# Mequon Clinical Associates, SC

## ADULT HISTORY

DATE:_____

INSTRUCTIONS: Your therapist would like you to answer these questions. This will help him or her better understand your situation.

Name: _____ D.O.B. _____/_____/_____

In case of an emergency, please give the name and telephone number of your nearest relative:

Name: _____ Phone: _____

### PSYCHOLOGICAL HISTORY

**What problem(s) caused you to come to therapy at Mequon Clinical Associates?**

_____

_____

_____

When did problem begin? _____

Has the problem been constant since its beginning? Yes ___ No ___

What is the worst symptom you've had? _____

Is problem ever absent? Yes ___ No ___ If yes, when? _____

Who made the decision to come to therapy? _____

**Check if you have had any of these problems or symptoms lately:**

| | | | |
|---|---|---|---|
| ___ Anxiety | ___ Changes/problems in eating | ___ Headaches | ___ Loss of hope |
| ___ Tearfulness | ___ Changes/problems in sleeping | ___ Fatigue/tiredness | ___ Excessive worry |
| ___ Nervousness | ___ Chronic Pain | ___ Sexual difficulties | ___ Impulsive behavior |
| ___ Depression | ___ Difficulty concentrating | ___ Irritability | ___ Violent behavior |
| ___ Fears | ___ Loss of interest in usual activities | ___ Other _____ | |

**Have there been any recent illnesses or deaths among your family or close friends?** ___ Yes ___ No
Explain: _____

**Have there been any recent major losses among your family or close friends?** ___ Yes ___ No
Explain: _____

**Have there been any recent crises or major changes in your life?** ___ Yes ___ No
Explain: _____

**Have you ever intentionally hurt yourself or made a suicide attempt?** ___ Yes ___ No
Explain: _____

**Have you ever taken medication for anxiety, depression, sleep, or other emotional conditions?** ___ Yes ___ No
Explain: _____

**Have you been in counseling or psychotherapy before?** ___ Yes ___ No
If so, for what issues? _____
What was the therapist's name and when did this occur? _____

**Have you had any hospitalizations for emotional problems?** ___ Yes ___ No
Explain: _____

**Please name any people or organizations who you feel provide help and support to you.** _____
_____

## MEDICAL HISTORY

**List any current medical conditions and disabilities:** _____

_____

**Are you taking any medications?** ___ Yes ___ No
If yes, list current medications and daily dosages: _____

_____

**List past medical conditions (include surgeries):** _____

_____

**Name of your physician(s) and telephone numbers & addresses:** _____

_____

**Have you had a medical exam within the past year?** ___ Yes ___ No
List any significant findings: _____

## DRUG AND ALCOHOL USE

Please describe the drug and alcohol use of your family. Use the number which best states how often each person uses each drug. For your children, please write in the name of the child at the top of the column.

*0 = Never; 1= less than once a month; 2 = 1-4 days a month; 3 = almost daily; 4 = daily; 5 = used in past, not using now*

| SUBSTANCE | SELF | PARTNER/SPOUSE | CHILD | CHILD | YOUR PARENTS |
|---|---|---|---|---|---|
| Caffeine | ____ | ____ | ____ | ____ | ____ |
| Nicotine | ____ | ____ | ____ | ____ | ____ |
| Beer/Wine/Liquor | ____ | ____ | ____ | ____ | ____ |
| LSD | ____ | ____ | ____ | ____ | ____ |
| Marijuana | ____ | ____ | ____ | ____ | ____ |
| Inhalants | ____ | ____ | ____ | ____ | ____ |
| Sedatives | ____ | ____ | ____ | ____ | ____ |
| Amphetamines | ____ | ____ | ____ | ____ | ____ |
| Cocaine/Crack | ____ | ____ | ____ | ____ | ____ |
| Others (specify) | ____ | ____ | ____ | ____ | ____ |

Are you concerned about your drug or alcohol use? ___ Yes ___ No
Is someone who cares about you concerned about your use of drugs or alcohol? ___ Yes ___ No
Do you ever feel guilty about your use of drugs or alcohol? ___ Yes ___ No
Are you concerned about the drug or alcohol use of someone in your family? ___ Yes ___ No
Did you grow up in a home in which a parent abused drugs or alcohol? ___ Yes ___ No
Has anyone in your family been in treatment for drug or alcohol abuse? ___ Yes ___ No
If yes, list who and for what treatment: _____

## FINANCIAL / LEGAL HISTORY

**Do you have serious financial concerns?** ___ Yes ___ No
If yes, explain: _____
**Have you ever been arrested?** ___ Yes ___ No
If yes, explain: _____
**Have you ever been involved with Protective Services?** ___ Yes ___ No
If yes, explain: _____

## SCHOOL, MILITARY & WORK HISTORY

**Are you currently enrolled in school?** ___ Yes ___ No
If yes, what is field of study? _____
**What is your highest grade completed?** _____
**Have you served in the Military?** ___Yes ___No
If yes, which branch? _____ When? _____ Overseas? _____ Combat? _____
**What is your occupation?** _____
**Are you currently employed?** ___Yes ___No What is length of time at current job? _____
If not employed, how long were you employed at last job held? _____

# The Patient Health Questionnaire (PHQ-9)

Patient Name _____ Date of Visit _____

| Over the past 2 weeks, how often have you been bothered by any of the following problems? | 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 asleep, 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're 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 |

**Column Totals** _____ + _____ + _____

**Add Totals Together** _____

10. If you checked off any problems, how difficult have those 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

Janssen CarePath

# HIPAA Patient Authorization for Janssen CarePath

The below authorization is in connection with Janssen CarePath programs my doctor has discussed with me and I have agreed to be enrolled in.

I hereby authorize the use and/or disclosure of my private health information, described below, which includes "Protected Health Information" as defined in federal laws called the Privacy Regulations developed under the Health Insurance Portability and Accountability Act of 1996 (as amended, "HIPAA"). In general terms, I understand that Protected Health Information is health information that identifies me or that could be used to identify me. I understand that this authorization is voluntary. Our Privacy Policy governs the use of the information you provide.

**The following person(s) or class of persons are authorized to share my information:**

1. Physicians, pharmacists, other healthcare providers or support staff who have provided or will provide treatment or services to me (referred to as "My Healthcare Providers")
2. The approved third-party service providers administering and supporting Janssen CarePath offerings, under contract with Janssen Pharmaceuticals, Inc. These service providers are authorized to manage, administer, and/or support Janssen CarePath programs, including but not limited to SpravatoESubmission.com and MySpravatoConsent.com (referred to as "Janssen CarePath")
3. My health plan or other third-party payer (referred to as "My Payer")

**The following person(s) or class of persons are authorized to receive and use my information:**

1. My Healthcare Providers
2. Janssen CarePath
3. My Payer

**Description of the information that may be used and/or shared:**

My "Personal Health Information," which includes my diagnosis, prescribed therapy, insurance information, name, address, phone number, and a description of the resources I have requested or received from Janssen CarePath. For prescribed therapies, I understand that the information disclosed about me may include mental health information and/or records.

**The information will be used and/or shared for the following purpose(s) as applicable:**

1. Enroll me in, determine my eligibility for, and contact me about Janssen medication support programs
2. Send me requested educational materials, information, and resources related to the Janssen CarePath program or my Janssen medication
3. Verify, investigate, assist with, and coordinate my coverage for my Janssen medication with My Payer
4. Identify treatment location and/or provide information and assistance to help my transition to my next treatment location
5. Share with my Healthcare Provider(s) information generated by Janssen CarePath that may be useful for my care
6. In response to a court order, subpoena, or otherwise required by law

I also authorize Janssen CarePath to de-identify and use my health information to improve, develop and evaluate Janssen CarePath, its offerings and materials, and to evaluate patient access to and adherence to my Janssen medication.

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CarePath

I understand that my Protected Health Information will not be used or disclosed by Janssen CarePath for any other purpose without my prior authorization unless permitted by law or unless information that specifically identifies me is removed. I understand that Janssen CarePath will make every effort to keep my information private. I understand that if my information is accidentally shared, federal privacy laws do not require that the person/party receiving it will not disclose the information further and that such information provided to a third party may no longer be protected by federal privacy laws.

I understand that I am not required to sign this HIPAA Patient Authorization Form. My choice about whether to sign will not change the way my Healthcare Providers or Payer treat me. If I refuse to sign the HIPAA Patient Authorization Form, or cancel or revoke my authorization later, I understand that this means I will not be able to participate or receive assistance from Janssen CarePath.

1. I understand that I am entitled to a signed copy of this authorization.
2. I understand that this authorization shall expire either when I stop receiving Janssen CarePath resources or 10 years from the date of this authorization, whichever occurs first.
3. I understand that I may cancel or revoke this authorization at any time by notifying Janssen CarePath in writing at Janssen CarePath, P.O. Box 13135, La Jolla, CA 92037. I understand this will not affect information used and disclosed prior to receipt of my cancellation or revocation.
4. I understand that I have the right to review my health information that has been disclosed upon written request to Janssen CarePath, P.O. Box 13135, La Jolla, CA 92037.

**Redisclosure:** I understand that my Protected Health Information may be redisclosed by Janssen CarePath, for the purposes outlined above—to my health plan(s) or other third-party payer(s), my healthcare providers, and any individual I designate as a caregiver—and I specifically authorize such redisclosures.

☐ I would like to receive information and updates about SPRAVATO™ (esketamine) Nasal Spray CIII.

Patient name _____ Date of birth (mm/dd/yyyy) _____

Patient address _____

City _____ State _____ ZIP _____

Patient email _____

Patient sign here _____ Date _____

If the patient cannot sign, patient's legally authorized representative must sign below:

By _____ Date _____
(Signature of person legally authorized to sign for patient)

Describe relationship to patient and authority to make medical decisions for patient:

_____

Please call Janssen CarePath at 844-777-2828 or follow up with your doctor if you have questions about Janssen CarePath or this authorization.

**Please read the full Prescribing Information, including Boxed WARNING and Medication Guide for SPRAVATO™, and discuss any questions you have with your doctor.**

Janssen

# Mequon Clinical Associates, SC

**Patient Name:**_____ DOB:_____
Please print

Other Adult:_____ Relation to patient:_____

Address:_____ Phone:_____

_____ Email:_____

_____ Referred by:_____

**Reminder Preference (please check only one box):**
☐ Phone Call (Home #) ☐ Phone Call (Cell #) ☐ Text Message

## FINANCIAL POLICY

Payment is expected at the time of service. You are ultimately financially responsible for all services you or members of your household receive from Mequon Clinical Associates.

**Consent to Treatment/Privacy Policy**
I hereby consent to treatment as agreed upon by my MCA Provider and myself, and I understand my rights as a patient. I have received and understand the written Notice of Privacy Practices provided by Mequon Clinical Associates.

_____initials

**Private Pay**
**If you will be paying for visits privately (i.e., not through an insurance company or your insurance is a Medicaid policy), clinic policy requires payment at time of service. Please be prepared to make payment upon arrival for your session.**

_____initials

**Health Insurance**
I have been advised that Mequon Clinical Associates does not accept any Medicaid insurance (which includes HMO Medicaid and Badgercare policies) and that I will be financially responsible if I have or obtain a Medicaid policy in the future.

I authorize insurance payment of medical benefits to Mequon Clinical Associates for services described on the itemized claim form. I also authorize the release of information necessary to process this claim. Payment of benefits should be paid directly to Mequon Clinical Associates. **I recognize and accept personal responsibility for all services rendered and will make payment in full of any self-pay charges, co-payments, or deductibles, and for any balance outstanding after payment or denial of such insurance benefits.**

_____initials

**Outstanding Patient Balances**
After insurance is billed any portion not covered will be billed to the patient. Any balance that is billed to the patient must be paid in full no later than 60 days from the billing date. The clinic charges a $30 fee to you for any returned checks, which is payable before or at the time of your next scheduled visit.

_____initials

**Cancelled Appointments**
I understand that any appointments cancelled or missed without 24 hours notice may be charged a minimum fee of $75 and **my insurance does not cover this fee. If you are 15 or more minutes late for your appointment, it will be at the providers discretion to charge this fee.**

_____initials

**Failure and/or Inability to Pay**
**In the event it becomes necessary to assign your account to a collection agency, you are responsible for any/all costs of collection which may include attorney fees and other costs incurred.**

_____initials

**I have read and understand the above financial policy.**

**Client / Financially Responsible Party Signature:** _____

**Date:** _____ **Please Print Name:** _____

# MEQUON CLINICAL ASSOCIATES

# SPRAVATO TREATMENT CONSENT FORM

This is a patient informed consent for the treatment of Spravato. This consent form outlines the treatment that your doctor has prescribed for you, the risks of this treatment, the potential benefits of this treatment to you, and offers to discuss any questions, concerns, or alternatives with Dr. Taxman.

The information contained in this consent form is also described in detail in the Full Prescribing Information which is available from our clinic or by visiting: https://www.janssenlabels.com/package-insert/product-monograph/prescribing-information/SPRAVATO-pi.pdf. Not all information in the Full Prescribing Information is stated here, so you may read the information provided in the Full Prescribing Information if you wish and discuss any questions that you have with your doctor.

Dr. Taxman has explained the following information to me:

a. Spravato is a Schedule III controlled substance with a potential for misuse/abuse and it can increase risk of drug abuse in those with a history of drug dependence. Spravato may interact with other psychotropic medications; CNS depressants, psychostimulants, and antidepressants. I will inform my doctor of any suicidal or increased suicidal thoughts as Spravato may be associated with increased suicidal thoughts in patients 18-24 years of age. _____

b. Spravato results in sedation in about half of patients undergoing treatment. Delayed or prolonged sedation may occur in some instances resulting in impaired ability to drive and operate machinery. I understand that I am not to drive or operate machinery until the next day after a restful sleep. I will have an adult over the age of 18 available for transportation after treatment with Spravato. _____

c. I will inform the doctor if I have ever had, or if I experience any of the following: aneurysmal vascular disease (thoracic and abdominal aorta, intracranial and peripheral arterial vessels), arteriovenous malformation, intracranial hemorrhage, hypersensitivity to Spravato, ketamine, or any other substance. I understand Spravato may have rare, but possible, side effects including but not limited to the following: dizziness, nausea, vertigo, hypoesthesia, anxiety, lethargy, vomiting, depersonalization, insomnia, flashbacks, hallucinations, increased blood pressure, encephalopathy, short-term cognitive impairment, long term cognitive impairment (long-term treatment), impaired ability to drive, ulcerative cystitis, and dramatic increase in blood pressure that may be associated with increased risk of stroke or death. _____

d. I do not have high blood pressure – **or** – My blood pressure is well controlled (circle one).

e. I understand Spravato is not recommended for use during pregnancy and may post risk of harm to myself and the embryo/fetus. I confirm that I am not pregnant currently. In the event of pregnancy at any point during my treatment, I will inform my doctor. _____

f. I understand Spravato may combine with breast milk while nursing and may be harmful to infants. I confirm I am not breastfeeding currently. _____

g. My doctor has explained each treatment phase to me. I understand that the induction phase will require 2 treatments per week for 4 weeks with the optimization phase following the next month at 1 treatment per week for 4 weeks. After the optimization phase, my doctor will then determine my course of treatment based on my response to the first two phases. I am aware that my doctor may recommend additional treatments at this time. It has been explained to me that I will need to arrange transportation home with an adult over the age of 18 following treatment with Spravato. I may have a friend or family member with me at each treatment if I so choose. _____

h. I understand that I should refrain from eating at least 2 hours prior to each treatment and drinking at least 30 minutes to minimize any nausea and/or vomiting that may result as a side effect from my treatment. I was also advised to refrain from nasal corticosteroid or nasal decongestant medication for at least 1 hour prior to my treatment. _____

i. It was explained to me that I will be asked to sit in the treatment chair and to blow my nose prior to the first device administered. My doctor will place my head at a 45-degree angle and instruct me how to self-administer each Spravato device. My blood pressure will be taken several times throughout my treatment session. The first time will be prior to my treatment to determine that my blood pressure is within normal limits and my doctor may proceed with the day's treatment. My doctor will again take my blood pressure 40 minutes after my treatment and at least once more prior to going home to confirm my blood pressure is still within or has returned to normal limits. My doctor has instructed me that I am required to stay for a minimum of 2 hours after my treatment for observation and monitoring.

I have been informed of the benefits of risks of Spravato treatment and have been given the opportunity to ask all questions I felt necessary. I consent to the administration of Spravato and will follow treatment guidelines given by the doctor.

Patient Name (Printed): _____ Date: _____

Patient Signature: _____ Date: _____

Witness: _____ Date: _____