Laura N. Antar, M.D., Ph.D.
224 North Main Street
New City, NY 10956
Office: (845) 367-4800
Fax: (845) 367-4801

To My Patients:

Please read the following information about my policies about appointments, cancellations and confidentiality. Feel free to bring up questions about these policies at any time.

Private Pay Advantages:
No third-party invasion of your privacy. Confidential diagnosis and treatment. No insurance company or managed care interference for self-pay appointments. I have no split allegiance between an insurance company and you.

After a private 1:1, recommendations are made for your care. Together, we decide your treatment. You are informed of treatment options, effectiveness probabilities, risks and benefits, and cost. I will assist you in the decision process and the ongoing unfolding treatment adjustments. Take full control of your confidential health.

Insurance:
Be sure to check your health care coverage for outpatient mental health care. Usually, there is a yearly deductible and a co-payment for each visit. I have not contracted with any insurance, but will do my best to help you submit to your own insurance by providing you with necessary treatment plans and receipts so that you may submit as "out of network." Psychiatric illnesses with a biological cause (most depressions, many anxiety disorders, bipolar disorder, and some other illnesses) are covered, as long as medically necessary, without a yearly maximum, just like other medical illnesses. Remember that you will be responsible for any charges that are not covered by your insurance. Be sure to get the details. I will help you as best I can, but your insurance company or employer is the best source of information about actual coverage.

Electronic Medical Records, Prescriptions and Prior Authorizations:
In today's health care system, medical records are stored electronically, which involves my office utilizing an Electronic Medical Record (EMR) System. The EMR that I use is entirely cloud based, meaning that records are nearly impossible to lose, and there is no data stored directly on my computer hard drive (which prevents loss in crashes, and makes your data less vulnerable to hackers). This is a secure, HIPPA-compliant system, designed to maintain patient privacy, and through which we can communicate confidentially. I believe it is safer than keeping your records in my office, and soon expect to have all of my charts entirely electronically based. Additionally, the Electronic Medial Record has a patient portal called Patient Fusion through which you may access portions of your medical record, make appointments, and in the future, access your own lab work. The EMR will also remind you of your appointments one week and one day

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before hand. If you would not like to receive these email reminders, please let me know and I will remove you from the automatically generated notice.

My prescriptions are sent through the HIPPA-compliant E-scripts, also electronically, which is the safest means to transfer information confidentially directly to your pharmacy. E-prescribing substantially reduces medical errors, and will soon be required under New York State law of all prescribers.

Finally, for prior authorizations required by certain insurance companies before they will approve non-formulary medications, I send the request through a HIPPA-compliant company that ensures safe, rapid and confidential processing and faxing to the insurance company.

Appointments: Appointments are scheduled according to each patient's needs and the availability of the physician. The time of your appointment is reserved for you. **Absences that are not approved in advance or are not the result of a serious medical illness, will be charged in half. Please note that if you arrive late to your appointment, you may only use your remaining time, but you will be charged for the usual fee.** Your insurance company will not reimburse for missed appointment fees. They are your responsibility.

If you cancel your appointments too often, I will bring this up with you. If you continue to cancel or miss frequently, I may end the treatment.

Maintaining Patient Status: In our area of healthcare, it is very important that you be seen on a regular basis. At the end of each appointment, I will discuss with you within what period of time we should schedule a follow-up appointment in the office. If you fail to keep and/or maintain follow-up appointments for a period of 120 days or greater, I will conclude that you have terminated the patient-physician relationship.

Fees: You, the patient, or your legal guardian, is financially responsible for the total cost of services rendered. Full payment is expected **at the time of the office visit with me**. If you are unable to pay for your service, you will be asked to reschedule for another time and charged the full appointment fee.

Phone calls: Emergency calls are handled as a priority. If you are having an emergency of a medical nature, please call 911 immediately. Calls that require that I call you back will be handled in as timely a manner as possible. Please leave a phone number where you will be available for a return call. In case of a life or death psychiatric emergency, please call the local emergency room, or go directly to your nearest hospital, and later leave a message on my machine and I will get in touch with you as soon as possible.

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Medication Refills: I handle all refills during your regular scheduled appointments. If a medication refill becomes necessary, please provide me with your pharmacy phone number, medication name and how you are currently taking your medication. You will be required to make an appointment with me, then I will call in enough medication to last until your appointment. I appreciate your cooperation in keeping track of your medication supply in order to avoid running out. Allow 24 to 48 hours for telephone prescriptions. **There is a $30 administrative fee for refill requests between appointments.**

Confidentiality:
Your patient records are strictly confidential. For this reason, no information concerning you as a patient is released without your written consent (an exception is limited information sent to other doctors or your pharmacist). Disclosure of information to anyone such as an attorney and/or a family member must be requested by written authorization by the patient. In an emergency situation when you, the patient, are at imminent risk of death or serious medical consequence, I will release minimal, critically relevant information to assist in preventing dire medical consequences that may result if that relevant information is not released. In the case of a minor, their legal guardian must sign the authorization. **The physician is legally bound to break doctor-patient confidentiality in cases of threat of harm to self or others and in reports of child or geriatric abuse.**

If you are using your insurance to pay, the carrier requests the diagnostic code (a number), the dates of service, and the type of treatment (evaluation, therapy or medication). If you have a managed care plan, that plan will sometimes request more detailed information about your symptoms and life situation in order to authorize treatment. If you would like to know exactly what they request and/or what I release, please let me know. Otherwise, I will consult you only if the request seems too detailed, personal or too comprehensive (like requesting the whole chart). Most parties agree to a simple treatment summary.

I do not submit claims to insurances. The EMR I use, will remind you about appointments one week and one day in advance, as a courtesy. If you would not like to receive reminders, please let me know and I can remove you from the automatically generated list. Please note, should you for any reason not receive a reminder, you are still fully responsible for making your appointment.

I sometimes obtain consultation for my cases. Specific information is exchanged in these meetings, but will not go beyond the consultants.

Coverage:
If I am out of town, the name and number of the covering psychiatrist will be on my answering machine.

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Discontinuation of Treatment:
I will usually discontinue treatment with a patient only after considerable discussion and usually for one of the following reasons: (1) not paying the bill, (2) canceling too often, or (3) not doing any work in treatment. If you foresee a problem in any of these areas, please let me know. If I see a difficulty in any of these areas, I will bring it up with you right away so we can discuss it and correct the problem.

You can discontinue with me at any time in person, by phone, or in writing. I am not easily offended if you want to quit or change providers. Transfer will be facilitated if we can first confer about ending. You can usually re-open your case simply by calling me if you ended treatment in good standing or if you have made changes that will allow the treatment to go forward again.

Hopefully, these policies will make our interactions easier, but sometimes there are snags or unplanned issues. Please bring to my attention any questions about or difficulties with these policies. I try to be flexible but consistent. Thank you.

I have read and agree to these practice policies _____ _____
Signature Date

Laura N. Antar, M.D., Ph.D.

Individual (Patient) Rights

1) All patients have the right to inspect and copy their own protected health information (the medical record) on request, except for mental health records, which must be reviewed with a psychiatrist first. In cases where exposure to the record might be harmful to the patient, the psychiatrist may deny the request. If you request a copy of your psychiatric record, I will generally review the record with you myself. I rarely have information in the chart that a patient should not or could not read, but much may require explanation.
2) Patients also have the right to amend or append their medical (or psychiatric) record. I, as your physician, have the right to deny such a request if I believe that the information in the medical record is accurate, but in that case, the patient request must still be attached to the medical record.
3) Patients have the right to an accounting of all disclosures to other parties. This means that if you ask me for a list of whom I have released psychiatric information to, I will supply it to you.
4) Patients have the right to have reasonable requests for confidential communication accommodated.
5) You can give written authorization for me to disclose your psychiatric information to anyone you choose, and you may revoke the authorization in writing at any time.
6) Patients can file a complaint with me or with the Office of Civil Rights in the Department of Health and Human Services about any violation of the rights listed above. There will be no prejudice for filing such a complaint.
7) Patients have the right to receive a written notice of privacy practices from providers and health plans.

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New Privacy Provisions and Changes

New HIPAA (Health Insurance Portability and Accountability Act) Privacy Standards were created to protect patient's health information when it is disclosed, but also to facilitate the flow of medical information between treaters. With other medical treaters, billing, and for safety or security reasons, there is less protection of confidentiality than there used to be. However, in other areas, such as releasing psychotherapy records, there is more privacy protection. Please read the following so that you understand your rights as a patient as well as the new rules about patient confidentiality. Feel free to ask me any questions about privacy, confidentiality, or your psychiatric record.

1) Permission from the patient is no longer required for transfer of psychiatric and medical information between treaters as long as only the necessary information is supplied. This means that if your primary care doctor, pharmacist, or an emergency room physician calls to find out if you are in treatment, what the diagnosis is, or what medications you are on, I can convey this information if it is medically relevant to your treatment with them. In practice, I will almost always discuss this with you personally before or after the fact, depending on the urgency and depth of the request. If you think this might present a problem for you, let me know ahead of time.
2) Permission from the patient is no longer required for transfer of psychiatric information needed for business pertaining to insurance or payment as long as only the necessary information is supplied (usually the diagnosis and type of treatment, but perhaps more). In practice, many insurance companies still require you to sign the first insurance sheet for authorization. In general, I do discuss any unusual requests for information from an insurance company with a patient first.
3) Remember that if all the psychiatric records are requested, a treatment summary is usually given instead, except if the treatment consists solely of psychopharmacological treatment or brief medication visits. While brief medication visits fall under HIPAA guidelines, psychotherapy visits are specifically excluded, meaning authorization from the patient is still required for release of the information in those notes and a summary is given in place of the record.
4) The substance abuse records from alcohol and drug programs are exempt from any disclosure without patient permission. If you are admitted to a treatment program for substance abuse, be sure to sign a release for me so I can talk to the

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treaters and obtain a discharge summary and lab data upon your discharge. Without this, I cannot obtain any information.

5) I may have to disclose some of your psychiatric information when required to do so by law. This includes mandated reporting of child abuse or elder abuse (this is not new).
6) National security and public health issues. I may be required to disclose certain information to military authorities or federal health officials if it is required for lawful intelligence, public health safety or public security.

Signature: _____

Date: _____

Fee Schedule

New Patients

90 minute Initial Consultation (adults) (90791, 90792)	$450.00
60 minute Initial Consultation, parents alone (90791, 90792)	$350.00
60 minute Initial Consultation, child/adolescent alone (90701, 90792)	$350.00

Evaluation/Management(E/M)+Psychotherapy

10-15 minute brief medication visit	$150.00
16-30 minute medication management	$200.00
45 minute medication or medication plus therapy:	$300.00
60 minute medication or medication plus therapy	$400.00
Refills or prescriptions made between appointments (1 week supply)	$30.00

Missed appointments half fee

Appointments not kept and not cancelled **48 hours in advance--**cancellation of any kind should be uncommon). One emergency (sickness, weather, conflict etc.) miss or short-notice cancellation per year will not be charged. Please do not ask for rescheduling or exceptions.

Lateness: Your appointment is reserved time. If you arrive late, you are still responsible to pay for time you were not present: your session time will not be extended or rescheduled. Insurance only covers face-to-face time.

Collateral Calls greater than 10 minutes:

Calls/Phone Sessions/ Phone Consultations	11-15 minutes	$150.00
Calls/Phone Sessions/ Phone Consultations	16-30 minutes	$200.00
Calls/Phone Sessions/ Phone Consultations	31-45 minutes	$300.00
Calls/Phone Sessions/ Phone Consultations	46-60 minutes	$375.00

Calls for which a short office visit would have been appropriate, but circumstance: expedience, convenience or safety, required phone contact (ex. student at college, medical questions/concerns, **parent communication including advice or updates**, calls for coordination of care to therapists/ teachers/agencies). **Insurance does not reimburse phone calls: it requires face-to-face contact.**

Forms and Reports:

Form completion requiring physician's time: $200 per hour or $100.00 per half hour (prorated).

Visits Outside the Office

$375 per hour including travel time (ex. classroom visits/ CSE meetings).

- Patients who are not seen for more than three months are considered discharged from the practice and may need a re-evaluation to enter the practice again.
- Follow-up sessions are scheduled less frequently as you improve to a maximum of three- month intervals.

I accept this policy and fee schedule. **Name:**_____ **Date:**_____

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CONSENT FOR TREATMENT

My professional records are separately maintained and no one else can have access to them without your specific, written permission.

The undersigned patient or responsible party (parent, legal guardian or conservator) consents to, and authorizes services, by Laura N. Antar, M.D., Ph.D., PLLC These services may include psychotherapy, medication therapy, laboratory tests, diagnostic procedures and other appropriate alternative therapies.

The undersigned understands that he/she has the right to:

1. Be informed of and participate in the selection of treatment modalities.
2. Receive a copy of this consent.
3. Withdraw this consent at any time.

The undersigned also understands that he/she has the responsibility to:

1. Pay for services, in full, at the time of visit.
2. Abide by the policies of the patient information guidelines as presented at the time of initial visit.
3. Acquire any lab tests or other medical treatments (physical exams or physician referrals) deemed medically necessary in order to maintain a safe and healthy lifestyle.

_____
Signature of Patient Date Signed

_____
Signature of Parent, Legal Guardian or Conservator Date Signed

_____
Signature of Witness (if appropriate) Date Signed

PATIENT INFORMATION—Please fill out completely.

Last Name:_____First Name_____ M.I.__

Street Address_____

City_____State_____Zip_____Gender F M

Home Phone:_____Office Phone:_____ Cell_____

Email:_____Birthday_____SS#_____

Marital Status: (circle) Single/ Married/ Divorced/ Widowed/ Separated/ Partnered/ Other

Employer/School Name and phone number:_____

Spouse's Name and daytime phone number:_____

Responsible Party: Provide information on who is responsible for paying for the service (if different).

Name:_____ SS#_____

Address:_____ Phone:_____

Relationship to Patient?_____

Emergency Contact:
(Name/number/relation)_____

****Insurance Information: Please provide insurance card for copying.**

Name of Insured:_____ ID#_____

Insured's date of birth:_____ Relationship to patient_____

Name of Insurance Co:_____

Phone number and address:_____

Employer of Insured: _____Group #_____

Have you contacted your insurance for out-of-network authorization? **YES or NO**

Phone for Authorization number:_____ Authorization #_____

MEDICAL HISTORY

Name:_____ Date:_____

Hospitalizations (including psychiatric) :

	Year:	Condition:
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Surgeries:

	Year:	Type:
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____

Other serious medical conditions:_____

Current Medicines:

	Name:	Dosage:	Schedule:	Side Effects:
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

Are you allergic to any medication? YES NO

If so, what happens if you are exposed to that medication? (hives, rash, etc.)

_____

Have you ever had a seizure? YES NO

If so, when was the last time?_____

Have you had a loss of consciousness? YES NO

If so, when was the last time?_____

Name and number (if known) of the doctors you have seen in the last 3 years:

1._____ 3._____

4._____ 4._____

Family Health and Psychiatric History (Depression, Anxiety, Bipolar, Drugs, etc.)

Family Member / Condition:_____

Family Member / Condition:_____

Has any family member committed suicide? YES NO

Family Member:_____

TREATMENT HISTORY

Name:_____ Date:_____

Have you had any counseling or psychiatric care in the past? **YES NO**

Have you had any psychiatric hospitalizations in the past **YES NO**
If Yes, please give approximate Dates and reason: _____

_____

Have you ever been on medication for nerves, anxiety, depression or insomnia? **YES NO**

If yes:

Medication name	Did It Help?	Any Problems Associated With It?
1. _____	Yes No	_____
2. _____	Yes No	_____
3. _____	Yes No	_____

Have you had out-patient therapy? **YES NO**
Number of therapies: _____

Kind of Therapy (if known): _____

Last therapist name: _____

Approximate Dates / Reason for Visits: _____

_____

Have you had any other type of psychological therapy? Please circle type if yes. **YES NO**

Marital or family therapy/ ECT/ Group therapy/ Hypnosis/ Other

Have you ever felt you ought to cut down on your drinking or drug use? **YES NO**

Have people annoyed you by criticizing your drinking or drug use? **YES NO**

Have you ever felt bad or guilty about your drinking or drug use? **YES NO**

Have you ever had a drink or used drugs first thing in the morning to steady
Your nerves or to get rid of a hangover? **YES NO**

Have you ever had any hospital or outpatient treatment for alcohol or drugs? **YES NO**

Have any blood relatives had a problem with alcohol or drugs? **YES NO**

Have any blood relatives suicided or had a psychiatric hospitalization? **YES NO**

Have you been diagnosed as manic-depressive, or considered to possibly be? **YES NO**

Have you ever been on Lithium? **YES NO**

BEHAVIORAL HEALTHCARE PROBLEMS HISTORY
(please include as much detail as you can)

Name:_____ Date_____

Have you had panic attacks, hyperventilation or anxiety or nervousness? **YES** **NO**
Describe: _____
_____

Do you do a lot of hand washing or going back and checking windows, doors, stoves, etc.? **YES** **NO**
Describe: _____
_____

Are you bothered with thoughts that keep coming back into your mind? **YES** **NO**
Describe: _____
_____

Have you had any traumas, catastrophes, or bad accidents? **YES** **NO**
Describe: _____
_____

Have you had any losses or death? **YES** **NO**
List:_____
_____

What are your current stresses?
List: _____
_____
_____

Have you been abused? **YES** **NO**

	How	By Whom	When
Physically:		_____	_____
Sexually:		_____	_____
Emotionally:		_____	_____

Do you have sexual concerns? **YES** **NO**
Describe: _____

Have you attempted suicide? **YES** **NO**

How many times?_____
Last time:_____First time:_____

Have you become violent? **YES** **NO**

To property?_____How? _____
To people?_____ Whom?_____

Have you been arrested? **YES** **NO**

What were the charges?_____

Have you had an eating disorder, or made yourself throw up to lose weight? **YES** **NO**

PATIENT HEALTH QUESTIONNAIRE (PHQ)

This questionnaire is an important part of providing you with the best health care possible. Your answers will help in understanding problems that you may have. Please answer every question to the best of your ability unless you are requested to skip over a question.

Name_____ **Age**_____ **Sex:** ☐ **Female** ☐ **Male** **Today's Date**_____

1. During the last 4 weeks, how much have you been bothered by any of the following problems?	**Not bothered**	**Bothered a little**	**Bothered a lot**
a. Stomach pain	☐	☐	☐
b. Back pain	☐	☐	☐
c. Pain in your arms, legs, or joints (knees, hips, etc.)	☐	☐	☐
d. Menstrual cramps or other problems with your periods	☐	☐	☐
e. Pain or problems during sexual intercourse	☐	☐	☐
f. Headaches	☐	☐	☐
g. Chest pain	☐	☐	☐
h. Dizziness	☐	☐	☐
i. Fainting spells	☐	☐	☐
j. Feeling your heart pound or race	☐	☐	☐
k. Shortness of breath	☐	☐	☐
l. Constipation, loose bowels, or diarrhea	☐	☐	☐
m. Nausea, gas, or indigestion	☐	☐	☐

2. Over the last 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**
a. Little interest or pleasure in doing things	☐	☐	☐	☐
b. Feeling down, depressed, or hopeless	☐	☐	☐	☐
c. Trouble falling or staying asleep, or sleeping too much	☐	☐	☐	☐
d. Feeling tired or having little energy	☐	☐	☐	☐
e. Poor appetite or overeating	☐	☐	☐	☐
f. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	☐	☐	☐	☐
g. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐
h. 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	☐	☐	☐	☐
i. Thoughts that you would be better off dead or of hurting yourself in some way	☐	☐	☐	☐

FOR OFFICE CODING: Som Dis if at least 3 of #1a-m are "a lot" and lack an adequate biol explanation.
Maj Dep Syn if answers to #2a or b and five or more of #2a-i are at least "More than half the days" (count #2i if present at all).
Other Dep Syn if #2a or b and two, three, or four of #2a-i are at least "More than half the days" (count #2i if present at all).

3. Questions about anxiety.		NO	YES
a.	In the last 4 weeks, have you had an anxiety attack — suddenly feeling fear or panic?	☐	☐
If you checked "NO", go to question #5.			
b.	Has this ever happened before?	☐	☐
c.	Do some of these attacks come suddenly out of the blue — that is, in situations where you don't expect to be nervous or uncomfortable?	☐	☐
d.	Do these attacks bother you a lot or are you worried about having another attack?	☐	☐

4. Think about your last bad anxiety attack.		NO	YES
a.	Were you short of breath?	☐	☐
b.	Did your heart race, pound, or skip?	☐	☐
c.	Did you have chest pain or pressure?	☐	☐
d.	Did you sweat?	☐	☐
e.	Did you feel as if you were choking?	☐	☐
f.	Did you have hot flashes or chills?	☐	☐
g.	Did you have nausea or an upset stomach, or the feeling that you were going to have diarrhea?	☐	☐
h.	Did you feel dizzy, unsteady, or faint?	☐	☐
i.	Did you have tingling or numbness in parts of your body?...	☐	☐
j.	Did you tremble or shake?	☐	☐
k.	Were you afraid you were dying?	☐	☐

5. Over the <u>last 4 weeks</u>, how often have you been bothered by any of the following problems?		Not at all	Several days	More than half the days
a.	Feeling nervous, anxious, on edge, or worrying a lot about different things.	☐	☐	☐
If you checked "Not at all", go to question #6.				
b.	Feeling restless so that it is hard to sit still.	☐	☐	☐
c.	Getting tired very easily.	☐	☐	☐
d.	Muscle tension, aches, or soreness.	☐	☐	☐
e.	Trouble falling asleep or staying asleep.	☐	☐	☐
f.	Trouble concentrating on things, such as reading a book or watching TV.	☐	☐	☐
g.	Becoming easily annoyed or irritable.	☐	☐	☐

FOR OFFICE CODING: Pan Syn if all of #3a-d are 'YES' and four or more of #4a-k are 'YES'. Other Anx Syn if #5a and answers to three or more of #5b-g are "More than half the days".

	NO	YES
6. Questions about eating.		
a. Do you often feel that you can't control what or how much you eat?	☐	☐
b. Do you often eat, within any 2-hour period, what most people would regard as an unusually large amount of food?	☐	☐
If you checked "NO" to either #a or #b, go to question #9.		
c. Has this been as often, on average, as twice a week for the last 3 months?	☐	☐

7. In the last 3 months have you often done any of the following in order to avoid gaining weight?	**NO**	**YES**
a. Made yourself vomit?	☐	☐
b. Took more than twice the recommended dose of laxatives?	☐	☐
c. Fasted — not eaten anything at all for at least 24 hours?	☐	☐
d. Exercised for more than an hour specifically to avoid gaining weight after binge eating?	☐	☐

	NO	YES
8. If you checked "YES" to any of these ways of avoiding gaining weight, were any as often, on average, as twice a week?	☐	☐

	NO	YES
9. Do you ever drink alcohol (including beer or wine)?	☐	☐
If you checked "NO" go to question #11.		

10. Have any of the following happened to you more than once in the last 6 months?	**NO**	**YES**
a. You drank alcohol even though a doctor suggested that you stop drinking because of a problem with your health.	☐	☐
b. You drank alcohol, were high from alcohol, or hung over while you were working, going to school, or taking care of children or other responsibilities.	☐	☐
c. You missed or were late for work, school, or other activities because you were drinking or hung over.	☐	☐
d. You had a problem getting along with other people while you were drinking.	☐	☐
e. You drove a car after having several drinks or after drinking too much.	☐	☐

11. If you checked off any problems on this questionnaire, how difficult have these 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**
☐	☐	☐	☐

FOR OFFICE CODING: Bul Ner if #6a,b, and-c and #8 are all 'YES'; Bin Eat Dis the same but #8 either 'NO' or left blank.
Alc Abu if any of #10a-e is 'YES'.

MOOD DISORDER QUESTIONAIRE

Patient Name:_____ Date:_____

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

a)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**

b) You were so irritable that you shouted at people or started fights or arguments? **YES NO**

c) You felt much more self-confident than usual? **YES NO**

d) You got much less sleep than usual and found you did not really miss it? **YES NO**

e) You were much more talkative or spoke much faster than usual? **YES NO**

f) Thoughts raced through your head or you could not slow down your mind? **YES NO**

g) You were so easily distracted by things around you that you had trouble concentrating or staying on track? **YES NO**

h) You had much more energy than usual? **YES NO**

i)You were much more active or did many more things Than usual **YES NO**

j) You were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? **YES NO**

k) You were much more interested in sex than usual **YES NO**

l) You did things that were unusual for you or that other people Might have though were excessive, foolish, or risky? **YES NO**

m) You spend money so much that it got you or your family In trouble? **YES NO**

If you checked YES to more than one of the above, have several Of these things ever happened during the same period of time? **YES NO**

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?
No problem Minor Problem Moderate Problem Serious problem

Laura N. Antar, M.D., Ph.D.
224 North Main Street
New City, NY 10956
Office: 845-367-4800
Fax: 845-367-4801

Release of Information

I hereby authorize: Laura N. Antar, M.D., Ph.D.

Check:
☐ Release information to: Name: _____
☐ Obtain information from: Address: _____
☐ Exchange information with: _____
_____
Telephone: _____

The information requested or authorized for release or exchange pertains to:
Check:
☐ Mental Health
☐ Education
☐ HIV/AIDS
☐ Sexually transmitted diseases
☐ Drug or alcohol abuse

This authorization will be valid until it is either revoked by the patient or the patient is discharge from treatment. I may cancel this authorization by signing, dating, and writing "CANCEL" on this original form or by sending a written, signed and dated request to the doctor above indicating my desire to cancel. I understand that once my information has been released, the recipient might re-disclose it, my doctor has no control over it and privacy laws may no longer protect it. The purpose of this authorization is to improve the quality of my mental health evaluation or treatment.

_____ _____
Patients Name (print) **Date of Birth**

_____ _____
Patients Signature Date

_____ _____
Guardian's Signature (if patient is a minor) Date