JOHN W. GRACE,M.D.,P.A.
INTAKE PAPERWORK

We are **IN-NETWORK** with the following insurances and able to verify benefits the fastest.

1. Medicare
2. Aetna Insurance- [Majority of Policies IN-Network Including -Strategic Resource Company- [Aetna Specialty Group Insurance]
3. Cigna Insurance
4. Cigna Great West
5. Tri Care Humana Military Policies
6. ChampVa-
7. GEHA

We are out-of-network with all other insurances and the verification of benefits can take considerable time, up to two months depending on the policy and current staff availability.

In addition, the following plans generally have limited out-of-network benefits and end up being largely self-pay. Keep in mind that psychiatric care tends to be very expensive (often several thousand dollars over the first months of treatment). It is usually much more cost-effective to see a provider within your insurance.

1. BCBS Primary Insurance Policies [All Policies]
2. FHCP-Medicare Advantage Plans- Affiliate of BCBS
3. Freedom, Insurance [All Plans]
4. Ultimate Insurance [All Plans]
5. Beacon Health Options [All Plans]
6. Magellan Health- [All Plans]
7. Optimum Healthcare
8. WellCare Insurance

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THIS PAPERWORK IS AVAILABLE ELECTRONICALLY THROUGH THE PATIENT PORTAL AT NO CHARGE. **FOR OUT-OF-NETWORK PATIENTS, THERE IS A $25.00 NON-REFUNDABLE CHARGE FOR THIS PAPERWORK IF YOU PICK IT UP AT THE OFFICE THAT COVERS THE COST OF PRINTING.**

AFTER COMPLETING ALL OF THEM IN FULL RETURN THEM TO THE OFFICE. WE WILL REVIEW AND NOTIFY YOU IF WE ARE ABLE TO ACCOMMODATE YOU. IF YOU HAVE NOT HEARD FROM US **WITHIN 72 HOURS** WE ARE UNABLE TO ACCOMMODATE YOU AT THIS TIME. **WE ARE UNABLE TO DISCUSS THE REASONS FOR NON-ACCEPTANCE AS SOME MAY BE RELATED TO PRIVACY ISSUES.** YOU MAY CONTACT US IN SIX MONTHS TO SEE IF SOMETHING HAS CHANGED AND WE ARE ABLE TO ACCOMMODATE YOU AND WE WILL KEEP YOUR PAPERWORK ON FILE.

BY SIGNING BELOW YOU AGREE TO THE FOLLOWING:

1. I UNDERSTAND THAT I WILL BE CHARGED $25.00 PRINTING COST THAT IS **NON-REFUNDABLE** AS A COST OF PRINTING THIS PAPERWORK. IT IS AVAILABLE FREE ONLINE THROUGH THE PATIENT PORTAL. PATIENT FUSION.

2. I UNDERSTAND I MAY NOT BE ACCEPTED AS A PATIENT AND IF I DO NOT HEAR FROM YOU WITHIN 72 HOURS OF RETURNING THIS COMPLETED PAPERWORK, I WILL ASSUME YOU ARE UNABLE TO ASSIST ME AND SEEK CARE ELSEWHERE.

NAME:

DATE:

SIGNATURE:_____

YOU MUST HAVE HEALTH INSURANCE THAT COVERS LABORATORY AND IMAGING SERVICES. WHO IS YOUR CURRENT PRIMARY INSURANCE PLAN (INCLUDE FULL PLAN NAME, POLICY NUMBER, GROUP NUMBER, NAME OF MAIN BENEFICIARY) AND CONTACT INFORMATION TO VERIFY.*

SECONDARY INSURANCE, IF APPLICABLE (INCLUDE FULL PLAN NAME, POLICY NUMBER, GROUP NUMBER, NAME OF MAIN BENEFICIARY)..IF NONE WRITE "NONE"*

WHICH PHARMACIES HAVE YOU USED IN THE PAST? DO WE HAVE YOUR PERMISSION TO CONTACT THEM AS WELL AS THE DRUG ENFORCEMENT AGENCY TO REVIEW YOUR PRESCRIPTION HISTORY?

HOW DO YOU WANT US TO HANDLE YOUR INSURANCE?(circle below)

- Please verify my benefits prior to scheduling, I understand this may- take considerable time if I am out-of-network.

- I am willing to be self-pay initially. Any insurance credits received will be returned to me once benefits are verified. I understand that self-pay psychiatric care can be very expensive (up to thousands of dollars the first several months) depending on my clinical needs.

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LEGAL NAME:

PREFERRED METHOD OF BEING ADDRESSED INCLUDING PRONOUNS (IF DIFFERENT FROM ABOVE):

GENDER:

DATE OF BIRTH:

ADDRESS:

PRIMARY PHONE NUMBER*

SECONDARY PHONE NUMBER

EMAIL:

CONTACT INFORMATION- May we leave confidential voicemails, medical texts, and emails in these contacts for tele-med and scheduling purposes? (CIRCLE BELOW)

YES- YOU MAY CONTACT ME THROUGH THESE ELECTRONIC SOURCES TO IMPROVE ACCESS TO CARE INCLUDING TELEMEDICINE

NO- I PREFER TO HAVE ALL DEALINGS FACE TO FACE THROUGH THE OFFICE

FAMILY PLANNING Since this office is primarily concerned with medication management and many psychiatric medications carry some risk to the newborn. It is important to avoid pregnancy while on medication if possible. (Circle the appropriate response below.)

-THIS DOES NOT APPLY TO ME. I am unable to become pregnant at this time either because I am not a biologic female, I have passed menopause, or have had medical conditions or procedures that makes pregnancy impossible.

-THERE IS VERY LITTLE CHANCE OF BECOMING PREGNANT. Either I am abstinent or practice highly reliable forms of birth control (pills, condoms, vasectomy of partner, etc). I understand the risk of pregnancy on medication and will let you know immediately if something changes in this regard.

-I AM CURRENTLY PREGNANT OR TRYING TO BECOME PREGNANT.

CURRENT PROVIDERS OF MEDICAL CARE (SPECIALTY AND CONTACT INFO)*

CURRENT HEIGHT WEIGHT RECENT BLOOD PRESSURE AND PULSE. HAVE YOU HAD RECENT LABS OR GENETIC TESTING? IF YES, PLEASE BRING A COPY TO YOUR INITIAL APPOINTMENT. *

EMERGENCY CONTACT INFORMATION. NOTE: IN ADDITION TO THE MEDICAL PROVIDERS ABOVE SOME MEDICAL/ PSYCHOTHERAPEUTIC CONFIDENTIAL INFORMATION MAY BE SHARED WITH THESE ENTITIES FOR SAFETY AND CONTINUITY OF CARE. YOU MAY ALSO LIST OTHER ORGANIZATIONS (ATTORNEYS, INSURANCE COMPANIES, ETC) THAT YOU WISH TO PROVIDE ACCESS TO YOUR RECORDS.

CURRENT MEDICATIONS AND SUPPLEMENTS (DOSE AND HOW TAKEN) IF NONE THEN WRITE “NONE”*. (BRING A COPY OF YOUR FORMULARY OR A LINK TO ONE TO YOUR APPOINTMENT)

ALLERGIES AND SIGNIFICANT EFFECTS TO MEDICATIONS (MEDICATIONS, FOOD, ENVIRONMENTAL) WHAT HAPPENS? IF NONE THEN WRITE "NONE". *

WHICH OF THE FOLLOWING MEDICAL CONDITIONS HAVE YOU HAD (CIRCLE BELOW)

Chronic pain (Describe source below)
Head injury with loss of consciousness.
Diabetes
Thyroid Problems
COPD (emphysema)
Multiple sclerosis.
Parkinson's Disease
High Blood Pressure
High Cholesterol
Chronic Kidney Failure
Heart Disease
Glaucoma
Restless Legs
Fibromyalgia
Rheumatoid Arthritis
Neuropathy
Lyme Disease
Lupus

ADDITIONAL MEDICAL CONDITION OR ELABORATION. PLEASE DESCRIBE SOURCES OF CHRONIC PAIN:

SURGICAL HISTORY (WHAT AND WHEN)

PSYCHIATRIC HOSPITALIZATIONS AND PREVIOUS SUICIDE ATTEMPTS (WHEN OCCURRED AND DETAILS REGARDING SUCH) IF NONE TYPE "NONE."*

PREVIOUS PSYCHIATRIC DIAGNOSES AND SIGNIFICANT TREATMENT TRIALS (POSITIVE OR NEGATIVE)

PREVIOUS PSYCHOTHERAPY (WHEN, HOW LONG, AND TYPE OR FOCUS). IF NONE TYPE "NONE". *

FAMILY MEDICAL AND PSYCHIATRIC HISTORY (SUBSTANCE USE, SUICIDE ATTEMPTS AND COMPLETION, GOOD AND BAD TRIALS TO MEDS, RELATION AND NATURE)*

TRAUMATIC EVENTS (CIRCLE BELOW)

I am a survivor of horrible childhood abuse.
I have experienced severe bullying in childhood.
I was sexually assaulted as an adult.
I have dealt with physically abusive relationships.
I was verbally abused in past relationships.
I have had a lot of trauma from medical procedures.
I have survived severe motor vehicle accidents.
I served in the military and experienced life threatening combat.
I have a lost a child.

WHICH OF THE ABOVE EVENTS MOST CHANGED YOU? IN WHAT WAYS?

CURRENTLY USING WHICH OF FOLLOWING (CIRCLE BELOW)
Alcohol
Alcohol
Caffeine
Marijuana
Sedatives (valium, xanax, etc) in manner not prescribed
Painkillers (oxycontin, heroin, kratom) in manner not prescribed
Stimulants (amphetamine, adderall, ritalin) in a manner not prescribed.
Hallucinogens (LSC, PCP, Mushrooms, GHB, Ecstasy, Bath Salts, Huffing)

DESCRIBE FREQUENCY AND AMOUNT OF USE

MISUSED BRIEFLY IN THE PAST (CIRCLE BELOW)

Alcohol
Alcohol
Caffeine
Marijuana
Sedatives (valium, xanax, etc) in manner not prescribed
Painkillers (oxycontin, heroin, kratom) in manner not prescribed
Stimulants (amphetamine, adderall, ritalin) in a manner not prescribed.
Hallucinogens (LSC, PCP, Mushrooms, GHB, Ecstasy, Bath Salts, Huffing)

DESCRIBE SIGNIFICANT RESPONSES TO ABOVE

HAD SIGNIFICANT PROBLEMS FROM IN PAST*

Alcohol
Alcohol
Caffeine
Marijuana
Sedatives (valium, xanax, etc) in manner not prescribed
Painkillers (oxycontin, heroin, kratom) in manner not prescribed
Stimulants (amphetamine, adderall, ritalin) in a manner not prescribed.
Hallucinogens (LSC, PCP, Mushrooms, GHB, Ecstasy, Bath Salts, Huffing)

DESCRIBE PATTERN AND PROBLEMS INCLUDING PROLONGED TREATMENT FOR IN PAST*

WHAT APPROACH DO I WANT TO TAKE TO MY CARE?
(CIRCLE BELOW)

"I am most interested in my short-term quality of life (next 6 months to 2 years). I understand this means I may end up taking medications or making choices that might result in decrease in the overall length of my life or produce significant side effects later."

"Living longer and healthier overall means the most to me. I understand that some treatments might not be appropriate and am willing to have to some decrease quality of life in the short-term for more long-term health benefits down the road. I understand this may mean starting to come down or decrease some medications associated with long term risk, particularly sedating or sleeping agents."

WHY ARE YOU SEEKING TREATMENT AT THIS TIME? WHAT ARE YOUR GOALS FOR THIS EPISODE OF CARE. WE TRY TO DO UPDATES/ TREATMENT PLANS AT LEAST A FEW TIMES A YEAR, MORE IF NECESSARY. SO THINK OF THE NEXT 3-6 MONTHS WHAT WOULD YOU LIKE YOUR GOALS/FOCUS OF CARE TO BE? TRY TO MAKE THEM REALISTIC, MEASURABLE, AND ACHIEVABLE*

WHO REFERRED OR SUGGESTED YOU COME AND WHY? IF NO ONE REFERRED YOU THEN WRITE "SELF"*

REVIEW OF SYMPTOMS WHICH OF THE FOLLOWING SYMPTOMS CURRENTLY APPLY? (EXPLAIN IN NEXT BOX)*

Weight loss
Weight gain.
Fever
Fatigue
Changes in your skin
Changes in nails
Open sores or rashes
Itching
Lumps or moles that are new or changed?
Headaches
Head Trauma
Seizures
Glaucoma
Vision problems
Hearing problems
Ringing in ears
Room spinning
Ear Pain
Nose bleed
Runny nose
Bleeding or soreness in your mouth or tongue
Sore throat
Hoarseness
Swollen glands
Lumps or nodules in breasts
Discharge from the breasts
Chest pains
Heart beating too fast
Shortness of breath
Any wheezing
Swelling in the feet
Coughs
Problem swallowing
Indigestion or heartburn
Nausea and vomiting
Diarrhea
Constipation
Increase or decreased appetite
Changes in your stool
Increased or Decreased Urination
Problems urinating
Change in color or smell or urine
Change in frequency of urine
Urinating at night
Drinking a lot
Incontinence
Changes in periods
Vaginal discharge
There is a history of pregnancy
There is a chance I'm currently pregnant
Sexual Difficulties
Impotence
Erection Problems
Discharge from penis
Pain in Joints
Swelling of feet or legs
My fingers change color in cold

Seizures
Tremors
Weakness or unusual sensations
Tremors
Easy bruising or bleeding
Intolerance of heat or cold

Blanking out, where you didn't remember where you were or how you got here
Traveled out of the country

PLEASE ELABORATE ON ANY OF THE CIRCLED RESPONSES

WHICH DESCRIBE YOUR MENTAL HEALTH SYMPTOMS? (CIRCLE)

GENERAL TRAITS: I am easily overwhelmed.
GENERAL TRAITS: I can manage a lot of things but have a history of overextending myself.
GENERAL TRAITS: I tend to take care of others and neglect myself.

HOARDING :I have a real problem holding onto things excessively, to the point that it affects my space or lifestyle.

OBSESSIONS: I have really clear and specific obsessions (with germs, numbers, rituals, etc) that take up at least thirty minutes of my day and sometimes many more.
OBSESSIONS: I tend to think in circles when nervous.

PANIC ATTACKS: I have had panic attacks.

SOMATIZATION: I have had a lot of physical complaints that seem related to emotional state.

MANIA: I have a family hx. of bipolar disorder.
MANIA: I have had really clear mania in past. Periods where sleep was not required without any feelings of tired. This was not related to either taking or withdrawing from any substances or medication.
MANIA: I have a history of clear seasonality to mood.
MANIA: I have had possible mania or cyclic irritability.
MANIA: I am a night owl.

MAJOR DEPRESSIVE EPISODES: I have had multiple periods of depression lasting at least two weeks during which I had five of the following nine symptoms (sadness, loss of interest, weight change, sleep problems, agitation, fatigue, feeling worthless or guilty, concentration difficulties, thoughts of death or suicide)

GENERALIZED ANXIETY DISORDER: I tend to worry about everything for at least the last six months. This worrying affects at least three of following (energy, concentration, muscle tension, sleep, restlessness)

ADULT ATTENTION DEFICIT DISORDER: I have trouble focusing throughout life including paying attention throughout childhood in school. This affects me in at least six of the following ways (fail to give close attention to details, trouble holding attention, often doesn't seem to listen, trouble finishing tasks due to getting distracting, trouble organizing tasks, reluctance to do things that require consistent focus (taxes, etc), often loses things, easily distracted, often forgetful)

PSYCHOSIS: I nearly always have some level of reality disturbance in the form of paranoia or hallucinations.
PSYCHOSIS: I occasionally have disturbance in reality.
PSYCHOSIS: My mind sometimes plays tricks.
PSYCHOSIS: I have hallucinations.

ANGER PROBLEMS: I have a problem with temper.
ANGER PROBLEMS: I overreact to stress.
ANGER PROBLEMS: I overreact to small insults.
ANGER PROBLEMS: I am triggered by disrespect.
ANGER PROBLEMS: I am triggered by authority figures.
ANGER PROBLEMS: I can have severe anger during decompensation.

PTSD-Intrusion symptoms: Some of the traumatic events I've lived through still haunt me in at least one of following ways (recurrent memories, dreams, flashbacks, or marked distress when I am exposed to reminders of them.)

PTSD-Avoidance symptoms: Some of the traumatic events I've lived through still cause me to avoid things (people, places, subjects) that mind remind me of the traumas.

PTSD-Alteration symptoms: Some of the traumatic events I've lived through have changed the way I think in at least one of the following ways (can't remember details of traumatic events, see myself in a persistent negative way, always feeling guilty, detached, or unhappy).

PTSD-Hyperarousal symptoms: Some of the traumatic events I've lived through have made me hyper-alert causing at least one of the following (irritability, reckless behavior, jumpiness, concentration difficulties, sleep problems)

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In trying to capture your story it is important to know three things

1. WHERE YOU STARTED? TELL US THE STORY OF THE FIRST PART OF YOUR LIFE.

2. WHERE YOU HAVE BEEN? SUMMARIZE EVERYTHING FROM THE START TO THE CURRENT PICTURE OF YOU.

3. WHERE YOU ARE? DESCRIBE YOUR CURRENT SELF AND HOW LONG YOU HAVE BEEN THAT WAY.

WHERE YOU STARTED: WHAT IS THE STORY OF UPBRINGING AND CHILDHOOD. WHERE WERE YOU BORN? HOW MANY SIBLINGS DID YOU HAVE? WHAT KIND OF WORK DID YOUR PARENTS DO? WHAT WERE YOU LIKE AS A CHILD (OUTGOING, SHY, ATHLETIC)? WERE THERE ANY PROBLEMS AT HOME OR SCHOOL? (BULLYING, POOR ACADEMICS, PHYSICAL, MENTAL, SEXUAL ABUSE)*

WHO YOU WERE: STORY FROM ADOLESCENCE UP UNTIL THIS "VERSION" OF YOU INCLUDING EDUCATION, OCCUPATIONS, RELATIONSHIPS (MARRIAGES, CHILDREN, ECT), TRAUMAS, AND GENERAL PERSONALITY IN THIS PERIOD (SHY, OUTGOING, ETC): *

CURRENT STORY: INCLUDING EDUCATION, OCCUPATIONS, RELATIONSHIPS (MARRIAGES, CHILDREN, ECT), TRAUMAS, GENERAL PERSONALITY IN THIS PERIOD (SHY, OUTGOING, ETC), AND CURRENT LIVING SITUATION. WHO IS YOUR SUPPORT SYSTEM? WHAT IS THE STRENGTHS AND WEAKNESSES OF YOUR SUPPORT SYSTEM?*

(VOCATIONAL HISTORY) WHAT KIND OF WORK HAVE YOU DONE THROUGH LIFE AND ARE CURRENTLY DOING? IF YOU ARE DISABLED FROM WORK, HOW LONG AND FROM WHAT CONDITIONS? (IF ADDRESSED ABOVE SAY "SEE ABOVE")*

EDUCATION HISTORY: DESCRIBE HOW FAR YOU WENT IN SCHOOL, AREAS OF STUDY, STRENGTHS AND STRUGGLES(IF ADDRESSED ABOVE SAY "SEE ABOVE")*

MILITARY HISTORY: BRANCH OF THE SERVCE DATES OF SERVICE RANK AT DISCHARGE TRAUMATIC EVENTS DURING SERVICE DISCIPLINARY ACTIONS DURING SERVICE(IF ADDRESSED ABOVE SAY "SEE ABOVE")*

RELATIONSHIP HISTORY: DESCRIBE SIGNIFICANT PAST RELATIONSHIPS INCLUDING MARRIAGES, CHILDREN AND FRIENDSHIPS(IF ADDRESSED ABOVE SAY "SEE ABOVE")*

LEGAL HISTORY (ARRESTS, CHARGES, WHEN OCCURRED). IF NONE TYPE "NONE."(IF ADDRESSED ABOVE SAY "SEE ABOVE")*

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TREATMENTS TRIED IN PAST
(PLEASE CIRCLE ALL TREATMENTS YOU HAVE TRIED IN PAST)

ALTERNATIVE REMEDIES

Vitamin B12
Vitamin D
Deplin
Sam-E,
5-HTTP,
CoQ10,
Fish Oil,
Flaxseed Oil,
Melatnonin,
St. John's Wort
Psylocybin (mushrooms)
Methyline blue
Ketamine

COGNITIVE ENHANCERS

Donepezil (Aricept)
Rivastigmine (Exelon)
Galantamine (Razadyne)
Dextromethorphan / Quinidine

ATTENTION DEFICIT MEDICATIONS

Methylphenidate (Ritalin, Concerta)
Amphetamine and dextroamphetamine (Adderall)
Dextroamphetamine (Dexadrine)
Phentermine (Adipex-P, Lomaira)
Lisdexamfetamine (Vyvanse)
Modafinil (Provigil)
Armodafinil (Nuvigil)
Atomoxetine (Strattera)
Clonidine
Guanfacine (Tenex)

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TREATMENTS TRIED IN PAST
(PLEASE CIRCLE ALL TREATMENTS YOU HAVE TRIED IN PAST)

SLEEP AGENTS

Trazadone (Desryl),
Melatonin
Zolpidem (Ambien)
Zaleplon (Sonata)
Eszopiclone (Lunesta)l
Temazepam (Restoril)
Benadry
Suvorexant (Belsomra)
Doxepin (Sinequan)
Trazadone (Desyryl)

MOOD STABILIZERS

Lithium
Valproic Acid (Depakote)
Lamotrigine (Lamictal)
Carbemazipine (Tegretol),
Haloperidol (Haldol)
Ziprasidone (Geodon)
Olanzipine (Zyprexa)
Quetiapine (Seroquel)
Aripiprazole (Abilify)).
Oxcarbazepine (Trileptal)
Levetiracetam (Keppra)
Topiramate (Topamax)
Gabapentin (Neurontin)
Pregabalin Lyrica
Brexpiprazole (Rexulti)
Lurasidone(Latuda)
Pimavanserin (Nuplazid)
Cariprazine (Vraylar)

ANXIETY TREATMENTS

(Lorazepam (Ativan)
Alprazolam (Xanax)
Diazepam (Valium)
Buspirone (Buspar)
Triazolam (Halcyon)
Clonidine (Catapras)
Prazosin (Minipres)
Baclofen
Tizanidine (Zanaflex)
Hydroxizine (Vistaril)

DEPRESSION TREATMENTS

Ketamine derivatives
Electrical Stimulation
Botox Injections
Fluoxetine (Prozac)
Paroxetine (Paxil)
Sertraline (Zoloft)
Venlafaxine (Effexor)
Mirtazapine (Remeron)
Buproprion (Wellbutrin, Zyban)
Citalopram (Celexa)
E-Citalopram (Lexapro)
Amitryptiline (Elavil)
Nortriptiline (Pamelor)
Clomipramine (Anafranil)
Doxepin (Sinequan)
Vilazadone (Viibryd)

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PLEASE DESCRIBE ANY SIGNIFICANT REACTIONS TO ANY CIRCLED TREATMENTS ABOVE (GOOD OR BAD)

BY YOUR SIGNATURE BELOW YOU AGREE TO THE FOLLOWING:

1. I am NOT currently a danger to myself or others. Emergencies should be dealt with by contacting 911 or presenting to the nearest emergency room. The Vines in Ocala, Springbrook Hospital, Shand's Hospital.

2. I have read and accept the policies and general instructions of John W. Grace, M.D. and completed this paperwork to the best of my ability.

3. I have insurance that allows me to receive labs and imagining and I have an active primary care physician that will assist in my care should medical needs arise.

4. I UNDERSTAND I MAY NOT BE ACCEPTED AS A PATIENT AND IF I DO NOT HEAR FROM YOU WITHIN 72 HOURS OF RETURNING THIS COMPLETED PAPERWORK, I WILL ASSUME YOU ARE UNABLE TO ASSIST ME AND SEEK CARE ELSEWHERE.

5. I UNDERSTAND I MAY CONTACT THE OFFICE IN SIX MONTHS TO SEE IF SOMETHING HAS CHANGED AND YOU ARE ABLE TO ACCOMMODATE ME AT THAT TIME.

SIGNATURE: _____

DATE: _____