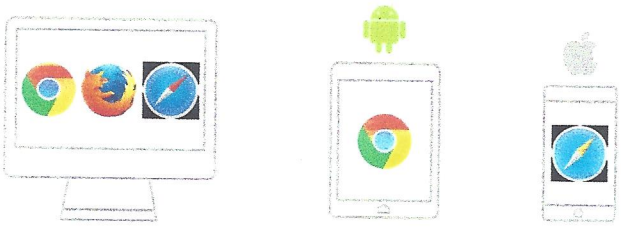
GETTING STARTED FOR PATIENTS

How to check in for your video visit

1 Use a computer or device with camera/microphone



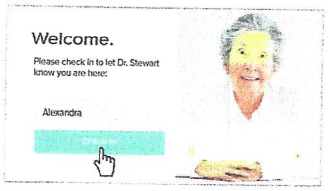
PC and Mac
Chrome | Firefox | Safari

Android
Chrome

iOS
Safari

2 Enter your clinician's doxy.me web address into the browser

3 Type in your name and click check in



- ✓ Secure
- ✓ No software to download
- ✓ HIPAA compliant
- ✓ No registration needed

4 Allow your browser to use your webcam and microphone

5 Your care provider will start your visit

Call Tips

- Have a good internet connection
- Restart your device before the visit
- Use the Start Test button in the waiting room
- Need help? Send us a message https://doxy.me

Phone 631-467-0867 Fax 631-467-0892

Marie G. Surpris, D.O.

Child, Adolescent and Adult Psychiatrist

BienÊtre

MEDICAL INFORMATION REQUEST

DATE: _____

TO: _____

TEL: _____

PATIENT: _____

Dear Doctor,

Please forward any recent bloodwork (within the past year) for this patient to the above fax number.

Thank you for your cooperation.

Marie G. Surpris, D.O.

* Please forward to your doctor.

Attention Patients:

Along with email reminders, we will be offering text reminders for your up-coming appointments.

This is a courtesy. It remains your full responsibility to remember your appointment and give 24-hour notice if you are unable to attend.

Missed appointments will be automatically charged in full as per office policy.

Please sign below, giving us permission to send you your appointment reminders.

Cell #: _____ **OPT OUT** ☐

Email address: _____ **OPT OUT** ☐

Patient Name: _____

Signature_____ **Date:**_____

Phone 631-467-0867 Fax 631-467-0892

Marie G. Surpris, D.O.

Child, Adolescent and Adult Psychiatrist

BienÊtre

Date: _____

Patient Name_____ Age_____ Date of Birth_____

Parent or Legal Guardian's Name: _____D.O.B: _____

Address: _____Zip: _____

Home Phone: _____ Work Phone: _____

Cell Phone: _____

Insurance: _____ID#_____

BIN: _____ PCN: _____ GROUP: _____

Pharmacy: _____ Phone: _____

Address: _____Zip: _____

_____

Signature (Patient/Legal Guardian)

Credit Card Agreement

Please print clearly.

Patient:_____

D.O.B:_____

Address:_____

Phone:_____

CC#_____

EXPIRATION: _____

CODE: _____(3/4 digit # on back of card)

I agree for Dr. Marie Surpris to keep my credit card information on file for payments of missed and Telemedicine/Facetime appointments.

Dates of Service:

_____ _____ _____ _____

_____ _____ _____ _____

_____ _____ _____ _____

SIGNATURE:_____

DATE:_____

Marie G Surpris, D.O.

Phone: 631-467-0867 / Fax: 631-467-0892

Permission for Telehealth Visits

Telehealth is a way to visit with healthcare providers, such as your doctor or nurse practitioner.

You can talk to your provider from any place, including your home. You don't have to go to a clinic or hospital.

You talk to your provider by phone, computer, or tablet using video so you and your provider can see each other.

We will not record visits with your provider.

- If people are close to you, they may hear something you did not want them to know. You should be in a private place, so other people cannot hear you.
- We use telehealth technology that is designed to protect your privacy.
- If you use the Internet for telehealth, use a network that is private and secure.

If you sign this document, you agree that:

- We talked about the information in this document.
- We answered all your questions.
- You want a telehealth visit.

Your name (please print) Date

Signature

21 E. Second Street, Suite 102
Riverhead, N.Y. 11901

2233 Nesconset Hwy. Suite 100
Lake Grove, N.Y. 11755

Phone 631-467-0867 Fax 631-467-0892

BienÊtre

Marie G. Surpris, D.O.

Child, Adolescent and Adult Psychiatrist

Office Policy

At this Evaluation Center, we strive for efficient and quality care. To ensure the best medical care possible, we have adopted the following office policy:

1. Appointments are scheduled on a **monthly** basis, unless otherwise specified. Follow-up appointments of 30- minutes-$200. *If 3 months' laps between appointments then a one- hour appointment will be needed to continue treatment. Lapses longer than 3 months will result in a discharge from this practice.*

2. We do not over book our appointments. **The appointment time given to you is your time- please be prompt.**

3. You may receive a courtesy **text and** email to remind you of your appointment, however, **you are responsible to remember your appointment**. *Unless an appointment is cancelled with at least 24-hour notice, payment for the visit is due in full.*

4. We expect payment in full at the time of your visit. We accept credit cards and checks payable to *Dr. Marie Surpris*. *If a check is returned with insufficient funds, only a cash or certified check will be accepted thereafter.*

5. A charge of $20 for bank fees is required for any check returned.

6. To adequately monitor treatment and compliance with medication policy, scripts will be called in only for a one week supply or at the doctor's discretion.

A credit card number must be provided and on file for Telemedicine, phone or missed appointments.

Marie G. Surpris, D.O.

Patient Initial: _____

631-467-0867 Fax 631-467-0892

Marie G. Surpris, D.O.

Child, Adolescent and Adult Psychiatrist

BienEtre

Policy for Missed Appointments

It is important for all patients to attend all appointments scheduled. Missed or cancelled appointments are counterproductive and slow down the treatment. When you do not show up for a scheduled appointment, it creates an unused appointment slot that could have been used for another patient. It is very important that you call within 24 hours in advance to cancel your appointment.

Our policy is to hold you responsible for all missed appointments not cancelled 24 hours in advance. **All missed appointments will be billed In full directly with your credit card on file.**

If needed **the option of a phone conference for 30 minutes at the time of the appointment can be made and prescriptions will then be electronically prescribed.**

I have read and **understand** the above statement. I understand that I will be billed for all avoidable missed appointments and late communications. I agree to be responsible for paying for them.

A credit card # must be provided and on file for phone, Telemedicine and missed appointments.

_____ _____

Client or Parent/ Guardian's Signature Date

Phone 631-467-0867 Fax 631-467-0892

Marie G. Surpris, D.O.

Child, Adolescent and Adult Psychiatrist

BienEtre

CONSENT FOR RELEASE OF INFORMATION

Date: _____

Name of Patient: _____

D.O.B.:_____

Extent or nature of information to be disclosed:

_____

From: (Doctor, Therapist or Organization disclosing information):

Name:_____Tel.#_____

Address:_____

Name:_____Tel.#_____

Address:_____

To: Dr. Marie G. Surpris, D.O.

I understand that I have the right to revoke this consent at any time except to the extent that action has been taken thereon. I also understand that my consent will expire when acted upon, or six (6) months from this date, whichever occurs first.

I understand that such disclosure is bound by Title 42 of the Code of Federal Regulations governing the confidentiality of the patient records, when applicable. Title 42 prohibits you from making any future disclosure of this information without my specific written consent, or as otherwise permitted by such regulations. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

_____

Signature of Parent/Guardian Date

ADHQ (Self- Report)

Last Name_____ First Name_____ Date_____

Birth date_____ Age_____ Grade_____

1. Did you ever have trouble staying in your seat? At school? At work? At home? (e.g. during dinner)? Yes □ No □

2. Were you always moving in your chair? Were you always told to stop or to sit still? Yes □ No □

3. Was it ever difficult for you to play quietly? Did you ever get in trouble for not playing quietly? Yes □ No□

4. Did you talk a lot? All the time? More than other kids? Was it ever a problem? Yes □ No □

5. Did you often do one thing and then start something else without finishing the first thing? (e.g. house chores) What about starting on a game and running off to do something else? Yes □ No□

6. Did you ever have trouble paying attention? Do you usually have trouble keeping your mind on schoolwork or a project? Yes □ No□

7. Did you ever have trouble finishing things (e.g. homework, chores)? Did you have trouble following instructions? Did the teacher ever have to tell you what to do after the rest of the class had already started doing it? Yes □ No□

8. Could almost anything get your mind off of what you were doing? At school? At work? In a game? When there were noises or people moving around in the room, did you have trouble sticking to what you were doing? Yes □ No□

9. Did you talk when others were talking without waiting until they were finished? Do you do this a lot? Yes □ No□

10. Did you ever give answers to questions before someone finished asking? Did you call out answers in school without the teacher called on you? Yes □ No□

11. Was it hard for you to wait your turn while playing with other kids? Did you push in line? Was it hard to wait in line at the store or at the movies? Yes □ No□

12. Did you get in trouble because you rushed into doing things without thinking about what might happen? Like running into the street without looking? Yes □ No□

13. Did you often lose things? (e.g. toys, books, etc.)? How often? What about losing papers from school, like permission slips? Yes □ No□

14. Did your parents or your teachers ever complain that you did not listen to them? How often? Yes □ No□

Marie G. Surpris, D.O.
Child, Adolescent and Adult Psychiatrist

BECK'S ANXIETY SCALE

Date:_____

Last Name_____ First Name_____

Please check your answer.

MILDLY= **It did not bother me much.**
MODERATELY= **It was unpleasant but I could stand it.**
SEVERELY= **I could barely stand it.**

	Not at all	Mildly	Moderately	Severely
!. Numbness or tingling	☐	☐	☐	☐
2. Feeling hot.	☐	☐	☐	☐
3. Wobbliness in legs.	☐	☐	☐	☐
4. Unable to relax.	☐	☐	☐	☐
5. Fear of the worst happening.	☐	☐	☐	☐
6. Dizzy or lightheaded.	☐	☐	☐	☐
7. Heart pounding or racing.	☐	☐	☐	☐
8. Unsteady.	☐	☐	☐	☐
9. Terrified.	☐	☐	☐	☐
10. Nervous.	☐	☐	☐	☐
11. Feeling of choking.	☐	☐	☐	☐
12. Hand trembling.	☐	☐	☐	☐
13. Shaky.	☐	☐	☐	☐
14. Fear of losing control.	☐	☐	☐	☐
15. Difficulty breathing.	☐	☐	☐	☐
16. Fear of dying.	☐	☐	☐	☐
17. Scared.	☐	☐	☐	☐
18. Indigestion or discomfort in abdomen.	☐	☐	☐	☐
19. Faint.	☐	☐	☐	☐
20. Face flushed.	☐	☐	☐	☐
21. Sweating (not due to heat).	☐	☐	☐	☐

Date Reviewed_____

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (☑) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...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?	◯	◯
...you were so irritable that you shouted at people or started fights or arguments?	◯	◯
...you felt much more self-confident than usual?	◯	◯
...you got much less sleep than usual and found you didn't really miss it?	◯	◯
...you were much more talkative or spoke faster than usual?	◯	◯
...thoughts raced through your head or you couldn't slow your mind down?	◯	◯
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	◯	◯
...you had much more energy than usual?	◯	◯
...you were much more active or did many more things than usual?	◯	◯
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	◯	◯
...you were much more interested in sex than usual?	◯	◯
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	◯	◯
...spending money got you or your family in trouble?	◯	◯
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

Depression

Nearly 20 million Americans experience depression,[1] but many will never seek treatment. The Depression Self-Rating Test is a simple 16-question quiz that can help identify common symptoms of depression and their severity. Remember—depression is more than just feeling down—it is a real medical condition that can be effectively treated.

Please complete the following questionnaire and return it to your healthcare provider.

Name:_____ Date of Birth:_____ Today's Date:_____

Instructions: Please circle the one response to each item that best describes you for the past seven days.

1. *Falling asleep:*
   - 0 I never take longer than 30 minutes to fall asleep.
   - 1 I take at least 30 minutes to fall asleep, less than half the time.
   - 2 I take at least 30 minutes to fall asleep, more than half the time.
   - 3 I take more than 60 minutes to fall asleep, more than half the time.

2. *Sleep during the night:*
   - 0 I do not wake up at night.
   - 1 I have a restless, light sleep with a few brief awakenings each night.
   - 2 I wake up at least once a night, but I go back to sleep easily.
   - 3 I awaken more than once a night and stay awake for 20 minutes or more, more than half the time.

3. *Waking up too early:*
   - 0 Most of the time, I awaken no more than 30 minutes before I need to get up.
   - 1 More than half the time, I awaken more than 30 minutes before I need to get up.
   - 2 I almost always awaken at least one hour or so before I need to, but I go back to sleep eventually.
   - 3 I awaken at least one hour before I need to, and can't go back to sleep.

4. *Sleeping too much:*
   - 0 I sleep no longer than 7–8 hours/night, without napping during the day.
   - 1 I sleep no longer than 10 hours in a 24-hour period including naps.
   - 2 I sleep no longer than 12 hours in a 24-hour period including naps.
   - 3 I sleep longer than 12 hours in a 24-hour period including naps.

5. *Feeling sad:*
   - 0 I do not feel sad.
   - 1 I feel sad less than half the time.
   - 2 I feel sad more than half the time.
   - 3 I feel sad nearly all of the time.

6. *Decreased appetite:*
   - 0 There is no change in my usual appetite.
   - 1 I eat somewhat less often or lesser amounts of food than usual.
   - 2 I eat much less than usual and only with personal effort.
   - 3 I rarely eat within a 24-hour period, and only with extreme personal effort or when others persuade me to eat.

7. *Increased appetite:*
   - 0 There is no change from my usual appetite.
   - 1 I feel a need to eat more frequently than usual.
   - 2 I regularly eat more often and/or greater amounts of food than usual.
   - 3 I feel driven to overeat both at mealtime and between meals.

8. *Decreased weight (within the last two weeks):*
   - 0 I have not had a change in my weight.
   - 1 I feel as if I've had a slight weight loss.
   - 2 I have lost 2 pounds or more.
   - 3 I have lost 5 pounds or more.

9. *Increased weight (within the last two weeks):*
   - 0 I have not had a change in my weight.
   - 1 I feel as if I've had a slight weight gain.
   - 2 I have gained 2 pounds or more.
   - 3 I have gained 5 pounds or more.

10. Concentration/Decision-making:

0 There is no change in my usual capacity to concentrate or make decisions.

1 I occasionally feel indecisive or find that my attention wanders.

2 Most of the time, I struggle to focus my attention or to make decisions.

3 I cannot concentrate well enough to read or cannot make even minor decisions.

11. View of myself:

0 I see myself as equally worthwhile and deserving as other people.

1 I am more self-blaming than usual.

2 I largely believe that I cause problems for others.

3 I think almost constantly about major and minor defects in myself.

*12. Thoughts of death or suicide:**

0 I do not think of suicide or death.

1 I feel that life is empty or wonder if it's worth living.

2 I think of suicide or death several times a week for several minutes.

3 I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have actually tried to take my life.

13. General interest:

0 There is no change from usual in how interested I am in other people or activities.

1 I notice that I am less interested in people or activities.

2 I find I have interest in only one or two of my formerly pursued activities.

3 I have virtually no interest in formerly pursued activities.

14. Energy level:

0 There is no change in my usual level of energy.

1 I get tired more easily than usual.

2 I have to make a big effort to start or finish my usual daily activities (for example: shopping, homework, cooking, or going to work).

3 I really cannot carry out most of my usual daily activities because I just don't have the energy.

15. Feeling slowed down:

0 I think, speak, and move at my usual rate of speed.

1 I find that my thinking is slowed down or my voice sounds dull or flat.

2 It takes me several seconds to respond to most questions, and I'm sure my thinking is slowed.

3 I am often unable to respond to questions without extreme effort.

16. Feeling restless:

0 I do not feel restless.

1 I'm often fidgety, wringing my hands, or need to shift how I am sitting.

2 I have impulses to move about and am quite restless.

3 At times, I am unable to stay seated and need to pace around.

* If you or someone you know has thoughts of suicide, seek professional help immediately through your healthcare provider, or call 411 to get the phone number for the nearest local suicide hotline.

To Score:

Enter the highest score on any 1 of the 4 sleep items (1–4)	____
Item 5	____
Enter the highest score on any 1 appetite/weight item (6–9)	____
Item 10	____
Item 11	____
Item 12	____
Item 13	____
Item 14	____
Enter the highest score on either of the 2 psychomotor items (15 and 16)	____
TOTAL SCORE (Range 0–27)	____

Higher scores show the presence of symptoms that might be consistent with depression and indicate the need for an evaluation by a healthcare provider. Only a doctor can diagnose depression because there are other clinically relevant factors that must be considered to diagnose depression. Return this questionnaire to your doctor for formal evaluation

Reference: 1. National Institute of Mental Health website. Depression Research at the National Institute of Mental Health Fact Sheet. Available at: http://counselingresource.com/quizzes/qids-depression/index.html. Accessed November 28, 2004.

Marie G. Surpris, D.O.

Child, Adolescent and Adult Psychiatrist

LIFE HISTORY QUESTIONNAIRE (Adult)

Date:_____

Last Name: _____ **First Name:**_____

D.O.B: _____**Age:** _____ **Gender:** *M* ☐ *F* ☐

CHIEF CONCERNS

Please describe the reason for which you are consulting:

MEDICAL HISTORY (if you check a box, please give details below):

☐ Any operations?	☐ Any major illnesses?	☐ Family medical problems
☐ Any hospitalizations	☐ Any serious accidents or head injuries?	☐ Any activity restrictions
☐ Any allergies		☐ Wears glasses or contacts?
☐ Asthma?	☐ Any bad reactions to medicines	☐ Uses a hearing aid?
☐ Chronic ear infections?	☐ Any seizures?	☐ Other medical problems

_____

_____

Current Medical Care:

Primary Care Doctor: _____ Tel._____

Address: _____

Date of last physical exam: _____ (If possible bring a copy)

Current Mental Health Professional (s): Does not apply: ☐

1._____ Tel._____

Profession_____

Counseling or therapy?_____ Medication?_____ Group?_____

Other service?_____ Date started:_____

2._____ Tel._____

Profession_____

Counseling or therapy?_____ Medication?_____ Group?_____

Other service?_____ Date started:_____

Current Medications:

List all medicines you are currently taking, both psychiatric and other (e.g., for asthma, allergies, contraception, etc)

Name of Medication	Dose	Date began	Reason for medication	Response (benefits & side effects)

Were you ever **hospitalized** before? Please give place, dates, and reasons

_____

_____

_____

FAMILY

Parents: *(Adoptive parents should provide as much information in this section as they know about birth parents, and enter "unknown" for items they don't have information about).*

Biological mother's name_____ Age: _____

Occupation:_____ Highest education_____

Please note any history of mother (continue on back if needed):

[1] School or learning problems _____

[2] Psychological treatment (please note dates, type of problem, and medications, if any) _____

_____

[3] Psychiatric hospitalization_____

[4] Alcohol or drug abuse_____

[5] Legal problems _____

[6] Life-threatening or other serious illness in past _____

Biological father's name_____ Age:_____

Occupation:_____ Highest education_____

Please note any history of father (continue on back if needed):

[1] School or learning problems _____

[2] Psychological treatment (please note dates, type of problem, and medications, if any) _____

_____

[3] Psychiatric hospitalization_____

[4] Alcohol or drug abuse_____

[5] Legal problems _____

[6] Life-threatening or other serious illness in past _____

_____

Parents are currently:

[1] Married ☐ [2] Unmarried ☐ [3] Separated ☐

[4] Divorced ☐ Date_____

Father remarried? ☐ Mother remarried ☐ Deceased ☐

ARE YOU:

Single ☐ Married ☐ Divorced ☐ Widow ☐

Husband's / Wife's name _____ Age _____

Occupation _____ Highest Education _____

Please note any history of husband/wife:

[1] School or learning problems _____

[2] Psychological treatment (please note dates, type of problem, and medications, if any) _____

_____

[3] Psychiatric hospitalization_____

[4] Alcohol or drug abuse_____

[5] Legal problems _____

[6] Life-threatening or other serious illness in past _____

_____

Children at home? Yes ☐ No ☐

Name	Age	Relation	School & Grade or occupation	Sp. Ed. Services?	Mental Health Services?

Previous Evaluation and Treatment:

Please list below any professionals you may have consulted in the past.

Name of Doctor, Agency Hospital, etc.	Location (City, State)	Dates (Mo/Yr)	Briefly explain service provided

Please list below all psychiatric medications you have taken in the past.

Name of Medication	Highest Dose	Dates	Reason for Medication	Benefits and side effects

Employment History

Employer	Location	Dates	Comments

Social and Leisure:

What activities do you enjoy?_____

_____

_____

_____

List your talent, special abilities, and strengths. _____

_____

_____

_____

Do you belong to any groups, teams or organizations? _____

_____

_____

_____

_____

_____

FAMILY PSYCHOLOGICAL HISTORY

It is helpful to know if your relatives have any history of mental health difficulties.

	Parents	Siblings	Grand-parents	Aunts/ Uncles	Cousins
Schizophrenia					
Depression					
Bipolar disorder of Manic-Depression					
Very anxious or nervous					
Alcohol abuse					
Drug abuse					
Autism					
Obsessive-compulsive					
Mental retardation					
Panic attacks					
Bahavior problems					
Learning problems					
Tics					
Attention-Deficit Hyperactivity					
Legal problems					
Had a problem, but not sure what it was					