Gerardo P. Sison, Jr., M.D.
34650 US Hwy. 19 North
Suite 107
Palm Harbor, Florida 34684

IMPORTANT MESSAGE

Please note that if paperwork is not completed at the time of your appointment, the office may need to reschedule your appointment to another time. Please understand that each appointment is scheduled to give everyone appropriate time with the doctor and delay due to tardiness to your appointment time is unfair to the next patient. If you have any questions regarding completion of these forms prior to your appointment, please call the office 24 hours or sooner before your appointed time.

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Suite #107
Palm Harbor, Florida 34684

Please complete the attached forms and return to us at the time of your first visit along with your health insurance card and a photo ID.

DATE OF VISIST_____ **TIME**_____

Most misunderstandings about your insurance coverage can be avoided if you understand what your policy provides. Many insurance policies pay according to a schedule of benefits that is based on various criterions and may have different criteria for behavioral and mental health. Please verify this information with your insurance company prior to your initial visit.

PLEASE GIVE 24-48 HOUR NOTICE TO CANCEL OR RESCHEDULE A NEW PATIENT APPOINTMENT.

In order for you to receive the best quality of treatment, we recommend that you leave small children at home; unless they are the patient.

If you have any questions before or after your appointment, please do not hesitate to contact us at (727) 787-3422 during normal office hours.

DIRECTIONS TO THE OFFICE: We are located on US HWY 19 North, between Alderman Road and Nebraska Avenue, in a 3-story white building (IMA Medical Group Building.)
We are the driveway before Beacon Grove Subdivision if you are heading south on US Hwy 19.

LANDMARKS NEAR US: We are next to the Fountains Shopping Plaza where Tiffany's Restaurant and the Wing House are located.

I hereby authorize the release of any medical information necessary for the processing of insurance. I hereby assign all medical benefits to which I am entitles to Gerardo P. Sison, Jr., M.D. This assignment is to be considered as valid as an original. As a courtesy, I understand that medical claims to my insurance company are being filed on my behalf. I also understand that I am responsible for all unpaid balances of covered expenses, co-payments, or deductibles. Any request for reports to outside agencies are subject to a minimum of $50.00 fee to be paid by the patient prior to report being sent.

_____ _____

Patient/Parent/Legal Guardian's Signature Date

OFFICE FINANCIAL POLICY

You are responsible for all expenses incurred as part of your treatment. While my staff will assist you in filing for your insurance claims, payment is expected at time of service. If you belong to a managed care network, your insurance claims will be filed for you. Co-payments, non-covered services, and deductibles remain your responsibility and must be paid when services are rendered.

To aid in the billing process, please provide my staff with accurate information about your insurance carrier as well as your ID number. Please have you insurance card available at the time of visit. You are responsible for the balance remaining after payment from insurance company is received or if payment is not received from the insurance company in a reasonable amount of time.

A 24-hour notice is required for cancellation of appointment. A fee of $25.00 will be charged for those who cancel less than 24 hours or do not show up for their scheduled appointment.

I acknowledge that I have read and understood the office financial policy for Gerardo P. Sison, Jr., M.D.

_____ _____

Patient/Parent Signature or Guardian Date

Gerardo P. Sison, Jr., M.D.
34650 US Hwy. 19 North
Suite 107
Palm Harbor, Florida 34684

FEE SCHEDULE:

This is not a comprehensive list of all fees in this office. Please inquire about current fees prior to authorizing any service that is not covered by our insurance company. Please initial EACH item.

_____ * $25 Return Check fee for checks of $49.00 or less

_____ * $35 Return Check fee for checks greater than $50 but less than $300.00

_____* $25 No show or late cancellation fee

_____*$50 Disability and/or FMLA form preparation (1-2 pages)

_____*$95 Disability and/or FMLA Form preparation (3-4 pages)

I have read, understood, and agree to the above fees.

_____ _____

Patient's Signature Date

_____

Parent/Guardian Signature

DATE_____

NAME:_____

PAST MEDICATIONS	DOSAGE	SIDE-EFFECTS
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

****

CURRENT MEDICATIONS	DOSAGE
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

GERARDO P. SISON, JR., M.D, P.A.

Diplomate, American Board of Psychiatry and Neurology
Child, Adolescent and Adult Psychiatry

34650 U.S. Highway 19 North, Suite 107
Palm Harbor, Florida 34684

Telephone: (727) 787-3422
Fax: (727) 787-5624

CONSENT TO RELEASE INFORMATION

I authorize: The office of Gerardo P. Sison, Jr., M.D.
34650 U.S. Highway 19 North, Suite 107
Palm Harbor, Fl 34684

To release medical information to AND obtain information from:
ANY PHYSICIAN, HOSPITAL, OR OTHER HEALTH CARE PROVIDER PROVIDING MEDICAL CARE TO ME AT ANY TIME.

This authorization will automatically expire one year from the date of signature, unless otherwise specified.

This consent may be revoked at any time by sending written notice to the above-named provider of information. Any release of information made prior to the revocation of this compliant authorization is not a breach of confidentiality. Disclosed information may be reviewed by contacting the provider information.

Patient's Name _____

Signature of Patient or legal Guardian:_____ Date:_____

Complete Address:_____

Relationship, if not the patient:_____ Patient's DOB:_____

I authorize these FAMILY MEMBERS/FRIENDS to have access to my medical information:

Name_____ Relationship:_____

Name_____ Relationship:_____

Name_____ Relationship:_____

Name_____ Relationship:_____

To the recipient of this information. This information has been disclosed to you from records protected by federal confidentiality rules. The federal rules prohibit you from making further disclosure without additional consent.

Gerardo P. Sison, Jr., M.D.
Child, Adolescent, and Adult Psychiatry

Patient's Last Name First Middle

Address City State ZIP

Home Telephone Date of Birth Social Security No.

Marital Status _____S_____M_____D_____W Male or Female

Driver's License #_____ State of _____

Employer_____ Work Phone:_____

Address_____

In case of emergency, contact_____
at telephone#_____ Relationship to patient_____

Who referred you to this office?_____

Name of Insurance Company_____

Policy Number_____ Group Number_____

(PLEASE PRESENT YOUR INSURANCE CARD AND DRIVER'S LICENSE)

You are required to obtain the first authorization number from your insurance company:

Name of Policy Holder Date of Birth Relationship to Patient

Social Security Number of Policy Holder_____

CO-PAYMENTS AND/OR DEDUCTIBLES ARE DUE AT TIME OF EACH VISIT

GERARDO P. SISON, JR., M.D., P.A.

ADULT History Form

NOTE: ALL INFORMATION GIVEN BY YOU OR YOUR FAMILY IS TREATED AS CONFIDENTIAL AND MAY BE RELEASED ONLY UPON YOUR CONSENT OR AS REQUIRED BY LAW.

IDENTIFICATION DATA

Name: Last	First	Middle	Age	Birthdate	Sex ☐ Male ☐ Female

Address: Street	City	State	Zip	Home Phone	Work Phone

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed	Religion	Soc. Sec. #

Education: Circle Highest Grade Completed 1 2 3 4 5 6 7 8 9 10 11 12	College Degrees	Veteran? ☐ Yes ☐ No

Employment History: Present Employer	How Long Employed?	Occupation
Previous Employer		Occupation
Previous Employer		Occupation

FAMILY HISTORY

FAMILY MEMBERS	AGE	SEX	EMOTIONAL PROBLEMS? YES	EMOTIONAL PROBLEMS? NO	LIVING? YES	LIVING? NO	OCCUPATION
Spouse's Name							
Mother's Name		F					
Father's Name		M					

Number Of Children Of Person Completing This Form _____	AGE OF OLDEST _____ AGE OF YOUNGEST _____	NUMBER LIVING _____ DECEASED _____
Number Of Brothers and/or Sisters Of Person Completing This Form _____	AGE OF OLDEST _____ AGE OF YOUNGEST _____	NUMBER LIVING _____ DECEASED _____
Other Persons Living In Same Household	Relationship	
Notify In Case Of Emergency (Other Than Family Member)	Address	Home Phone #

INSURANCE INFORMATION PLEASE REFER TO YOUR MEMBERSHIP OR INSURANCE CARD

Primary Insurance Coverage	Policyholder's Name	Group #	Policy #
Secondary Insurance Coverage	Policyholder's Name	Group #	Policy #

REFERRING PHYSICIANS CONTACT

To afford you coordinated clinical care, MCC suggests providing your referring physician with assessment data and treatment recommendations resulting from your interview

If you want your referring physician notified of assessment data and treatment recommendations, you must complete the authorization for the **Release of Confidential Information.**

COMPLETE OTHER SIDE

HEALTH DATA

Do you have any current medical problems? (please describe)

Is it being treated? ☐ YES ☐ NO

If yes, by whom?

Who is your primary care physician?

What medication(s) are you taking?

Have you ever had a drug allergy or sensitivity?
☐ YES ☐ NO IF YES, TO WHICH DRUG?

Have you ever seen any of the following for help with a problem? (excluding this visit?)
☐ PSYCHIATRIST ☐ PSYCHOLOGIST ☐ SOCIAL WORKER ☐ COUNSELOR ☐ MINISTER ☐ SUBSTANCE ABUSE PRACTITIONER

For what?

When?

Previous Psychiatric or substance abuse hospitalization?
☐ YES ☐ NO If yes, where and when?

CHEMICAL USE HISTORY

Do you drink alcoholic beverages? ☐ YES ☐ NO

If yes, what do you drink? ☐ BEER ☐ WINE ☐ HARD LIQUOR

How often do you drink? ☐ DAILY ☐ 3-5 TIMES PER WEEK ☐ 1-2 TIMES PER WEEK ☐ LESS FREQUENTLY

Do you sometimes drink more than you had planned?	☐ YES	☐ NO
Have family or friends ever expressed concern about your drinking?	☐ YES	☐ NO
Have you ever been arrested for alcohol or drug related charges?, DWI, public intoxication, D&D, etc.	☐ YES	☐ NO
Have you ever been treated for drinking? (gone to AA)	☐ YES	☐ NO
Have you ever had episodes where you were unable to remember periods when you were drinking?	☐ YES	☐ NO

Indicate which of the following you use (have used):		USE CURRENTLY (WITHIN 1 YEAR)	HAVE USED IN PAST	HAVE NEVER USED
TRANQUILIZERS	(Valium, Librium, Tranxene, Azene Miltown, Equanil, Xanax, Centrax)	☐	☐	☐
PAIN PILLS	(Darvon, Darvoset, Empirin, Codeine, Percodan, Demerol, Dilaudid, Heroin, Talwin)	☐	☐	☐
DIET PILLS	(Amphetamines, Speed, Dexedrine, Ritalin, White Crosses, Zip)	☐	☐	☐
SLEEPING PILLS	(Doriden, Placidyl, Dalmane Seconal, Tuinal, Nembutal, Amytal, Phenobarbital, Noctec, Somnos)	☐	☐	☐
HALLUCINOGENS	(Marijuana, Hashish, Hashoil, THC, LSD, Mescaline, Psilocyn, Psilocybin, MDA, PCP, Angel Dust, Mushrooms)	☐	☐	☐
COCAINE	(Crack, Base, Snow, Blow)	☐	☐	☐
VOLATILES	(Aerosols, Paint Thinner, Glue, Lacquer, Amyl Or Butyl Nitrite "poppers", Gasoline)	☐	☐	☐
OTHERS-LIST	.....	☐	☐	☐

Have family or friends ever expressed concern over your use of drugs?	☐ YES	☐ NO
Have you ever been arrested for any offense involving drugs?	☐ YES	☐ NO
Have you ever been treated for substance abuse?	☐ YES	☐ NO
Have you ever overdosed on drugs (accidental or purposeful)?	☐ YES	☐ NO

HOW CAN WE BEST HELP YOU?

INTERESTED IN:

- ☐ INDIVIDUAL COUNSELING
- ☐ GROUP
- ☐ MARRIAGE COUNSELING
- ☐ RELAXATION
- ☐ SUBSTANCE ABUSE
- ☐ FINANCIAL ADVICE
- ☐ MEDICATION
- ☐ OTHER

MINI Patient Health Survey

Patient name: ..... Date: .....

SECTION I

NO	YES	
☐	☐	1. Have you been consistently depressed or down, most of the day, nearly every day, for the past two weeks?
☐	☐	2. In the past two weeks, have you been less interested in most things or less able to enjoy the things you used to enjoy most of the time?

If your answer to both questions above is "NO", please proceed to Section II without answering question 3 below.

3. Over the past two weeks, when you felt depressed or uninterested:

☐	☐	a Was your appetite decreased or increased nearly every day? Did your weight decrease or increase without trying intentionally (i.e. by ±5% of body weight or ±8 lbs or ±3.5kg for a 160 lb/70kg person in a month)? (If yes to either, please check "YES".)
☐	☐	b Did you have trouble sleeping nearly every night (difficulty falling asleep, waking up in the middle of the night, early morning wakening or sleeping excessively)?
☐	☐	c Did you talk or move more slowly than normal or were you fidgety, restless or having trouble sitting still almost every day?
☐	☐	d Did you feel tired or without energy almost every day?
☐	☐	e Did you feel worthless or guilty almost every day?
☐	☐	f Did you have difficulty concentrating or making decisions almost every day?
☐	☐	g Did you repeatedly consider hurting yourself, feel suicidal, or wish that you were dead?

SECTION II

☐	☐	1. In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?

If your answer to this question is "NO", you have completed section II – please do not answer the questions below. Please proceed to Section III.

2. In the past 12 months:

☐	☐	a Did you need to drink more in order to get the same effect that you got when you first started drinking?
☐	☐	b When you cut down on drinking did your hands shake, did you sweat or feel agitated? Did you drink to avoid these symptoms? (If yes to either, please check "YES".)
☐	☐	c During the times when you drank alcohol, did you end up drinking more than you planned when you started?
☐	☐	d Have you tried to reduce or stop drinking alcohol but failed?
☐	☐	e On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol?
☐	☐	f Did you spend less time working, enjoying hobbies, or being with others because of your drinking?
☐	☐	g Have you continued to drink even though you knew that it caused you problems?

MINI Patient Health Survey

SECTION III

	NO	YES
1. Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way? Did the spells peak within 10 minutes? (If yes to either please check "YES".)	☐	☐
2. At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?	☐	☐

If your answer to both questions above is "NO", please proceed to Section IV without answering any other questions below in Section III.

3. Have you ever had one such attack followed by a month or more of persistent fear of having another attack, or worries about the consequences of the attack?	☐	☐
4. During the worst spell that you can remember:		
a Did you have skipping, racing or pounding of your heart?	☐	☐
b Did you have sweating or clammy hands?	☐	☐
c Were you trembling or shaking?	☐	☐
d Did you have shortness of breath or difficulty breathing?	☐	☐
e Did you have a choking sensation or a lump in your throat?	☐	☐
f Did you have chest pain, pressure or discomfort?	☐	☐
g Did you have nausea, stomach problems or sudden diarrhea?	☐	☐
h Did you feel dizzy, unsteady, lightheaded or faint?	☐	☐
i Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside of or detached from, part or all of your body?	☐	☐
j Did you fear that you were losing control or going crazy?	☐	☐
k Did you fear that you were dying?	☐	☐
l Did you have tingling or numbness in parts of your body?	☐	☐
m Did you have hot flushes or chills?	☐	☐
5. In the past month, did you have such attacks repeatedly (2 or more) followed by persistent fear of having another attack?	☐	☐

SECTION IV

1. In the past month, were you fearful of or embarrassed by being watched or being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public alone or with others, writing while someone watches, or being in social situations?	☐	☐
2. Is this fear excessive or unreasonable?	☐	☐
3. Do you fear these situations so much that you avoid them or suffer through them?	☐	☐
4. Does this fear disrupt your normal work or social functioning or cause you significant distress?	☐	☐

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question as best you can. Upon completing this form, you will be able to print your completed form and take it to your health care practitioner.

1. Has there ever been a period of time when you were not your usual self and...

...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○ Yes	○ No
...you were so irritable that you shouted at people or started fights or arguments?	○ Yes	○ No
...you felt much more self-confident than usual?	○ Yes	○ No
...you got much less sleep than usual and found you didn't really miss it?	○ Yes	○ No
...you were much more talkative or spoke much faster than usual?	○ Yes	○ No
...thoughts raced through your head or you couldn't slow your mind down?	○ Yes	○ No
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○ Yes	○ No
...you had much more energy than usual?	○ Yes	○ No
...you were much more active or did many more things than usual?	○ Yes	○ No
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○ Yes	○ No
...you were much more interested in sex than usual?	○ Yes	○ No
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○ Yes	○ No
...spending money got you or your family into trouble?	○ Yes	○ No

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ○ Yes ○ No

3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights? Please select one response only.

○ No Problem ○ Minor Problem ○ Moderate Problem ○ Serious Problem

Zung Self-Rating Depression Scale*

Patient Name

_____

Age

_____

Sex

_____

Date

_____

Instructions

Read each sentence carefully. For each statement, check the bubble in the column that best corresponds to how often you have felt that way during the past two weeks.

For statements 5 and 7, if you are on a diet, answer as if you were not.

	Please check a response for each of the 20 items.	None or a little of the time	Some of the time	Good part of the time	Most or all of the time
1	I feel downhearted, blue, and sad	○	○	○	○
2	Morning is when I feel the best	○	○	○	○
3	I have crying spells or feel like it	○	○	○	○
4	I have trouble sleeping through the night	○	○	○	○
5	I eat as much as I used to	○	○	○	○
6	I enjoy looking at, talking to, and being with attractive women/men	○	○	○	○
7	I notice that I am losing weight	○	○	○	○
8	I have trouble with constipation	○	○	○	○
9	My heart beats faster than usual	○	○	○	○
10	I get tired for no reason	○	○	○	○
11	My mind is as clear as it used to be	○	○	○	○
12	I find it easy to do the things I used to do	○	○	○	○
13	I am restless and can't keep still	○	○	○	○
14	I feel hopeful about the future	○	○	○	○
15	I am more irritable than usual	○	○	○	○
16	I find it easy to make decisions	○	○	○	○
17	I feel that I am useful and needed	○	○	○	○
18	My life is pretty full	○	○	○	○
19	I feel that others would be better off if I were dead	○	○	○	○
20	I still enjoy the things I used to do	○	○	○	○

INFORMED CONSENT AND AUTHORIZATION TO RELEASE OR RECEIPT OF INFORMATION

THE UNDERSIGNED PATIENT OR LEGAL REPRESENTATIVE OF THE PATIENT, HEREBY AUTHORIZES THE RECEIPT OF RELEASE OF THE INFORMATION SPECIFIED BELOW TO THE FOLLOWING PHYSICIAN OR MENTAL HEALTH PROFESSIONAL PURSUANT TO FLORIDA STATUES 90.42, 490.32, 90.503, 456.16, 458.21 AND 394.459 (B), 381.609 (2) (F), 396.112, 397.053 AND FEDERAL LAW 42. I UNDERSTAND THAT MY RECORDS HAVE A PRIVILEGED AND CONFIDENTIAL STATUS. I AM WAIVING THAT STATUS FOR THE PURPOSE CONTAINED WITHIN THIS AUTHORIZATION.

RELEASE TO/FROM _____

_____

ADDRESS CITY STATE ZIP

RELEASE TO: GERARDO P. SISON, JR., M.D. CHILD, ADOLESCENT AND ADULT PSYCHIATRY
FROM: 34650 U.S. 19 NORTH #107 PALM HARBOR, FLORIDA 34684 (727) 787-3422
FAX (727) 787-5624

SPECIFIC INFORMATION TO BE RELEASED OR RECEIVED:

MEDICAL / PHARMACOLOGICAL PSYCHOLOGICAL TESTING CONSULT REPORTS
PSYCHIATRIC EVALUATION HOSPITAL ADMISSION PSYCHIATRIC EVALUATION
HOSPITAL DISCHARGE SUMMARY OTHER: _____

INFORMATION CONCERNING AIDS, HUMAN IMMUNODEFICIENCY VIRUS INFECTION, ARC, AIDS-RELATED COMPLEX AND THE PERFORMANCE OF ANY TESTS, COUNSELING AND THE RESULTS AND TREATMENT THEREOF IS / IS NOT ALSO AUTHORIZED.

A GENERAL MEDICAL AUTHORIZATION OF SUBPOENA DUCES TECUM WITHOUT A SPECIFIC AUTHORIZATION TO RELEASE PSYCHIATRIC INFORMATION MUST HAVE THIS WAIVER FROM THE PATIENT OR LEGAL REPRESENTATIVE.

PROHIBITION ON RE-DISCLOSURE: THIS INFORMATION HAS BEEN DISCLOSED TO YOU FROM THE RECORDS WHO CONFIDENTIALITY IF PROTECTED BE FEDERAL REGULATION (42 CFR PART 2) AND ANY FURTHER RE-DISCLOSURE FROM THE RECEIVING PARTY IS STRICTLY PROHIBITED.

THIS CONSENT IS SUBJECT TO REVOCATION AT ANY TIME UPON THE RECEIPT OF WRITTEN NOTIFICATION BUT WILL HAVE NO EFFECT OR ACTION ALREADY TAKEN. THIS AUTHORIZATION IS VALID FOR A CONTINUING DISCLOSURE. I FURTHER UNDERSTAND THAT I HAVE RIGHT TO REFUSE TO SIGN THIS AUTHORIZATION AND THAT THE PHYSICIAN OR MENTAL HEALTH PROFESSIONAL, NAMED HEREIN, IS RELEASED FROM ALL LEGAL LIABILITY THAT MAY ARISE FROM THE RELEASE OF THE INFORMATION REQUESTED.

PATIENT'S NAME: _____

SOCIAL SECURITY OF PATIENT: _____ DATE OF BIRTH _____

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE _____

WITNESS: _____ INFORMATION RELEASE BY: _____

_____

TODAY'S DATE