

Transcultural Care
Olamide Alabi, DNP, PMHNP-BC
415 Highway 6 West, Oxford, MS 38655
Phone 662 234 5317 Fax 662 269 6089
Email: info@transcultural-care.com

Patient Registration Information

Last Name: _____ First Name: _____ Middle Initial: _____

Preferred Name: _____ SSN _____ DOB: ___ / ___ / ___ Gender: M ___ F ___ Other ___

Address: _____ City: _____ State: _____ Zip: _____

Mailing Address (If Different Than Above): _____

Mobile Phone: _____ Can we leave a detailed voicemail on this line (circle one)? Yes / No

Work phone: _____ Can we leave a detailed voicemail on this line (circle one)? Yes / No

Place of Employment: _____ Please circle one: Full time Part time

Pharmacy _____ : **Address** _____ **City** _____ **State:** _____ **Zip:** _____
Email: _____

Primary Care Provider: _____ Phone: _____

Who were you referred by?: _____

Emergency Contact: _____ Emergency Contact Phone: _____

Emergency Contact Relation: _____

Billing Address: Check if same as above ()

Last Name: _____ First Name: _____ Middle Initial: _____

Relationship to patient: _____

DOB _____ Driver's License _____ State _____

Address: _____ City _____ State _____ Zip _____

Mailing Address (if different from above) _____ City _____ State _____ Zip _____

Primary Phone: _____ Message Ok? Yes / No Work phone: _____

I acknowledge that I have received a copy of Transcultural Care's Privacy Practices (otherwise known as HIPPA).

Patient name or guardian/parent: _____ Date: _____

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Insurance information:

Please bring your insurance card(s) and ID to your first appointment. The primary insurance is usually based on the earliest birthday of the subscribers.

Primary Insurance: _____

Customer Service Phone Number: _____

Place of Employment: _____

Subscriber/Member Name (if other than patient): _____

DOB: _____ SS# _____

Subscriber Id # _____ Group/Policy # _____

Relationship To Patient/Patient: _____

Please check with your insurance company to find out your benefits and responsibilities, including if you have a deductible and the amount of your co-pay.

Please be prepared to pay your co-pay and deductible (if applicable) at the time of the visit. We accept cash, checks, all major credit cards, and HSA/FSA cards.

Deductible (if applicable) _____ New Deductible begins _____

Co-pay or Co-insurance _____

I authorize Transcultural Care LLC to bill my insurance company as well as release any information needed to do so and assign benefits Transcultural Care LLC.

Printed Name: _____ Signature: _____ Date: _____

Responsible party (If Under 18): _____

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Financial Responsibility:

Please provide the following credit card information. **PLEASE NOTE:** This information must be completed. All information is kept confidential and will only be used for missed appointments or to clear up any outstanding balance (over 60 days past due).

Credit Card Number: _____

Exp. Date: _____ CVV Code (3 digit code printed on back of card): _____

Zip Code for the Debit/Credit Card listed above: _____

Name (as printed on card): _____

Patient Signature: _____ Date: _____

Please read carefully and initial each of the following: By signing this form, I am authorizing Transcultural Care LLC, to charge my credit card in the event I fail to show for a scheduled appointment or if I do not give notification of my inability to attend a scheduled appointment at least 24 business hours in advance. I am aware that weekends and holidays do not count as normal business hours (appointments on Monday must be cancelled by the Friday before). I understand there will be a fee of \$100.00 for each missed follow-up appointment and a fee of \$250.00 if I miss my initial intake appointment. I am aware that my insurance will not cover a missed appointment and that I am responsible for this fee. I understand and agree that my card may be charged without me being present. I will not dispute for sessions that I have received or for sessions I have cancelled less than 24 business hours in advance. Initial: _____

If I arrive more than 10 minutes late to an appointment it will be considered a late cancellation / missed appointment and I will be rescheduled for another time. Initial: _____

I further understand that I am responsible for updating my billing information, including changes to my address, credit card information, and insurance information, in the event that this information should change. I understand I am responsible for any fees incurred for a declined credit card transaction. I acknowledge that I am aware there is a \$35.00 fee for any declined credit card charge or returned check. Initial: _____

Balances past due for 90 days will be sent to an outside collections agency. Initial: _____

My co-pay, co-insurance, and deductible (when applicable) are due at my appointment time by cash, check, or card (credit/HSA/FSA). I am aware that any balances over 30 days may incur a 1.5% monthly finance charge (18% per annum) and that there is a \$5.00 billing fee per appointment, per cycle. It is understood that despite my means of payment at my appointment time, my credit card account will be charged for any outstanding balance over two months (60 days) if there is no response to the statements that are sent monthly. Initial: _____

Printed Name: _____ Signature: _____ Date: _____

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Confidentiality and Informed Consent for Treatment

Clinical records are confidential. Information about your treatment will not be released without your written permission with a few exceptions. Nurse Practitioners are required by law to report evidence of suicidal or homicidal intent, evidence of past or current child abuse, and evidence of past, or current elder abuse. Confidentiality may also be broken if the information could help save your life in a life-threatening emergency. Information may also be shared with medical providers who are concurrently providing medical treatment for you to promote coordination of care and the benefit to you of shared knowledge.

For your protection, digital communication through unsecured means is kept to a minimum. We utilize the OnPatient portal which is a secure, fully encrypted platform that will allow you to send/receive direct messages, access your health record, and schedule appointments. **Please use the OnPatient portal to ask any clinical questions rather than email. A registration link for OnPatient will be sent to you once you are scheduled. This is the best way to reach me if you have any questions.** If you do not wish to use the OnPatient portal, then please call the office telephone number, but it may take longer to receive a response. In either case, it may take 2-3 business days for a response. Please notify the office if you have any difficulties with accessing the portal.

You should know that sometimes during treatment, symptoms become worse before they become better, though this should subside as the work of treatment progresses. You may be asked to have laboratory work or EKG screens done outside of this office, or I may ask that records and test results from your PCP be sent to me. While you have the right to refuse any therapeutic technique, we must be able to discuss your thoughts and feelings about your treatment. You have the right to withdraw from treatment at any time or to ask to be referred to someone else.

You have the right to be informed of your mental health diagnosis after the mental health assessment is completed, and the purpose of any prescribed medication and their potential side effects. We will discuss risks, benefits, and alternatives. You should understand that some medications require a taper to avoid potentially uncomfortable discontinuation syndrome. Continued prescription of medications requires periodic reviews in the office where I can assess how you are doing and if the medication needs to be, or should be, continued. It is important for you to know that medications do not work for everyone.

Please determine who will be involved in your treatment and initial for each:

Name	Relationship	Phone:	Initial
	Primary care provider (PCP)		
	Therapist		
	Family Member		
	Other:		

My signature below indicates that I have read the above information and am requesting mental health treatment from Olamide Alabi, DNP, PMHNP-BC

Patient signature: _____ Date: _____

Parent/guardian signature (for patients under 18): _____ Date: _____

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Patient Policy Agreement – Please read each section carefully. Sign and date at the bottom.

These policies as well as our Privacy policy can also be found on our website - <http://www.transcultural-care.com>

1. Services are provided with the understanding that **you** (not an insurance company) are ultimately responsible for the cost of the services that you are purchasing. Insurance plans vary and not all services may be covered. You are responsible for knowing what services are covered by your particular plan, please check with your plan by calling the number on the back of your card **before** your appointment. If your need prior authorization for services, this must be completed before you are scheduled.
2. If your insurance does not pay your claim it will be your responsibility to contact them to resolve any issues of coverage or coordination of co-coverage. If you have a change in your insurance, it is your responsibility to notify the office as soon as possible to ensure that the correct company is being billed and that your account does not become past due.
3. The person signing below is the account guarantor and is accepting responsibility to pay for services rendered. This includes those provided to a child - regardless of custodial or legal agreements between parents.
4. Payment for deductibles, co-pays, uncovered services, or any balance due on your account are to be paid at the time of your – or your child’s – appointment. Please come, or send your child, prepared to do so. If you are not in a financial position to pay at the time of the appointment, we will be happy to reschedule the appointment for a more convenient time.
5. Accounts with unpaid balances over 90 days past the date of service will be given to an outside collection agency to bill and collect. An additional fee will be added to cover the expenses involved to do so. Your insurance will not pay for these additional charges.
6. If 12 months has passed since you were last seen, you will no longer be considered an established patient with us due to you not following up within the agreed upon amount of time.
7. Prescriptions will be written with enough refills to last until your next appointment. We recommend scheduling your next appointment at the end of each session so that we can be sure you are following your treatment plan and also do not run out of medication. My strict policies primarily reflect my concern for my clients' well-being. Self-assessment of psychiatric symptoms can be difficult and requires quite a bit of practice and feedback, especially early in treatment.
9. **Medication refills are done during the appointment time only.** If something unexpected occurs, please have your pharmacy fax a refill request. Do not email or call about refills. Please allow up to **5 business days** for the refill to be approved, if appropriate, and schedule an appointment as soon as possible.
10. Controlled substances such as benzodiazepines and stimulants are tightly regulated by the DEA. These medications can be very useful when indicated, but require more monitoring and must be part of a comprehensive treatment plan. If you do not adhere to the agreed upon treatment plan, then I will be unable to continue to provide care to you. There will be no early refills of controlled substances for any reason.

Patient name: _____ Date _____

Patient/Guarantor signature & relationship _____ Date _____

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Initial visit health history form

Patient's name: _____ **Date of birth:** _____ **Date:** _____

In a few sentences, please tell me what is bothering you and how long this problem has been going on:

Was there a recent change or situation that convinced you to make this appointment?

Have you ever been treated before by a mental health specialist (therapist, nurse practitioner, psychiatrist, psychologist)?

If so, please list their name and city/state. _____

Are you seeing any of these professionals currently? Which ones _____

Is it okay if I contact any of these people to obtain records? _____

Have you ever considered or attempted suicide? If so when and how? _____

Been hospitalized for mental health reasons? If so, when, where, and why? _____

Had violent behavior toward another person? Please describe circumstances: _____

Does anyone in your family have a history of mental health issues? If so, please specify the condition and their relationship to you: _____

Are you currently working student unemployed disabled retired

What is/was your occupation? _____

Who are you currently living with? _____

Highest level of education you have achieved: _____

Are you receiving or applying for FMLA or any form of short-term disability? Please be aware that you need to be seen at least three times before the provider will fill out any related documents and we cannot complete documents related to long-term disability.

Yes, I am receiving currently I am in the process of applying and understand the policy No

Are you currently: married partnered divorced single widowed

Please list any allergies or reactions to any medications (example: Penicillin itchy rash):

Please list all prescription medications being taken currently, why, and who is prescribing it.

Past psychiatric medications: If you have ever taken any of the following medications, please write the approximate dates, dose, how helpful they were, and any side effects (if you cannot remember, just do your best):

Antidepressants

Amitriptyline (Elavil)	Emsam (selegiline)	Pamelor (nortriptyline)	Sinequan (Doxepin)
Anafranil (clomipramine)	Lexapro (escitalopram)	Paxil (paroxetine)	Trintellix (vortioxetine)
Celexa (citalopram)	Luvox (fluvoxamine)	Pristiq (desvenlafaxine)	Viibryd (vilazodone)
Cymbalta (duloxetine)	Nardil (phenelzine)	Prozac (fluoxetine)	Wellbutrin (bupropion)
Effexor (venlafaxine)	Norpramin (desipramine)	Remeron (mirtazapine)	Zoloft (sertraline)

Mood stabilizers

Depakote (valproate)	Lithium (lithium carbonate)	Topamax (topiramate)	
Lamictal (lamotrigine)	Tegretol (carbamazepine)	Trileptal (oxcarbazepine)	

Antipsychotics/mood stabilizers

Abilify (aripiprazole)	Haldol (haloperidol)	Riperdal (risperidone)	Zyprexa (olanzapine)
Clozaril (clozapine)	Latuda (lurasidone)	Saphris (asenapine)	
Geodon (ziprasidone)	Rexulti (brexpiprazole)	Seroquel (quetiapine)	

Sedatives/hypnotics

Ambien (zolpidem)	Desyrel (trazodone)	Restoril (temazepam)	Sonata (zaleplon)
Belsomra (suvorexant)	Lunesta (eszopiclone)	Rozerem (ramelteon)	

Anxiety medications

Ativan (lorazepam)	Kapvay (clonidine)	Neurontin (gabapentin)	Xanax (alprazolam)
Buspar (buspirone)	Klonopin (clonazepam)	Valium (diazepam)	
Inderal (propranolol)	Minipress (prazosin)	Vistaril (hydroxyzine)	

ADHD medications

Adderall XR (amphetamine)	Strattera (atomoxetine)	Intuniv (guanfacine)	
Ritalin (methylphenidate)	Concerta (methylphenidate)		
Vyvanse (lisdexamfetamine)	Kapvay (clonidine)		

Other psychiatric medications taken not mentioned above:

Over the counter medications, herbs, supplements, or vitamins being taken:

Do you follow any particular diet?: _____

The last time blood was drawn for laboratory tests? _____ Who ordered it? _____

Why? _____ Were any of the tests abnormal? _____

Who is your primary care provider (PCP)? _____

For women only: Are you nursing, pregnant, or planning on becoming pregnant? yes no

Are you using any birth control or contraception? Which? _____

Review of physical health

Do you have any of the following symptoms? If so, please highlight or circle:

General: weakness, fatigue, fever or chills, weight gain, weight loss, increased appetite, decreased appetite

Head ears nose throat: headache, head injury, lightheadedness, vision changes, hearing problems, tinnitus, vertigo, nasal stuffiness, nasal discharge, nosebleeds, sinus trouble, dry mouth, hoarseness

Cardiac: chest pain or discomfort, palpitations, rapid heartbeat, dizziness with position changes, shortness of breath, fainting, swelling in feet/legs

Respiratory: dry cough, productive cough, shortness of breath, wheezing

Gastrointestinal: heartburn, nausea, diarrhea, constipation, abdominal pain, rectal bleeding

Skin: acne, rash, wounds, skin discoloration

Urinary: frequent urination, pain with urination, difficulty fully emptying bladder, incontinence

Sexual health: painful intercourse, difficulty achieving orgasm, low libido, excessive libido, erectile dysfunction

Neurological: seizure, migraine, dizziness, tremor, numbness, tingling

Musculoskeletal: new or worsened muscle pain, new or worsened joint pain, stiffness, involuntary movements

Is your medical provider (PCP) aware of the above issues? yes no

History of high blood pressure? _____ High cholesterol? _____ Heart mummer? _____

Irregular heartbeats? _____ Any other heart related concerns? Please specify

History of kidney disease? _____

Lung or breathing difficulties? (e.g., asthma.) _____

History of problems with the thyroid? _____

Problems with blood sugar? _____

Any surgeries? If so what and when? _____

Any other health concerns or history of problems not asked about above? _____

Any unusual or significant medical conditions in blood relatives? _____

Mental health

If you drink caffeine, how many drinks per day? (coffee, tea, energy drinks, soda): _____

If you drink alcohol, what is the most number of alcoholic drinks you'll drink per day? (1 drink is 12oz of beer, 1.5oz of spirits, or 5oz glass of wine): _____ How many days per week do you drink? _____

If you smoke marijuana, how often? _____

Do you use any other substances? How often? (meth, heroin, LSD, non-prescribed medications, etc.) _____

Do you think you may have a problem with alcohol or drug use? yes no

Have you ever received treatment for alcohol or substance abuse? yes no

If yes, for which substances? _____

Where were you treated and when? _____

Check once for any symptom currently present ✓ Check twice for major symptoms that are very bothersome ✓✓

Depressed mood Anxiety Excessive worry Panic attacks Difficulty concentrating

Excessive energy Hallucinations Decreased need for sleep Irritability Issues sleeping

Have you **ever** had feelings or thoughts that you did not want to live? yes no

Do you **currently** feel that you do not want to live? yes no

I own or have access to firearms yes no If yes, is the weapon properly secured? yes no

Do you have a history of legal problems? (DUI, domestic violence, arrests, prison, etc.) yes no

Do you have or think you have ADHD/ADD? yes no

If you were diagnosed with ADHD/ADD, how old were you? _____

Are/were you a survivor of any form of abuse?

Physical abuse yes no age of occurrence _____

Sexual abuse yes no age of occurrence _____

Emotional abuse yes no age of occurrence _____

I feel safe at home and in my relationships yes no

What are some activities that help you feel peaceful, content, or relaxed? _____

Please list at least 2 people that you feel you can count on if you are having a difficult time:

Is there anything else that you feel is worth mentioning? _____

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RELEASE OF INFORMATION

Patient's name: _____ Date of birth: _____

Information may be disclosed to or obtained from:

Specifically, I authorize the exchange of the following confidential information by my **initials**:

- _____ Mental health treatment information
- _____ Drug/alcohol treatment information
- _____ History/physical exam, and laboratory results
- _____ Other _____

I understand that any of the above requested information may include results of substance abuse and/or diagnosis and treatment of mental health disorders.

I understand that I can revoke this authorization at any time by providing a written letter of my intent to revoke but that revoking it will not affect disclosures made before the revocation letter is received. This consent shall expire in one (1) year following the end of treatment.

Patient's printed name _____

Patient signature _____ Date _____

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TELEPSYCHIATRY INFORMED CONSENT

Patient Name: _____

Location of Patient: _____ **Date of Birth** _____

Introduction:

Telepsychiatry is the form of telemedicine that allows patients to access psychiatric care using audio-video interfaces such as videoconferencing.

Electronic systems used will incorporate network and software security protocols to protect confidentiality of patient identification. Imaging data and other protected health information will be protected through measures that safeguard data and ensure the integrity against intentional or unintentional corruption.

Expected Benefits:

1. Improved access to psychiatric care by allowing the patient to remain in the home or office and in a geographical location that serves to be in the patient's best interest to remain due to restrictions in travel.
2. More efficient psychiatric evaluation and management.
3. Obtaining the expertise of a distant specialist.

Possible Risks:

As with any medical procedure, there are risks associated with telepsychiatry. These risks include but are not limited to: In rare cases, information transmitted may not be sufficient due to poor resolution to allow for appropriate medical decision making by the telepsychiatrist and client.⁷

Delays in medical evaluation and treatment could occur due to failure of equipment.

In some cases, there may be a lack of access to complete medical records, resulting in adverse drug reactions or allergic reactions as well as other judgmental errors.

Alternative Options:

There are available appointments to have face-to-face encounter visits in an office setting at the physical location of Transcultural Care and when consent is obtained for telepsychiatry, the client is agreeing to obtain telepsychiatric services.

Please initial you have read this page regarding benefits, risks, and alternative options: _____

Telepsychiatry Policies

Transcultural Care: Telepsychiatry Protocol

1. Telepsychiatry cannot provide any provision of medical or psychiatric emergencies. In the case of emergency, patients are encouraged to seek local help or call 911.
2. Patients who receive telepsychiatry services must be seen in person at least once a year.
3. New Patient consultations are done in person and telepsychiatry encounters are for follow up appointments
4. Guidelines generally considered standard for keeping medical records, release of information, and patient confidentiality will be applied to telepsychiatry as well.
5. No recording of the session is allowed in any circumstances. Patients need to notify the psychiatric provider if another person is present in the session.
6. After initial evaluation or anytime during treatment the psychiatric provider may recommend local psychiatric services, if patients' needs are judged to be not met through telepsychiatry or if other clinical grounds exist. Every effort will be made to provide local referrals.
7. Medication fills and refills can only be made after the session and is subjected and limited to local pharmacy's guidelines, limitations, and policies. Prescribing controlled medications will have a higher level of scrutiny and will be solely at the discretion of the telepsychiatrist based on clinical needs.
8. No shows and late cancellations of less than 24 hours of appointment time will be charged as the same rate as regular in-office appointments.
9. All payments will be made before the sessions.

I agree with the policies outlined above

Patient's Name: _____

Patient's Signature: _____

By signing this form, I understand the following:

1. I understand the laws that protect privacy and the confidentiality of medical information also apply to telepsychiatry, and that no information obtained in the use of tele-psychiatry which identified me will be disclosed to researchers and other entities about my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of tele-psychiatry in the course of my care at any time, without affecting my rate and future care or treatment.
3. I understand that I have the right to inspect all information obtained in the course of a telepsychiatry interaction, and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of psychiatric care may be available to me, and I may choose one or more of these at any time.
5. I understand that it is my duty to inform my psychiatric provider of any other healthcare providers in my medical/psychiatric care.
6. I understand that I may expect anticipated benefits from the use of telepsychiatry in my care, but then the results can be guaranteed or assured.

Patient Consent to the Use of Telepsychiatry

I have read and understand the information provided above regarding telepsychiatry, have discussed it with my psychiatric provider or such assistance may be designated, and all of my questions have been answered to my satisfaction. I hereby give informed consent for the use of telepsychiatry and my medical use.

I hereby authorize _____ to use telepsychiatry in the course of my diagnosis and treatment.

Signature of Patient: _____ *Date* _____

If Authorized Signer: _____ *Date* _____

Witness: _____ *Date* _____

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I, _____, UNDERSTAND AND AGREE TO THE FOLLOWING CONDITIONS REGARDING TREATMENT WITH TRANSCULTURAL CARE, LLC:

1. An initial evaluation will be completed to review all symptoms, medications, medical and family history. I am aware that psychological testing may be deemed necessary for some patients along with ADHD screening scales that may warrant completion by the patient or outside sources. I understand that this evaluation does not guarantee a diagnosis of ADHD, nor will there be a prescription written until all studies listed below are completed. A determination will be made and discussed during the evaluation.
2. I understand that if risk factors are identified, an electrocardiogram (EKG) or cardiac consult may be indicated to determine a baseline for overall heart function. This may need to be performed annually based on the initial results and/or an as needed basis. Some patients will need to complete these tests and consultations prior to starting medications.
3. All follow up appointments scheduled must be attended, and medication refills cannot be obtained without an appointment or approval from the provider. Replacement prescriptions will not be given for lost or stolen scripts, and the patient must have a follow up appointment. If medications are stolen, a police report must be filed and returned to the office to be included in the file.
4. Urine drug screen will be required from time to time.
5. The Mississippi Prescription Monitoring Program (PMP) is assessed prior to initial evaluation and at each visit, to verify prescriptive history. Medication for ADHD can only be obtained from a single provider. Refills can only be written for 30 days at a time. Refills beyond a 30 day supply will be dated for the earliest fill date.
6. If currently prescribed benzodiazepines, it is the policy of the practice that assistance may be provided (at the discretion of the provider) in tapering off these medications with the option of substituting with the other non-addictive/non benzo type medications. This will be further discussed during the appointment.

By signing below, I indicated that I agree with all of the terms set forth above

Patient Signature: _____ Print Name: _____ Date _____

Parent Signature: (if patient is a minor) _____ Print Name _____ Date _____