DR# _____

CHART#_____

HOPE SPEAKS, PLLC
PATIENT INFORMATION

Please print and provide complete information.

LAST NAME: _____ FIRSTNAME: _____ MI: _____

SSN: _____ DOB: _____ AGE: _____ SEX: _____

MARITAL STATUS: _____ EMPLOYER: _____

MAILING ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

EMERGENCY CONTACT: _____

RELATIONSHIP: _____ PHONE: _____

INSURANCE

IS MEDICARE PRIMARY? YES: NO:

INSURANCE CO NAME: _____ PHONE NO: _____

SUBSCRIBER NAME: _____ DOB: _____ SSN: _____

POLICY NO: _____ GROUP NO: _____

RELATIONSHIP: _____ EMPLOYER: _____

AUTHORIZATION TO RELEASE INFORMATION: I hereby authorize HOPE SPEAKS, PLLC to release any medical information concerning my care for the purpose of claims to federal, state, city, or town governmental agencies, third party payors of all categories, doctors, hospitals, and pharmacies.

DISABILITY: I understand that all providers of HOPE SPEAKS, PLLC DO NOT do any type of disability paperwork or any paperwork associated with disability.

CONSENT FOR MEDICAL/PSYCHIATRIC TREATMENT: I am authorizing my physician(s) and/or therapists to perform and/or direct another person to perform all tests, exams, evaluations, and any other care deemed necessary or advisable for the diagnosis, evaluation, and treatment of my medical/psychiatric condition. I understand that my provider(s) at the HOPE SPEAKS, PLLC is not responsible for the care by any other health care professional.

ACKNOWLEDGEMENT FOR TREATMENT BY OTHER PROVIDERS: Dr. Shoaf and his team of providers are dedicated to providing quality healthcare to our patients. Please be aware that there will be times hat you will be treated by one of the other qualified providers for your follow up appointments.

PATIENT/GUARDIAN SIGNATURE: _____ **DATE:** _____

HOPE SPEAKS, PLLC
NOTICE of PRIVACY PRACTICES

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

This office may use and disclose medical and financial information related to your care that may be necessary now or in the future to facilitate payment by third parties for services rendered by us, or to assist with, and in, or facilitate the collection of data for purposes. Such information may be released to insurance companies, HMO's and PPO's managed care organizations, IPA's, Medicare/Medicaid, or other governmental or third party payors, or any organizations contracting with any of the above entities to perform such functions. Medical records may be delivered to a primary care physician or any other physician that is directly or indirectly responsible for your medical care of the payment thereof.

We may use or disclose your protected health information to send your treatment or healthcare operations communications concerning treatment alternatives or other health related products or services. We may provide such communications to you in instanceswhere we receive financial remuneration from a third party in connection with such communications. You have the right to opt out of receiving any such compensated communications, and should inform us if you do not wish to receive them. Additionally, if we send such communications, the communications themselves note that we have received compensation for the communication, and will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future. We may use and disclose limited amounts of your protected health information to send you fund raising materials. Any such fundraising materials sent to you will have clear and conspicuous instructions on how you may opt out of receiving such communications in the future.

Other that expressly provided herein, any other disclosures of your protected health information will require your specific authorization. Most disclosures of protected health information for which we would receive compensation would require your authorization. Additionally, we would need your specific authorization for most disclosures of your protected health information to the extent it constitutes "psychotherapy notes" or is for marketing purposes.

You may request restrictions on certain uses and disclosures. This office is not required to agree to a requested restriction. You have the right to receive confidential communications of your protected health information. You have the right to inspect, copy, and amend your protected health information. You may also request an accounting of disclosures of your protected health information from this office. As stated above, in most instances we do not have to abide by your request for restrictions of disclosures, we will be obligated to abide them. Specifically, if you pay for an item or service in full, out of pocket, and request that we do not disclose the information relating to taht service to a health plan, we will be obligated to abide by that restriction. You should be aware that such restrictions may have unintended consequences, particularly if other providers need to know that information {such as a pharmacy filling a prescription}. It will be your obligation to notify any such other providers of this restriction. Additionally, such a restriction may impact your health plan's decision to pay for related care that you may not want to pay for out of pocket {and which would not be subject to the restriction}.

To the extent that this office maintains your Protected Health Information {PHI} in an electronic health record, we agree to account for all disclosures of such PHI upon your request for a period of at least three {3} years prior to such request, as required by HIPAA and HITECH regulations.

We are legally obligated to maintain the privacy of your protected health information and to provide you with this Notice of Privacy Practices and to abide by its terms. We reserve the right to change our privacy practices and apply revised privacy practices to protected health information. In certain instances, we may be obligated to notify you {and potentially other parties} if we become aware that your protected health information has been improperly disclosed or otherwise subject to a "breach" as defined by HIPAA.

You may register a complaint with this office if you suspect that your privacy rights have been violated. We will investigate the complaint and inform you of the findings. No retaliation will be made against you by this office because you registered a complaint. You may also file a complaint with the Secretart of the Department of Health and Human Services.

You may speak with the Office Manager to obtain additional information regarding any questions you may have concerning this notice or to receive a printed copy of the notice. This Notice of Privacy Practices is effective as of August 1, 2015

Patient/Guardian Signature: _____ **Date:** _____

Patient's Printed Name: _____

HOPE SPEAKS, PLLC
PATIENT FINANCIAL RESPONSIBILITY

Recognizing the need for patients to understand what is expected regarding payment of medical/mental services we have established our financial policy. Some of these items are required by law. It is our goal to remain sensitive to our patients' needs while providing quality medical care, and we encourage you to contact our office if a problem should arrise regarding your account.

1. **All co-pays and co-insurance required by your insurance company must be paid at the time services are rendered.** We accept cash, checks, and Visa, MasterCard, Discover and American Express cards. There is a $35.00 service charge on all returned checks. After receiving a returned check, HOPE SPEAKS, PLLC will only accept cash, money order, or credit card.

2. **It is the patient's responsibility to be aware of the contract benefits of his/her insurance carrier or any co-payment or deductible obligation.** If your insurance requires referrals for full benefits to be paid, it is your responsibility to verify that the referrals are in place prior to your visit.

3. **Our facility will file primary insurance claims for medical services rendered.** Claims for a secondary and third insurance will not be filed unless required by our contract. We cannot file claims correctly without accurate information from you. Proof of insurance must be presented at each visit.

4. **If you do not have insurance**, payment in full is expected at the time of service unless financial arrangements have been made in advance with our billing department.

5. **You will be responsible for any outstanding balance after your insurance company processes your claim.** If you are dissatisfied with the amount paid by your insurance company, please contact your insurance carrier.

6. **We are participating providers for Medicare.** This means that we must accept Medicare's allowed charge for the services rendered. Medicare will pay 80% of the approved amount. The patient is responsible for the remaining 20%, plus any out-of-pocket deductible. We will write off the difference between what we charge and what Medicare approves. If you have secondary insurance, we will submit the claim for the remaining balance after Medicare has paid. Please remember that although we accept assignment for Medicare, the patient, by federal law, is responsible for any portion of the approved amount not paid by Medicare or a secondary insurance.

7. **Responsibility for payment for services rendered to the child/children of divorced or separated parents** rests with the parent who seeks treatment at the time of service. Any court ordered judgment must be between the individuals involved, without including our facility.

8. **There will be a charge for all missed appointments without a 24 hour notice.** We reserve resources for your visit and would like to be available to others if you have a schedule change. If such scheduling problems arise, please contact us promptly.

It is our hope that you will find this information helpful. If you have any questions, please speak with our billing staff at 972-669-1733.

Patient's Signature OR Authorized Representative/Guardian **Date**

Witness's Signature **Date**

HOPE SPEAKS, PLLC 1200 EAST COLLINS BLVD. STE 300 RICHARDSON, TX 75081 PHONE 972-669-1733 SECURE FAX 972-644-7056

Chart # _____

MEDICATION CHECKLIST

Name: _____ Date: _____

Place a check mark next to any medication you are currently taking or that you may have taken in the past - even if it was for a short time. Then next to the medicine, write a brief description based on your experience with the medication. Examples: good, helped, side effects, made dizzy, gained weight, headaches, etc.

Anti-Depressants

Anafranil_clomiprimine
Brintellix_vortioxetine
Celexa_citalopram
Cymbalta_duloxetine
Deplin_Lmethylfolate
Desyrel_trazodone
Effexor_venlafaxine
Elavil_amitriptyline
Fetzma_levomilnacipra
Lexapro_escitalopram
Ludiomil_maprotiline
Luvox_maprotiline
Nardil_phenelzine
Nuvigil_armodafinil
Pamelor_nortriptyline
Parnate_tranylcyromine
Paxil_paroxetine
Pristiq_desvenlafaxine
Provigil_modafinil
Prozac_fluoxetine
Remeron_mirtazapine
Serzone_nefazodone
Sinequan_doxepin
Stavzor_valproic acid
Symbyax_olanzapine+fluoxetine
Tofranil_imipramine
Viibryd_vilazodone
Vivactil_protriptyline
Wellbutrin_bupropion
Zoloft_sertraline

Anti-Anxiety

Atavan_lorazepam
Buspar_buspirone
Klonopin_clonazepam
Librium_chloradiazipoxide
Niravam_alprazolam
Restoril_temazepam
Serax_oxazepam
Tranxene_clorazepate
Valium_diazepam
Vistaril_hydroxyzine Pamoate
Xanax_alprazolam

Insomnia/Sleep

Ambien_zolpidem
Dalmane_flurazepam
Doxepin_
Edular_zolpidem
Lunesta_eszoplidone
Restoril_temazepam
Rozerem_ramelteon
Silenor_doxepin hcl
Sonata_zaleplon
Trazedone_

Mood Stabilizers

Carbatrol_carbamazepine
Celontin_mesuximide
Depakote_divalproic acid
Dilantin_phentoin Na
Equatro_carbamazepine
Gabitril_tiagabine
Keppra_levetiracetam
Lamictal_lamotrigine
Lithium_
Mysoline_primidone
Nerontin_gabapentin
Phenobarbital_
Saphris_asenapine
Stavzor_valproic acid
Tegretol_carbamazepine
Topomax_topirimate
Trileptal_oxycrabamazepine
Zarontin_ethosuximide
Zonegran_zonisimide

Anti-Psychotics

Abilify_ariprazole
Clozaril_clozapine
Cogentin_benzatropine
FanApt_iloperidone
Geodon_ziprasidone
Haldol_haloperidol
Latuda_luvasidone
Loxitane_loxapine
Mellaril_thiondazine
Moban_molindone
Navane_thiothixene
Prolixin_fluphenazine
Risperdal_risperdone
Seroquel_quetiapine
Stelazine_trifluoperazine
Symbyax_olanzapine+fluoxetine
Thorazine_chlorpromazine
Trilafon_perphenazine
Zyprexa_olanzepine

Attention Deficit Stimulants

Dextroamphetamine +

Adderall_amphetamine salts
Adderall_XR
Concerta_methylphenidate
Cylert_
Daytrana_methylphenidate
Dexadrine_dextroamphetamine
Focalin_dexmethylphenidate
Focalin_XR_dexmethylphenidate
Metadate_methylphenidate
Methylin_methylphenidate
Methylphenidate_
Quillivant_
Ritalin_methylphenidate
Vyvanse_lisdexamfetamine dimelylate

Attention Deficit Non-stimulants

Clonidine (ER)
Guanfacine
Intuniv_guanfacine
Kapvay_clonidine
Strattera_atomoxetine
Vayarin_

Early Cognitive Delay - AlzheimersDementia

Aricept_donepezil
Cerefolin NAC
Cognex_tacrine
Exelon_rivastigmine
Lycoremine_galantamine
Metanx_(B6-B9-B12)
Namenda_memantine
Razadyne_galantamine
Reminyl_galantamine
Vayacog_

Migraine Relief/Prevention

Amerge_natatriptan
Axert_
Frova_frovatripan
Imitrex_sumatriptan
Keppra_levetiracetamir
Lamictal_tamotrigine
Prinivil_lisinopril
Midrin_
Neurontin_gabapentin
Relpax_eletriptan
Topamax_topiramate
Treximate_sumatriptan/naprxen na
Zomig_zolmitriptan

Pain

Amrix_
Anaprox_
Butalbital_
Butrans Patch_
Codeine_
Darvocet_
Esgic_
Fentanyl Patch_
Fiorcet_
Flexeril_
Hydrocodone_
Ketamine_
Lorcet_
Lortab_
Lorzone_
Lyrica_
Morphine_
Naprosyn_
Norco_
Opana_
Oxycodone_
Oxycontin_
Percocet_
Phrenilin_
Soma_
Stadol_
Suboxone_
Subutex_
Ultracet_
Ultram_
Vicodin_
Zanaflex_
Zydone_

HOPE SPEAKS, PLLC **1200 EAST COLLINS BLVD. STE 300 RICHARDSON, TX 75081 PHONE 972-669-1733 SECURE FAX 972-644-7056**

HEALTH HISTORY QUESTIONNAIRE

Date: _____ ***MEDICATION ALLERGIES:** _____

Name: _____ **M / F** **Age:** _____ **DOB:** _____ **CHART#:** _____

Address: _____ **Phone #:** _____

Current Medications and Dosages: _____

_____

Social History: **Alcohol** ___ **Tobacco** ___ **Other Drugs (List)** _____

Family Health History: _____

_____

***** Please check any symptoms or disorders that you have either past or present.**

Constitutional	Fever ☐Y ☐N; Weight Gain ☐Y ☐N; Weight Loss ☐Y ☐N; Night Sweats ☐Y ☐N; Insomnia ☐Y ☐N; Other ☐Y ☐N _____	**Renal/Urological Gynecologic**	Difficulty Urinating ☐Y ☐N; History of urinary tract infection ☐Y ☐N; Sexual Dysfunction ☐Y ☐N; Other ☐Y ☐N _____
Head and Neck	Visual Changes ☐Y ☐N; Eye Pain ☐Y ☐N; Nasal Bleeds ☐Y ☐N; Sore Throat ☐Y ☐N; Hoarseness ☐Y ☐N; Pain in Gums ☐Y ☐N; Ear Pain ☐Y ☐N; Hearing Loss ☐Y ☐N; Other ☐Y ☐N _____	**Musculoskeletal**	Joint Pain ☐Y ☐N; Back Pain ☐Y ☐N; Joint Swelling ☐Y ☐N; Other ☐Y ☐N _____
Connective Tissue Disease	Lupus ☐Y ☐N; Scleroderma ☐Y ☐N; Rheumatoid/Osteo Arthritis ☐Y ☐N; Sjogren's ☐Y ☐N; Other ☐Y ☐N _____	**Neurological**	Headaches ☐Y ☐N; Seizure ☐Y ☐N; Weakness ☐Y ☐N; Difficulty Speaking ☐Y ☐N; Other ☐Y ☐N _____
Respiratory	Difficulty breathing ☐Y ☐N; Hemoptysis ☐Y ☐N; Cough ☐Y ☐N; Wheezing ☐Y ☐N; Other ☐Y ☐N _____	**Endocrine**	Frequent Urination ☐Y ☐N; Fatigue ☐Y ☐N; Excessive Thirst ☐Y ☐N; Other ☐Y ☐N _____
Cardiovascular	Chest Pain ☐Y ☐N; Palpitations ☐Y ☐N; Feet/legs Swelling ☐Y ☐N; Other ☐Y ☐N _____	**Hematological**	Anemia ☐Y ☐N; Easy Bruising ☐Y ☐N; Other ☐Y ☐N _____
Gastrointestinal	Difficulty Swallowing ☐Y☐N; Vomiting ☐Y☐N; Diarrhea ☐Y☐N; Constipation ☐Y☐N; Abdominal Pain; Indigestion/ Heart Burn ☐Y☐N; Other ☐Y ☐N	**Immunological**	Hives ☐Y ☐N; Allergy to foods ☐Y ☐N; Other ☐Y ☐N _____

1. Have you ever been hospitalized overnight? ☐Y☐N If yes, why? _____
2. Have you ever had surgery? ☐Y☐N If yes, why? _____
3. Have you ever had racing of your heart of skipped beats? ☐Y ☐N
4. Have you had high blood pressure or high cholesterol? ☐Y ☐N
5. Have you ever been told you have a heart murmur? ☐Y ☐N When was your last EKG? _____ Results? _____
6. Has any family member or relative died of heart problems or of sudden death before age 50? ☐Y ☐N
7. Has a physician ever denied or restricted your participation in sports for any heart problems? ☐Y ☐N
8. Have you ever had a head injury or concussion? ☐Y☐N If yes, when? _____ CT or MRI? When? _____
9. Have you ever been knocked out, become unconscious, or lost your memory? ☐Y☐N If yes, when? _____
10. Have you ever had a seizure? ☐Y☐N If yes, when was last EEG or MRI? _____ Results? _____
11. Do you have frequent or severe headaches? ☐Y ☐N
12. Have you ever had any numbness or tingling in your arms, hands, legs or feet? ☐Y ☐N
13. Have you ever had a stinger, burner, or pinched nerve? ☐Y ☐N
14. Have you had any problems with your eyes or vision? ☐Y ☐N
15. Do you wear glasses, contacts, or protective eyewear? ☐Y ☐N
16. Do you want to weigh more or less than you do now? ☐Y ☐N
17. Do you feel stressed out? ☐Y ☐N
18. Have you ever had respiratory, cardiovascular, or gastrointestinal disorder? ☐Y☐N If yes, what? _____
19. Have you ever had any renal, urological, musculoskeletal, neurological, or an endocrine disorder? ☐Y☐N If yes, what? _____

I hereby state that, to the best of my knowledge, my answers to the questions above are complete and correct.

Signature of patient: _____ Date: _____

Signature of parent/guardian: _____ Date: _____

HOPE SPEAKS, PLLC

INITIAL SCREENING QUESTIONNAIRE FOR DR. NOE NEAVES

CHART#_____

NAME: _____ DATE: _____

AGE: _____ MARITAL STATUS: _____ EMPLOYMENT STATUS: _____

DATE SYMPTOMS BEGAN: _____ DATE SYMPTOMS WORSENED: _____

STRESSFUL EVENTS / SITUATIONS: _____

SYMPTOM CHECKLIST

___Depressed or Sad Mood
___Irritability / Short tempered
___Lack of Motivation / Drive
___Poor concentration
___Can't sleep well
___Appetite changes weight changes
___Loss of pleasure in activities/hobbies
___Diminished self-esteem
___Hopeless / Helpless
___Decreased energy / always fatigued
___Excessive guilt or worry
___Crying spells
___Decreased sex drive
___Intense fear of being fat

___Spending sprees / wanting money
___Special abilities / increased self-esteem
___Decreased need for sleep
___Too many great ideas to get out at once
___Racing thoughts / Can't keep up
___Increased energy / Hyperactivity
___Increased sex drive
___Making lots of plans / schemes / ideas
___Rapid Speech
___Talkative nonstop / Can't interrupt
___Day-to-Day Mood Swings

___Suspicious / Paranoia
___Hallucinations (seeing or hearing things)
___Unusual facial expresions
___Strange posturing / gestures
___Disorganized thoughts / confusion
___Bizarre behaviors
___Unusual or Unwanted beliefs / thoughts
___Washes hands constantly

___Anxiety about everything
___Intense episodes of fear
___Fear of going crazy / Losing control
___Chills / Hot Flashes
___Abdominal distress / nausea
___Chest discomfort / Choking
___Dizziness
___Numbness / Tingling
___Jumpy / On edge / easily startled
___Constantly alert / Vigilant
___Nightmares / Reliving trauma
___Avoidance of Stressors / Situations
___Heart Racing / Palpitation
___Sweating
___Trembling
___Shortness of breath
___"Lump in throat" / Can't swallow
___Attacks of intense anxiety / fear / panic
___Unable to leave home

___Counts things constantly
___Impaired intellect / thinking
___Language / Speech Difficulties
___Poor judgment / Impulsivity
___Unusual sleep pattern
___Disorganized / Confused
___Poor memory

SUBSTANCE ABUSE

___Amphetamines / Stimulants
___Cocaine / Crack
___Marijuana / Cannabis
___Alcohol
___Sedatives / Hypnotics
___Opiates / Narcotic Pain pills / Heroin

Suicidal thoughts ___YES ___NO
___Passing thoughts / no intent
___Persistent thoughts
___Current plans / definite intent
___Recent attempts
___Past attempts

___Pulling hair out
___Anger / Emotional Outbursts
___Binge eating / Purging
___Uncontrolled gambling
___Stealing or lying
___Ritualized behaviors / Obsessions

___Oppositional / Defiant Behaviors
___Childhood delinquency
___Attention / Concentration Difficulties
___Impulsivity / Can't wait
___Hyperactivity / Always moving / Restless
___Poor self care / Bathing / Dressing
___Can't perform at work / Home / School
___Aggressive / Assaultive to people / objects
___Isolative / Withdrawn from others
___Truancy from school
___Running away from home
___Self-mutilation / self-harm
___Sleeping all the time
___Staring spells
___Chronic pain
___Multiple unexplained bodily complaints
___Self-induced vomiting
___Constant agitation
___Intense fear of rejection / abandonment
___Bowel / bladder control problems
___Legal troubles

III. MEDICATIONS

Current: _____

Past Medications: _____

_____

IV. ALLERGIES TO MEDICATIONS: _____

V. PERSONAL PAST PSYCHIATRIC HISTORY: ___Counseling ___Psychiatrist ___Hospitalization ___Suicidal attempts

VI. PAST/CURRENT MEDICAL PROBLEMS: _____

VII. FAMILY HISTORY: ___Psychiatric/Emotional Illness ___Medical Diseases ___Suicide Attempts ___Drug/Alcohol Problems

Of the above symptoms, list the TOP THREE most important:

_____

Thank you