Scott Lurie, M.D., P.A.

Date: ______________Referred By: ____

Name: ____________________________________ Sex: Male/ Female Age: _______ DOB: _______

Patients Address:

____

Zip Code:_______________ email address: ______________________________

Telephone: __________________________/ ____________________________/ __________________
Home Work Cell

Social Security Number: __________________________________ Marital Status: __________

Occupation: ________________________________Employer:_______________________________________

Spouse:______________________________Occupation:________________________________

Emergency Contact: ______________________________ Contact Number: ____________________________

Full Names and ages of Children:

____

____

Others Living in Home___________________________________Relationship:__________________________

Personal Physician:
____

Address: ____

Phone: ___________________________

Therapist:
____

Address: ____

Phone: ___________________________

What problems bring you to seek help. Please describe the symptoms and their duration

What stressors have caused or worsened your situation?
What are your goals for treatment

Current Symptoms: Check all that apply:

Depressed mood		Decreased enjoyment		Insomnia	
Decreased energy		Difficulty concentrating		Decreased appetite	
Increased appetite		Decreased libido		Crying spells	
Feeling helpless		Feeling hopeless		Excessive guilt	
Irritability		Decreased need for sleep		Excessive energy	
Increased libido		Racing thoughts		Increased impulsiveness	
Excessive worry		Feeling keyed up/edgy		Anxiety attacks	
Avoidance		Social withdrawal		Compulsive behavior	
Suspiciousness		Thoughts of death		Thoughts of suicide	

Past Psychiatric History	
Have you ever been admitted to a psychiatric hospital	Y N
If yes how many times and when were you last admitted?	
Have you ever seen a psychotherapist?	Y N
If yes who and when?	
Have you ever attempted suicide?	Y N
If yes how many times and when did you last try to take your life?	
Do you have any compulsive rituals such as hand washing or checking?	Y N
Have you ever had an eating disorder?	Y N

Substance use history

Alcohol
How many days per week do you drink any Alcohol?
What is the most number of drinks you have in a day?
What is the least number of drinks you have in a day?
Have you ever felt that you needed to cut down your drinking? Y N
Have people annoyed you by criticizing your drinking? Y N
Do you ever drink alcohol in the morning to steady your nerves? Y N
Have you ever had legal, relationship, or work problems related to alcohol? Y N
Nicotine
Do you smoke tobacco? Y N If yes, how many packs per day?
Marijuana
Have you smoked marijuana in the last 3 months? Y N
How many days per week do you smoke marijuana?
Other Substances
Have you used any other prescription or non prescription drugs in the last 3 months except as prescribed by you doctor? Y N
Substance Abuse Treatment
Have you had treatment for alcohol or drug abuse? Y N
If yes please list where and when.

Family Psychiatric History: Please list any family members who have had any of the following.

Condition	No	Yes: List family members
Depression		
Anxiety		
Panic Attacks		
Bipolar Disorder		
Schizophrenia		
Suicide		
Alcoholism		
Drug Dependence		
Eating Disorder		
Obsessive Compulsive disorder		
Attention Deficit Disorder		

Allergies:____

All current medications, over the counter medications and supplements:

Medication	Date started	Side Effects

Medical/Surgical History

Current medical conditions	Previous Non-Psychiatric Hospitalizations	Previous Surgeries

Past Medical History/Family Medical History: Have you or anyone in your family had any of the following illnesses

Illness	You	Family Member: Please specify which ones
Hypertension		
Heart disease		
Thyroid disease		
Liver disease		
Diabetes		
High Cholesterol		
Seizures		
Brain Injury		
Chronic Fatigue		
Chronic Pain		

Menstrual/pregnancy History

Date of Last Menstrual Period:_____________

Are you pregnant or think you may be pregnant:_________

Do you want to become pregnant in the near future:______

Method of Birth control:_______________

Patient Signature: __________________________________Date:_________

Scott Lurie MD

1808 E7th St
Charlotte, NC 28204

Tel (704) 376-6577
Fax (704) 335-8941

STATEMENT OF PATIENT RIGHTS AND RESPONSIBILITIES AND AUTHORIZATIONS FOR CARE AND TREATMENT

This is to help you understand your rights and responsibilities and the level of cooperation that we need from you in order to help you realize the highest level of mental and emotional health of which you are uniquely capable. Our desire is to form a partnership with you regarding your mental health and related issues. Your assistance is crucial, and the interest and commitment that you bring to this partnership are essential to attaining significant resolution to your mental health concerns.

SECTION 1: Your Rights:

You are assured of the following rights:
- The right to be treated with dignity and respect by our staff and treating professionals.
- The right to fair treatment, regardless of your race, religion, gender, ethnicity, age, disability or sexual orientation.
- The right to have your treatment and other patient information kept private.
- The right to know about all your treatment choices, regardless of whether or not those choices are covered by your insurance, and regardless of the cost of those treatment choices, and to participate in the choice of treatment.

SECTION 2: Your Responsibilities

In order to provide you with the best of care, your commitment to your treatment and recovery is essential. We require that patients understand their role and responsibilities in their care:
- You have the responsibility to give Dr. Lurie, your provider, the information needed so that he can deliver the best possible care.
- You have the responsibility to let your treating professional(s) know if or when the treatment plan no longer works for you.
- You have the responsibility to follow your medication plan. You must tell your treating professional(s) about any medication changes, including medications prescribed for you by other health care providers.
- You have the responsibility to give our staff and treating professional(s) the same dignity and respect that you deserve.
- You have the responsibility to refrain from any action that could harm the lives of our employees, treating professionals, and/or other patients.
- You have the responsibility to keep your scheduled appointments. Missing your appointment(s) without proper prior notification could result in charges to your account, and repeated incidences of missed appointments with or without prior notification may result in your being unable to obtain medication refills on time and/or termination of Dr. Lurie's role as your treating professional.
- You have the responsibility to ask your treating professional(s) any questions you may have about your care, so that you can better understand your care and the role you play in that care.
- You have the responsibility to let our staff and your treating professional(s) know about any problems you may have paying your fees for services you are receiving, or plan to receive.
- You have the responsibility to follow your treatment plan and instructions for your care, once that care has been agreed upon by you and your treating professional(s). Failure to comply with your treatment plan may result in your being unable to obtain medication refills on time and/or termination of our role as your treating professional(s).

SECTION 3: By signing at the bottom of this form you acknowledge that you fully understand your rights and responsibilities, and your consent for care and treatment:

I have read and fully understand my rights and responsibilities in my partnership with Scott N. Lurie, M.D., P.A., in providing for my care, and agree to adhere to them, and acknowledge that I have received a copy of this statement. Further, I hereby consent to outpatient treatment and give permission for the physician and/or clinician to provide the services deemed necessary or advisable in the diagnosis and treatment of this patient. I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made as to the result of treatment received in this facility. I understand that the patient has the right to withhold consent to any medical service that is deemed necessary or advisable by the physician and/or clinician. My signature below indicates my understanding and approval of the above.

SECTION 4: Consent to Disclose Information to Primary Care Physician and/or Therapist

I understand that my records are protected under the applicable state law governing health care information that relates to mental health services and under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records 42 CRF Part 2, and cannot be disclosed without my written consent unless otherwise provided for in state or federal regulations. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it.

I, ____________________________________, herby authorize Scott Lurie, MD, PA
Please Print Patient's Name

Please check one:
______To release any applicable information to my Primary Care Physician
______To release any applicable information to my Therapist
______Not to release information to my Primary Care Physician or Therapist

Primary Care Physician's Name:
____
Address: ____ Phone:
____

Therapist's Name:
____
Address: ____ Phone:
____

PATIENT SIGNATURE: ___________________________________DATE:__________

SECTION 5: Financial Policies

Session Fees:
Dr. Scott Lurie does not accept health insurance as a direct form of payment. After your visit, you will be provided with a claim form (super bill) to submit to your insurance carrier for reimbursement. Your insurance provider will reimburse you directly whatever amount they deem is customary and reasonable. Insurance carriers vary widely in how much (or little) they reimburse.
Dr. Lurie is not a Medicare provider, so any patient that has Medicare as their primary insurance will not receive any reimbursement, and cannot submit the claim form to Medicare. In these cases, secondary insurance providers may also not reimburse for patient claims.
Payment is due in full at the time services are rendered. We currently accept Cash, Check, Visa, and MasterCard. All returned checks will be assessed an additional fee of $25.

No Show/ Late Cancellations:
Once an appointment time is scheduled, you will be expected to pay for it unless you provide 24 hour notice of cancellation. This charge is automatic unless we both agree that you were unable to attend due to circumstances beyond your control. All No Show/ Late Cancellations will be charged at the full rate of the scheduled session. You will be invoiced for these charges and payment is appreciated within 30 days.

Additional Charges/ Fees:
Occasionally your account may be assessed additional charges for other services provided by Dr. Lurie, to include, but not limited to, prescription refill requests, medical record requests, and completion of forms. These charges will be billed to you and payment is appreciated within 30 days.

If you have any questions in reference to the Financial Policy of Scott Lurie, M.D., P.A., please feel free to speak with our front office staff. They will be happy to assist you.

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Your signature below indicates that you fully understand the form in its entirety and received a copy of Scott Lurie, M.D., P.A. Notice of Privacy Policies.

Patient Name (Please Print): ____________________________________Date:________
Signature of Patient or Legal Representative:
____

If the patient is unable to consent or is a minor, please complete the following:
Patient is _____ Unable to consent because
____
_____ Minor
_________________________________/________________________________/
____
Responsible Party Signature Relationship Date