Robert F. McFadden, M.D. License: MD422714
1315 Walnut Street, Suite 1619 (215) 901-4766
Philadelphia, PA 19107 NPI: 1790162725

Please read and initial all sections.

AGREEMENT FOR TREATMENT

I am requesting treatment from Dr. Robert McFadden for myself. I understand that treatment is voluntary and that I may discontinue at any time. The fee for the initial consultation (45-60 minutes) is $450. The fees for ongoing follow up sessions is: $125 for a 15-minute session, $175 for a 30-minute session, and $225 for a 45-minute session. **I understand that this is a fee for service practice and Dr. McFadden does not accept insurance as partial or full payment. Payment is either check, cash, or a credit card kept on file by Dr. McFadden.** Dr. McFadden charges credit cards on file within 14 days of the end of each month. Please make out your check before the session begins so that our time will be used best.

*Initials*_____

CONFIDENTIALITY

All information I share with Dr. McFadden is strictly confidential unless I specifically authorize a release in writing or in compliance with certain legal requirements. This includes information shared with other health professionals. Dr. McFadden is required to inform others to take protective measures if a patient presents a physical danger to self or others, or if child or elder abuse is suspected. If I have any concerns about this, I will discuss them with Dr. McFadden.

*Initials*_____

MISSED APPOINTMENTS

I will make every effort to make appointments at the agreed time. If the appointment is not kept, and not cancelled with 24 hours advance notice, I understand I will be billed $125 for the missed appointment. Dr. McFadden will make exceptions for medical emergencies or other seriously urgent matters (that we agree are an unpredictable emergency). If I have any questions regarding this policy, I will ask Dr. McFadden.

*Initials*_____

TELEPHONE CONSULTATIONS

I understand telephone consultations may be suitable or even needed at times during treatment. If a brief call is all that is needed, there is no charge. If a call requires more than 10 minutes, I will be charged at the regular rate.

*Initials*_____

RESPONSIBILITY FOR PAYMENT

I agree that all fees I incur for services rendered by Dr. McFadden, regardless of my insurance coverage, are my responsibility. I understand that all fees are due and payable at the time of my appointment.

*Initials*_____

Patient Signature_____ Date_____

Name:

Address:

Phone number:

Emergency contact:

Date of birth:

How you found my practice:

Insurance and ID # (for prior authorization):

Symptoms you would currently like to address:

How you have managed these symptoms in the past:

Past medications (dosage too, if you remember) and response. Past talk therapy, and response:

Past and current substance use (please try to quantify):

Psychiatric and medical problems in close family members:

Your strengths and goals:

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ Age: ____ Sex: ❑ Male ❑ Female Date:_____

If this questionnaire is completed by an informant, **what is your relationship with the individual? _____**
In a typical week, approximately how much time do you spend with the individual? _____ hours/week

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

Copyright © 2013 American Psychiatric Association. All Rights Reserved.
This material can be reproduced without permission by researchers and by clinicians for use with their patients.