CONTEMPORARY CARE
Psychiatric Centers of Excellence

PATIENT HEALTH QUESTIONNAIRE 9 (PHQ 9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	◉ 0	○ 1	○ 2	○ 3
2. Feeling down, depressed, or hopeless	◉ 0	○ 1	○ 2	○ 3
3. Trouble falling or staying asleep, or sleeping too much	◉ 0	○ 1	○ 2	○ 3
4. Feeling tired or having little energy	◉ 0	○ 1	○ 2	○ 3
5. Poor appetite or overeating	◉ 0	○ 1	○ 2	○ 3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	◉ 0	○ 1	○ 2	○ 3
7. Trouble concentrating on things, such as reading the newspaper or watching television	◉ 0	○ 1	○ 2	○ 3
8. 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	◉ 0	○ 1	○ 2	○ 3
9. Thoughts that you would be better off dead or of hurting yourself in some way	◉ 0	○ 1	○ 2	○ 3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, 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**
■	□	□	□

Generalized Anxiety Disorder 7-item (GAD-7) scale

Date: _____ Name: _____ DOB: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	◉ 0	○ 1	○ 2	○ 3
2. Not being able to stop or control worrying	◉ 0	○ 1	○ 2	○ 3
3. Worrying too much about different things	◉ 0	○ 1	○ 2	○ 3
4. Trouble relaxing	◉ 0	○ 1	○ 2	○ 3
5. Being so restless that it's hard to sit still	◉ 0	○ 1	○ 2	○ 3
6. Becoming easily annoyed or irritable	◉ 0	○ 1	○ 2	○ 3
7. Feeling afraid as if something awful might happen	◉ 0	○ 1	○ 2	○ 3
Add the score for each column		+	+	+
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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

Contemporary Care, LLC - New Patient Registration Form

---

1. Patient Information

- **Full Name**: _____ **Date of Birth**:_____
- **Gender**: ☐ Male ☐ Female ☐ Non-binary ☐ Other: _____
- **Address**:
  _____
  _____
- **Cell Phone Number**: _____ **Home Number**:_____
- **Email Address**: _____
- **Occupation**:_____ **Employer:**_____

---

2. Emergency Contact Information

- **Emergency Contact Name**: _____ **Relationship:**_____
- **Phone Number**: _____

---

3. Primary Care Physician (PCP) or Referring Provider (If applicable) and Preferred Pharmacy

- **Primary Care Provider Name**: _____ Phone:_____
- **Referring Provider Name**: _____ Phone:_____
- **Preferred Pharmacy**: **Name and Address**:_____
  - **Phone:** _____

---

4. Insurance Information

- **Primary Insurance Company**: _____
- **Policy or ID Number**: _____
- **Policyholder Name**: _____
- **Policyholder Date of Birth**: _____
- **Relationship to Policyholder**: _____
- **Secondary Insurance (if applicable)**:
  - **Insurance Company**: _____
  - **Policy Number**: _____
  - **Group Number**: _____

---

6. Mental Health and Medical History

- **Reason for Seeking Treatment** (Please describe briefly):

  _____
  _____

- **Past Mental Health Diagnoses** (If applicable):

- **Recent Hospitalizations for Medical or Psychiatric Treatment** (Please list reason for hospitalization, facility name and discharge date):_____

- **Current Medications** (Please list all medications you are currently taking, including psychiatric medications):

- **Previous Psychiatric Treatment** ☐ Yes ☐ No
  If yes, please describe (including type of treatment, therapist, psychiatrist, and dates):

- **Smoking History** (If applicable): (please only check if you are currently using any of these smoking methods)
  - ☐ Cigarettes
  - ☐ Cigars/Pipes
  - ☐ Vaping

---

8. Consent for Treatment

I, the undersigned, hereby consent to the evaluation, diagnosis, and treatment as provided by the mental health professionals at this practice. I understand that treatment may involve both in person and telehealth individual therapy, counseling, or other services deemed appropriate by my therapist/mental health provider. I understand that both audio and video interactions conducted via telehealth are HIPPA compliant and these services meet all CMAP requirements and are clinically and medically appropriate as per section 17b-259b of the CT General Statutes. I understand that I can revoke my consent at any time by informing my provider in writing.

- **Signature of Patient or Legal Representative**: _____**Date**: _____

---

9. Confidentiality and Privacy Acknowledgment

I acknowledge that I have received or been offered a copy of the **Notice of Privacy Practices**, which explains how my health information will be used, disclosed, and protected under **HIPAA**. I understand that my mental health records are confidential and that any information shared will only be released with my written consent, except in specific circumstances allowed by law.

- **Signature of Patient**: _____**Date**: _____

---

10. Financial Responsibility and Billing Policy

I understand that I am responsible for the payment of services rendered by this practice, including co-pays, deductibles, or fees that are not covered by my insurance. I also understand that payment is due at the time of service unless other arrangements have been made. I also understand that I will be responsible for all fees and legal costs incurred by Contemporary Care regarding bill collection. Patient balances, deductibles, coinsurance, copay, no show, late cancellation, returned check fees will be automatically charged each week to the credit card on file if I do not make payment at the time of the appointment.

Additional fees beyond co-payments, deductibles, or fee for service.

A charge of $100.00 will be made for any no show or canceled appointment with less than 24-hour notice

A charge of $30.00 will be made for all returned checks in addition to the original fee.

A charge will be assessed for preparing letters and completing forms if not requested at the time of appointment.

- **Signature of Patient**: _____**Date**: _____

---

11. How Did You Hear About Us?

- ☐ Referral from a Friend or Family ☐ Insurance Network ☐ Online Search ☐ Social Media ☐ Other (Please specify): _____

Credit Card on File – Authorization

Contemporary Care, LLC requests that you keep a credit card on file. You may elect to present alternative payment methods for each service at the time of your appointment. If payment is not made at the time of service, you are authorizing Contemporary Care, LLC to charge your card on file for all remaining balances after your appointment. In the event that your credit card on file is charged, a receipt will be provided to you upon request. Please note that all credit card information is protected. All information is entered in and maintained via a secure credit card portal.

Name on Card:_____

Type of Card (MC, Visa, Discover, AMEX) _____

Credit Card Number:_____

Exp. Date:_____ Security Code:_____

(You may also provide this information in person or over the phone if you do not wish to complete this form)

I authorize Contemporary Care, LLC to retain the credit card information submitted by me via in writing or verbally, for the purpose of charging this card for all payments owed by me after services have been rendered where payment was not made at time of service. I agree to update any information regarding this account as needed.

Cardholder Signature:_____ Date:_____

Thank you for completing your registration form.