DANIEL FILENE, MD
178 MIDDLE STREET
SUITE 300
PORTLAND, ME 04101
PHONE / FAX (207) 774-0046

CLIENT REGISTRATION

Date____________ Name ____

Preferred phone: _______________ [ ] cell [ ] home [ ] work [ ] other
Alright to leave detailed messages on this phone? [ ] yes [ ] no

Other phone: _______________ [ ] cell [ ] home [ ] work [ ] other
Alright to leave detailed messages on this phone? [ ] yes [ ] no

Email address (*optional – please provide if you would like emailed appointment reminders and access to the online self-scheduling system*)

____

Mailing Address: ____

Street Address, if different: ____

Age _______ Date of Birth ______________ Referred by: __________________________________

Address & Phone of referrer, if another provider: ____

____

Current therapist, if not referrer: ____________________ Therapist Phone __________________

Primary care provider: _________________________ PCP Phone ____________________

PCP Address: ____

Pharmacy used, if applicable: _____________________ Pharmacy phone: _______________

Client Employer: ______________________________

Emergency contact (relationship & phone): ____

Person responsible for payment, if other than client (please give address & phone): _________________

____

FAMILY INFORMATION: Please note with an * if you are/were particularly close with a specific person.

	Name	Age	Living with you?	Serious Illnesses	Year deceased
Mother					
Father					
Siblings					
Children					
Spouse/partner					
Previous partner					
Other significant people					

Any experiences, deaths, or major losses in your life that have been particularly difficult for you?

____

____

____

EDUCATION

Degree(s) earned ____

Any learning problems in school? ____

Any behavioral or hyperactivity problems in school? ______________________________

____

RECENT WORK HISTORY: ____

____

MEDICAL HISTORY

Previously diagnosed medical conditions: ____

____

Any history of head injury? ____

Allergies (indicate what sort of reaction to each medication): ____

____

Medications you are currently taking, including dose and frequency

____

____

Psychiatric medications you have taken in the past (indicate if any were especially helpful or caused problems):

____

____

How much alcohol do you drink each day? _________ Week? _________

How many caffeinated beverages (coffee, Coke/Pepsi/etc.) do you drink each day? _______

How much do you smoke each day? __________

PRIOR PSYCHIATRIC TREATMENT

Please describe any prior psychiatric treatment, including any hospitalizations: ____________________

____

____

____

Why are you seeking help at this time? ____

____

What are your goals for treatment? ____

____

____

Name ________________________________ Date ____________

Symptom Checklist

Please check the column that best describes how frequently you have experienced each of the symptoms below. Use the last column to note the three symptoms that bother you the most.

	Never	Rarely	Sometimes	Often	Please note with a check the 3 most bothersome symptoms
Depressed Mood					
Intense Fears (planes, heights, insects, etc.)					
Unwanted or intrusive thoughts					
Doing things over and over (compulsions)					
No memory for blocks of time					
Hearing things not there					
Seeing things not there					
Suspiciousness					
Difficulty sleeping					
Eating difficulties					
Difficulty concentrating					
Reduced/excessive sex drive					
Anxiety					
Feeling panicked					
Frequent nightmares					
Wanting to harm yourself					
Difficulty with memory					
Unusually high energy					
Sexual difficulties					
Excessive drug/alcohol use					
Tremors					

	Never	Rarely	Sometimes	Often	Please note with a check the 3 most bothersome symptoms
Fear of social situations					
Fear of being overweight					
Vomiting/purging					
Difficulty controlling temper					
Aggressive impulses					
Flashbacks					
Excessive risk-taking					
Self-injurious behaviors					
Wanting to harm others					
Disorientation					
Impulsivity					
Low energy					
Low self-esteem					
Mood swings					
Premenstrual symptoms					
Fear of leaving the house					
Problems with partner					
Fear of dying					
Physical pain					
Fear of being sick					
Feeling detached from others					
Addictive behavior					
Feeling uneasy in public					
Other:					

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PSYCHIATRIST – CLIENT SERVICES AGREEMENT

Thank you for your interest in my private psychiatric practice. This document contains important information about my professional services and business practices. Please read it carefully and return a signed copy to me at or prior to our first meeting.

SERVICES

I treat adults and older adolescents for a variety of psychiatric issues, including depression, anxiety, bipolar disorder, addictions, PTSD, grief, adjustment problems, and stress. I have particular interest in treating anxiety-related issues such as obsessions/compulsions, panic attacks, and social anxiety. However, what brings you to seek help may simply be a sense that something is wrong, troubling, or less than ideal in your life; we can work together to define such issues and help you overcome them.

I provide both psychotherapy and medication management. Many clients find it advantageous to see the same individual for both therapy and medications. Other clients see me for medication management while continuing to work with a separate psychotherapist. Either plan can work well.

Please see my website (www.danfilenemd.com) for additional information about treatments I offer.

PRACTICE STRUCTURE

I work in an office suite with other independently-practicing mental health professionals. While I share office space with them, I am independent of other professionals in providing you with clinical services.

OFFICE HOURS

I am generally at my office Monday to Thursday, 9am – 5pm. However, these days and times vary depending on my client and personal schedule. I also occasionally am out of the office to provide services at Riverview Psychiatric Center.

INITIAL EVALUATION PHASE

Our first meeting will last approximately 1 1/4 hours. We will discuss the issues that have led you to seek assistance, your past history, current life status, and treatment goals. By the end of this meeting, my goal is to provide you with a sense of whether and how I may be able to help you. We may be able to work out an initial plan of treatment by the end of this meeting, but often an additional meeting or two is needed to fully develop a plan.

ONGOING SESSIONS

The nature and frequency of our ongoing meetings depends on a variety of factors:

If you will be seeing me primarily for medication management, we will usually meet for 20-30 minute sessions (after the evaluation phase). These meetings may occur as often as weekly (during initial medication trials, at times of particular medication problems, or during periods of stress) or as infrequently as three times a year (if you are feeling well and your medications are stable.) Except in unusual circumstances, we will need to meet at minimum once every four months; this is essential for maintaining good contact and oversight of your medications.

If you will be seeing me for psychotherapy, we will generally meet for 50 minute sessions on a more regular basis, often 2-4 times monthly. The exact frequency depends on your needs and preferences.

CONTACTING ME
The best way to contact me is generally my office phone (774-0046). If I am in the office and not with a client, I will answer the phone in person. Otherwise, please leave a message. I do generally check messages daily when out of the office, but if the matter is not urgent I may not return your call until I am back at the office.

Email is often the most efficient way to reach me for very routine matters such as scheduling appointments and requesting medication refills. My email address is drfilene@gmail.com. You may also access email to me via the "Contact Me" page on my website, www.danfilenemd.com. Please consider that email may have a lower level of privacy than the telephone; if you choose to use email, please do not use it to communicate about sensitive clinical matters.

In an urgent situations, please see "Emergencies", below.

MEDICATION REFILLS
It is our shared responsibility to ensure that you do not run out of your medications between appointments. It is safest and most efficient for me to write you new prescriptions when you are at the office in person, so please check on your supply of medication (and refills) prior to our office visits.

If you are running low on medication between visits, ***please contact me at least five days before you run out***. This ensures that I will have time to access your file, call in your prescription, and sort out any problems that might arise. As I will sometimes be out of the office when I receive your request for a refill, you can help me fill your prescription completely quickly if you leave ***all*** of the following information in your message:

☐ Your date of birth
☐ Your pharmacy phone #
☐ Your phone #
☐ The full medication name (e.g., Effexor XR, Ambien CR)
☐ The medication strength (e.g., 1mg, 20mg)
☐ The exact way you take the medication (e.g., "one-half tablet in the morning and two tablets at night.")

If I do not have all of this information, I will not be able to call in your prescription until I am at the office with your file, which may mean a delay of several days (e.g. if you call on Thursday evening and I am not in the office until Monday morning.)

EMERGENCIES
As a private solo practitioner, I do not have continuous "crisis management" services other than myself. If you anticipate (or have had a history of) needing frequent crisis services, you may be better served by working with an agency that can provide more comprehensive coverage from a variety of practitioners; this is something we can discuss during your initial visit.

However, I do strive to be available to clients whenever there is an urgent situation, and encourage you to contact me whenever a crisis arises. Please take the following steps to reach me in an emergency:
1) During usual office hours (M-F, 9-5), first call my office (774-0046). If I do not answer, leave a brief message stating that you have an urgent problem.
2) If you did not reach me at the office, or if after hours / weekend, call my cell phone (329-3888). If I do not answer, either leave a voice message or press "5" to leave a page.
3) If you still have not reached me, have not heard back from me quickly, and are in a hazardous situation, please do one or more of the following:
   a) If you are in Cumberland County, call the Cumberland County Crisis line at 774-HELP (774-4357) or 1-888-568-1112
   b) If you are outside of Cumberland County, call 1-888-568-1112
   c) Go to the nearest hospital emergency room, or,
   d) Call 911

Please know that having strong thoughts or impulses to harm yourself (or others) *is* a medical emergency; in such a situation it is completely appropriate to contact 911 or seek help at an emergency room. The personnel there will be able to get you help in a crisis.

PRIVACY
I believe privacy is a critical component of psychiatric treatment. Unless you are confident that the information you share with your psychiatrist is completely confidential, you will be held back from achieving your goals. I believe that operating as a solo private practitioner affords my clients the highest level of privacy protection. At larger clinics or agencies your personal information may be seen by receptionists, administrative assistants, dictation typists, billing clerks, etc. This is not the case in my practice; I am the only person with access to your file. As a rule, unless you provide specific authorization, I will release no information about you to anyone.

For details, including emergency exceptions to confidentiality, please see my full Privacy Policy. I will provide this to you at or before our first meeting. The policy is also available on the "Privacy" and "Forms" pages of my website.

PAYMENT
My practice operates on a fee-for service basis. This means that your fee for each meeting will be due at the session. In certain circumstances we can arrange a billing situation (for example, if another person will be paying for your treatment.) As payment I accept personal checks (preferred) or cash.

FEES
Initial Evaluation, 90 minutes: $300
Follow-up, 50 minutes: $175 (therapy only) / $225 (therapy & medication management)
Follow-up, 20-30 minutes: $125
Writing of reports, letters, etc. $150/hr
Telephone calls: No fee for brief calls. Calls >10 minutes pro-rated at hourly rate.
Legal services: Please contact me for fees.

Suboxone Initial Evaluation & Induction: $350

INSURANCE
I do not participate directly in any insurance networks or HMO panels. I find that involving insurance companies in mental health care can compromise the quality of care and clients' privacy. However, I can provide you with a detailed service receipt at each of our meetings, and many of my clients are able to obtain at least partial reimbursement for my services by submitting these receipts to their insurance companies. Many of my clients also now have insurance coverage with high annual deductibles or healthcare savings accounts; payments for my services may help count towards your deductible or be reimbursable to you from your HSA. You may wish to contact your insurance company to inquire about these matters prior to beginning treatment with me.

Even if you have insurance, you may wish to consider whether it might be worthwhile paying out-of-pocket for mental health services. To read further, please see the "Privacy" page of my website.

I regret at this time I am not able to accept any new clients who have Medicare or MaineCare.

CANCELLATIONS
When you make an appointment with me, it is time that I reserve exclusively for you. Barring emergencies, I will be ready to see you at our scheduled time. I do not double-book or over-book my schedule.

Because of this, I ask that you provide me with as much notice as possible should you need to cancel or change an appointment, by calling my office phone at 774-0046 (please do *not* contact me on my cell phone for cancellations; cell phone is for urgent/emergency situations only.)

My cancellation policy is as follows:

Cancellation 24 hours or more before appointment:	**No charge**
Cancellation less than 24 hours before appointment:	**$50.00**
Cancellation without notice (no-show):	**$75.00**

The associated fee must be paid prior to our rescheduling an appointment.

In case of extreme weather conditions *only*, you may request that we hold our meeting by telephone instead of in person. In such case, please call my office at or before your scheduled appointment time to let me know.

VACATIONS

I believe that changes of scenery, travel, and new experiences are beneficial to mental health. I encourage my clients to take vacation time away from their routine lives, and I do so myself from time to time. If I will be away for more than a short period of time, and/or if I will not be able to check messages or respond to my cell phone, I will leave information about my absence on my office telephone message, as well as on the homepage of my website. If I will be away and/or unavailable for an extended period, I will generally arrange clinical coverage with a colleague. Information on how to contact the covering colleague will also be found on my phone message and website. In certain cases, such as if you are experiencing acute problems at the time I am leaving for an absence, I may ask your permission to discuss your situation with my covering colleague prior to my departure. This will make it much easier for him or her to help you, if needed, while I am away.

RISKS ASSOCIATED WITH TREATMENT

Please be aware that there can be risks associated with both psychiatric medications and psychotherapy. It is my goal to protect your safety and well-being at all times. However, in many situations progress cannot be made without assuming some risk of adverse effects.

1) Risks associated with medications

All medications can have side-effects, some of which may be quite serious. Prior to starting any new medication, it is my responsibility to discuss with you the most common and most serious potential side-effects, and to help you weigh these risks against the potential benefits. I will answer any questions you may have about the medications I recommend, at any time. Please be aware, however, that I cannot practically inform you of every possible side effect of each medication.

Your responsibility lies in keeping me informed of any serious side-effects you experience, changes in your medical conditions, and new medications prescribed by other providers. I may also ask you to complete a written consent form for some medications.

I encourage you to read more information about specific medications you are taking. Please visit the links found on the "Pharmacology" page of my website, or ask me for direction to resources for more information.

2) Risks associated with psychotherapy

Many forms of psychotherapy carry risks of short-term emotional discomfort or anxiety in the process of achieving long-term improvement. For example, our work may at times cause you to experience distressing or painful memories, to expose yourself to situations or sensations that are anxiety-provoking, or to practice challenging new ways of thinking or behaving. However, these "side-effects" of therapy should not become intolerable or hazardous to you. If you feel that they are becoming so, please let me know immediately.

LIMITS TO OUR RELATIONSHIP
When we negotiate a treatment plan, we will discuss the nature and scope of our relationship. Please understand that in following the standards of my profession and the ethical guidelines of the American Psychiatric Association, I can only be your psychiatrist. I cannot have other roles in your life, such as friend, romantic partner, or client of your work or services.

As we live in a relatively small community, it is entirely possible that we will encounter each other outside of the office setting, for example at a restaurant or theatre. To protect your privacy in such circumstances, it is my policy not to acknowledge you first; please do not misunderstand this as a lack of recognition or caring! If you wish to acknowledge me and exchange a brief greeting, that is perfectly fine.

STATEMENT OF PRINCIPLES
I strive to comply with the advisories and ethical principles of American Medical Association and the American Psychiatric Association. If you have concerns about our work together, please let me know. If you feel that I, or any other medical or mental health professional, has treated you unfairly or unethically, please tell me.

Your signature below indicates that you have read this agreement and agree to abide by its terms. You have the right to revoke this agreement in writing at any time.

___________________________________ _______________
Signature of Client / Parent / Guardian Date

____
Printed Name

___________________________________ _______________
Daniel R Filene, MD Date

Daniel Filene, MD
178 Middle Street, Suite 300
Portland, ME 04101

ABOUT PRIVACY AND CONFIDENTIALITY IN MY PRACTICE

This notice describes the privacy procedures of my private psychiatry practice.

It is of the utmost importance to me that information about you, my client, remains absolutely confidential whenever possible. I believe that this is a critical element in developing the trust and openness essential in the process of addressing mental health issues. Unless you explicitly notify me otherwise, I will generally assume that you wish your personal information to remain strictly confidential. In any situation where I believe that release of information would be beneficial, it is my usual practice to request your written consent via a Release of Information (ROI).

To maximize your privacy, I do not involve other individuals or agencies in billing, scheduling, or other administrative aspects of my practice. I feel this provides you with a higher level of confidentiality than would be possible in a larger clinic or group practice. In the routine course of my practice, no one but me will access any of your demographic or clinical information.

If you are seeing a psychotherapist in addition to me, I will generally request your permission to remain in touch with that person. I may also ask your permission to allow contact with your primary care physician or others whose care may interact critically with our work. It is of course your choice whether to permit such contact or not.

The greatest level of privacy can be obtained by not involving insurance companies in your mental health care. However, if you request, I will supply you with invoices for our sessions, which you may submit to your insurance company seeking reimbursement. This allows you the greatest control over where and when any information about you is released. Please know that insurance companies *require* a diagnosis and description of the service rendered in order to cover any costs; this information will be indicated on my invoice.

There are unusual circumstances in which the law may require a health professional to release information about you without your authorization. These situations are very rare and I will work relentlessly to avoid them. Such situations include: (1) If I have reason to believe that you pose a direct threat of imminent harm to any individual (including yourself), and (2) If I have reason to believe that abuse or neglect of a child, elder, dependent or disabled person is taking place.

Finally, although client/psychiatrist communications are generally protected as confidential under the law, I may be required to use or disclose information about you in the course of a judicial or legal proceeding if I am ordered by a court to do so. I also reserve the right to use and disclose information about you if doing so is necessary to defend myself in legal action brought against me in relation to your care.

By signing, I acknowledge that I have received and reviewed a copy of this Notice of Privacy Practices.

____
Client (or Parent/Guardian, if applicable)

____
Date

Daniel Filene, MD
178 Middle Street
Portland, ME 04101
Phone/Fax (207) 774-0046
www.danfilenemd.com

MEDICARE / MAINECARE STATEMENT

I certify that I do not have healthcare coverage under Medicare Part B or Medicaid (MaineCare). Should I obtain such coverage in the future, I agree to notify Dr. Filene prior to the coverage becoming active.

____
Client name

______________________________ ________________
Signature Date