE OF REGULAR USE</th>
<th>DESCRIBE PATTERN <em>(frequency, duration, amounts, type, method of use)</em></th>
<th>LAST USE</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><strong>ALCOHOL</strong></em></td>
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<tr>
<td>Beer, Wine, Liquor</td>
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<tr>
<td><em><strong>COCaine/Crack</strong></em></td>
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<tr>
<td><em><strong>CANNABINOIDS</strong></em></td>
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<tr>
<td>Marijuana, Pot, Hashish</td>
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<tr>
<td><em><strong>AMPHETAMINES</strong></em></td>
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<tr>
<td>Crystal meth, Crank, Speed, Ice, Diet Pills, Benzedrine, Dextedrine, Ritalin, Adderall, Methedrine, Vyvance</td>
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<tr>
<td><em><strong>HALLUCINOGENS</strong></em></td>
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<tr>
<td>STP, PCP, LSD, Mescaline, Mushrooms, Ayahuasca, Peytone, Acid, Ketamine, Ecstasy</td>
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<tr>
<td><em><strong>CAFFINE</strong></em></td>
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<tr>
<td>Soda, Tea, Coffee</td>
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<tr>
<td><em><strong>NICOTINE</strong></em></td>
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<tr>
<td>Tobacco, Dip</td>
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<tr>
<td><em><strong>SEDATIVES</strong></em></td>
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<tr>
<td>Downer, Quaaludes, GHB</td>
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<tr>
<td><em><strong>SLEEPING PILLS</strong></em></td>
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<tr>
<td>Secinal, Ambien, Dalmane, Restoril, Halcoin</td>
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<tr>
<td><em><strong>TRANQUILIZERS</strong></em></td>
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<tr>
<td>Mellaril, Thorazine, Haldol</td>
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<tr>
<td><em><strong>BENZODIAZEPINES</strong></em></td>
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<tr>
<td>Valium, Librium, Xanax, Ativan, Traxene, Klonopin, Serax, Centranx</td>
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<tr>
<td><em><strong>OPIATES</strong></em></td>
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<tr>
<td>Heroin, Demerol, Codeine, Methadone, Morphine, Dilauidid, Percodan, Darvon, Lortab, Opium, Percocet, Oxycontin, Soma, Ultram, Vicodin, Hydrocodone</td>
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<tr>
<td><em><strong>INHALANTS</strong></em></td>
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<tr>
<td>Gasoline, Glue, Freon</td>
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<tr>
<td><em><strong>OVER THE COUNTER MEDS</strong></em></td>
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<tr>
<td><em><strong>HERBAL SUPPLEMENTS STERIODS</strong></em></td>
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<tr>
<td><em><strong>OTHER</strong></em></td>
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</tbody>
</table>
Psychiatric Treatment

Signature: __________________________________________ Date: _______/_____/______

Have you been/or currently being treated by a Psychiatrist? [ ] Yes [ ] No

If yes, please explain:
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Psychiatrist:
Name: __________________________________________
Address: _________________________________________
Phone number: ____________________________________

_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________

Why are you seeking treatment today? __________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
_____________________________________________________________________________________________
Please read each statement and decide how much of the time the statement describes how you have been feeling during the past several days.

<table>
<thead>
<tr>
<th>Make check mark (✓) in appropriate column.</th>
<th>A little of the time</th>
<th>Some of the time</th>
<th>Good part of the time</th>
<th>Most of the time</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. I feel down-hearted and blue</td>
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<tr>
<td>2. Morning is when I feel the best</td>
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<td>3. I have crying spells or feel like it</td>
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<td>4. I have trouble sleeping at night</td>
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<td>5. I eat as much as I used to</td>
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<td>6. I still enjoy sex</td>
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<td>7. I notice that I am losing weight</td>
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<td>8. I have trouble with constipation</td>
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<td>9. My heart beats faster than usual</td>
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<tr>
<td>10. I get tired for no reason</td>
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<td>11. My mind is as clear as it used to be</td>
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<td>12. I find it easy to do the things I used to</td>
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<tr>
<td>13. I am restless and can’t keep still</td>
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<td>14. I feel hopeful about the future</td>
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<td>15. I am more irritable than usual</td>
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<td>16. I find it easy to make decisions</td>
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<td>17. I feel that I am useful and needed</td>
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<tr>
<td>18. My life is pretty full</td>
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<td>19. I feel that others would be better off if I were dead</td>
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<tr>
<td>20. I still enjoy the things I used to do</td>
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</tbody>
</table>

Adapted from Zung, A self-rating depression scale, Arch Gen Psychiatry, 1965;12:63-70.
Adult Checklist of Concerns

Please mark all of the items below that apply, and feel free to add any others at the bottom under “any other concerns or issues.”

This is a strictly confidential patient medical record. Law expressly prohibits disclosure or transfer. You may add a note or details in the space next to the concerns checked.

- I have no problem or concern bringing me here
- Abuse--physical, sexual, emotional, neglect (of children or elderly), cruelty to animals
- Aggression, violence
- Alcohol use
- Anger, hostility, arguing, irritability
- Anxiety nervousness
- Attention, concentration, distractibility
- Career concerns, goals, and choices
- Childhood issues (your own childhood)
- Children, child management, child care, parenting
- Codependence
- Confusion
- Compulsion
- Custody of children
- Decision making, indecision, mixed feelings, putting off decisions
- Delusions (false ideas)
- Dependence
- Depression, low mood, sadness, crying
- Divorce, separation
- Drug use--prescription medications, over-the-counter medications, street drugs
- Eating problems--overeating, under eating, appetite, vomiting (see also “weight and diet issues”)
- Emptiness
- Failure
- Fatigue, tiredness, low energy
- Fears, phobias
- Financial or money troubles, debt, impulsive spending, low income
- Friendships
- Gambling
- Grieving, mourning, deaths, losses, divorce
- Guilt
- Headaches, other kinds of pains
- Health, illness, medical concerns, physical problems
- Inferiority feelings
- Interpersonal conflicts
- Impulsiveness, loss of control, outbursts
- Irresponsibility
- Judgment problems, risk taking
- Legal matters, charges, suits
- Loneliness
- Marital conflict, distance/coldness, infidelity/affairs, remarriage
- Memory problems
- Menstrual problems, PMS, menopause
- Mood swings
- Motivation, laziness
- Nervousness, tension
- Obsessions, compulsions (thoughts or actions that repeat themselves)
- Over-sensitivity to rejection
- Panic or anxiety attacks
- Perfectionism
- Pessimism
- Procrastination, work inhibitions, laziness
- School problems
- Self-centeredness
- Self-esteem
- Self-neglect, poor self-care
- Sexual issues, dysfunctions, conflicts, desire differences, other (see also “abuse”)
- Shyness, over sensitivity to criticism
- Sleep problems--too much, too little, insomnia, nightmare
- Smoking and tobacco use
- Stress, relaxation, stress management, stress disorders, tension
- Suspiciousness
- Suicidal thoughts
- Temper problems, self-control, low frustration tolerance
- Thought disorganization and confusion
- Threats, violence
- Weight and diet issues
- Withdrawal, isolation
- Work problems, employment, workaholic/overworking, can’t keep a job

Any other concerns or issues:

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Please look back over the concerns you have checked off and choose the one that you most want help with.

___________________________________________________________________________
___________________________________________________________________________
___________________________________________________________________________

Signature: ___________________________________________________________________ Date: _______/_______/________
Payment Policies of Our Practice

For services rendered, our practice accepts the following means of payment:

1. Cash or Check
2. Major credit cards: Visa, MasterCard, Discover, American Express

Fees for services are as follows: BR+ Treatment fees:

<table>
<thead>
<tr>
<th>10 day Detox</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 day Detox with PC</td>
</tr>
</tbody>
</table>

PLEASE CALL THE BUSINESS OFFICE FOR CURRENT PRICING

Additional Charges:

Staff Overtime: There will be additional charges for nursing overtime and late arrivals. We start at 8:00 AM, please be on time.

Consultation time: Includes phone, e-mail, and other electronic consultation (i.e. Skype, Text) minimum 1/4 hour

Dr. Krishna Doniparthi MD

$395 per hour / Initial
$195 per hour/ Follow up

We are a fee for service facility. Payment is expected at the time services are rendered. A 50% Deposit will be required upon securing the dates with the business manager.

I agree to pay any remaining balance and any invoices for additional treatment, consultations, or supplements.

We do not accept payments from insurance companies or file insurance claims. We will provide the necessary documentation in order for you to file.

Each treatment protocol is individualized. Product orders are made for each individual. We are not able to provide refunds.

I have read and understand the Payment Policy.

Signature: ___________________________________________________________________ Date:________/_______/________

Individual Responsible for Payment:

Signature: ___________________________________________________________________ Date:________/_______/________