Tom Cook, M.D.
BEYOND MENTAL HEALTH

1401 S. Beretania St. Suite 450
Honolulu, HI, 96814

Welcome!

We look forward to working with you.

Please ask about all our services, which include some of the newest and most innovative treatments for depression and anxiety, such as TMS, medical cannabis, and ketamine assisted therapy.

Our aim is to empower and acquaint you with the **newest**, and also, the **oldest** treatments available...and treatments you can actively participate in. We hope to boost your confidence in your own innate ability to heal, and we wish to bring you ***beyond mental health***.

We have many providers here:

Tom Cook, M.D. - founder of clinic, oversees all treatments
Matt Barrett, M.D. - mental health nutrition expert, TMS specialist

(Dr. Barrett, our nurse practitioner is available at peak times, when Dr. Cook, due to demand, is not available.)

Four excellent talk therapists work on site:

Michal Cohen, LCSW **Stephen Calvin, PhD**
Denise Marques, PhD **Erik Acuna, LCSW**

Cordially,

Tom Cook, M.D.

ph (808) 457-1082
fax (808) 356-1649

www.drcook.org

NEW PATIENT INFO

LAST NAME: _____ FIRST NAME: _____ MI ____

DATE OF BIRTH ___/___/_____ SEX ___ MARITAL STATUS _____

HOME PHONE# _____ CELL PHONE# _____

PHYSICAL ADDRESS _____

CITY _____ STATE _____ ZIP _____

MAILING ADDRESS _____

CITY _____ STATE _____ ZIP _____

SOCIAL SECURITY# _____-____-_____ EMAIL _____

EDUCATION? _____ OCCUPATION? _____

ETHNICITY? _____ RELIGION? _____

EMPLOYER? _____

DIAGNOSES

Please list ALL medical conditions:

PAST TREATMENTS

Describe in the space below, any mental health treatment you have received. Please briefly summarize names of clinicians, locations, and dates:

Medications, if any, will be listed on the next page.

Allergies? (*include all, or write 'none'*) _____

Is there any family history of diabetes, obesity, hypertension, or heart disease? NO _____ Yes ___

Rx: List all CURRENT MEDICATIONS:

Include doses! This list must be complete.

-
-
-
-
-
-

Do you have a history of trauma, or addiction? NO _____ Yes ___

Have you ever been hospitalized on a psychiatric ward, or have you ever attempted to harm yourself? NO _____ Yes ___

What seems to be the problem? *Please circle one or more.*

CANNOT SLEEP	SADNESS	MOODINESS	ANXIETY
JEALOUSY	ANGER	REMORSE or GUILT	IRRITABILITY
SEXUAL PROBLEM	BOREDOM	LONELINESS	FEEL NUMB
LOW ENERGY	ENERGY TOO HIGH	CANNOT FOCUS	FEEL UNSAFE
LOST WEIGHT	ON EDGE, JITTERY	PANICKY	NO APPETITE
FEEL THREATENED	CANNOT TRUST OTHERS	CANNOT STOP HAVING DISTURBING THOUGHTS	CANNOT STOP DOING SOMETHING
HEARING VOICES	NIGHTMARES	TREMBLING / SWEATING	TROUBLE BREATHING
MEMORY LOSS	ADDICTION	CONFLICT WITH A PERSON	NOTHING IS WRONG

Other: _____

Among your circled items above, please pick ONE main problem, ***and circle it several times.***

It began when? _____

Circle the services you may be interested in.

NUTRITION ADVICE	*TMS*	KETAMINE	CONCIERGE CARE
NATURAL SUPPLEMENTS	EMOTIONAL SUPPORT ANIMALS		PERSONALITY FEEDBACK
MEDICAL CANNABIS	TALK THERAPY	MEDICATION	LIFE COACHING

Tom Cook, M.D. - Beyond Mental Health
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TERMS AND CONDITIONS OF SERVICE, & PRIVACY CONSENT

Consent to Treatment - I authorize and consent to medical care and treatment by Thomas Cook, MD ("Dr. Cook") and Happy Happy Happy, LLC and Beyond Mental Health, (collectively, "Dr. Cook's Office") including diagnostic tests and procedures, which Dr. Cook finds necessary according to his professional judgment and which Dr. Cook's office gives and/or performs. Ongoing consent for any particular treatment or test, including pharmaceuticals, genomic testing, urine drug screens, will be obtained verbally, and documented with signatures when appropriate. Regarding *treatment locations,* I understand that Dr. Cook may practice from more than one location, and that Dr. Cook's Office may be working out of any one of several locations. I understand that each of these clinics are scheduled independently, and I agree that all follow-up appointments will occur at the same location as the one in which I was originally seen. I understand that that there are several collaborative providers at Dr. Cook's Office, that Dr. Cook will assign me to the best provider for my case, that this determination is his prerogative alone, and finally, that I may be obliged to switch providers at any time due to scheduling availability. I understand that the length of each E/M appointment is the prerogative of the providers in Dr. Cook's Office, based on their clinical judgment. I understand that in some rare instances, (e.g., TMS/ketamine) Dr. Cook's Office serves as a consulting and procedural clinic only, and that the primary responsible psychiatrist may be outside Dr. Cook's Office.

Record-keeping - Dr. Cook keeps records of each session noting the dates we meet, the topics we cover, progress reports from the client's perspective, interventions, Dr. Cook's diagnostic impressions, and next steps. This form itself is also a part of my medical record. I understand that Dr. Cook's EMR system is not an exhaustive or complete medical record, and that my medical record may include extra psychotherapy notes, psychometric testing, symptom scale, or other forms that are not stored electronically. It is my understanding that the medical info I have entered above on this form is both correct and complete. I attest that the current medication list I have written down is indeed a complete list of all my current medications, that the allergy list is a complete list of allergies, and that the 'medical conditions' line is a complete list of all pre-existing medical or psychiatric conditions diagnosed by other doctors. Regarding *access to records*, you are entitled to receive a copy of the records unless, in Dr. Cook's medical opinion, allowing you to see the records would be detrimental to your health, in which case Dr. Cook's office would be happy to make them available to an attorney authorized by you to receive the records. Because these are professional records, they can be misinterpreted and/or upsetting to untrained readers. It is recommended that you review treatment records in Dr. Cook's presence so that you can discuss the contents with him.

Diagnosis - If a third party such as an insurance company is paying for part of your bill, that third party normally must be given a diagnosis before paying the bill. Diagnoses are technical terms that describe the nature of your problems and indicate whether they are short-term or long-term problems. If Dr. Cook makes a diagnosis, he will discuss it with you.

Waiting Room - I understand that my personal belongings may be lost or stolen while in the Varsity Building or while in the office or on the premises of Dr. Cook's office, and that I will not hold Dr. Cook's Office responsible for these lost or stolen items. I also understand that Dr. Cook's Office will not be responsible for any injuries sustained while on the premises.

Missed Appointments - I understand that if I miss more than one scheduled appointment, I may or may not incur a $50 no-show fee. I understand that if I miss many appointments, I may be terminated from care. If I cannot keep the scheduled appointment, I agree to inform Dr. Cook's Office at least 48 hours prior to the appointment.

Phone Calls/Text/Emails - I am aware that Dr. Cook may or may not respond to emails I send him, that I may be charged $50 for any electronic communication which leads to clinical decision making such as medication changes or other recommendations. I understand that unencrypted email is not intrinsically a confidential means of communication. By using unencrypted email, and by engaging with Dr. Cook in email communications, I consent to the remote, but real, risk of exposure of my protected health information. If I have provided a personal email on the intake form, I thereby give consent, unless I directly state otherwise, for Dr. Cook's Office to send my protected health information to me by that unencrypted route. I realize that Dr. Cook's Office is *not* an urgent care clinic, that physician's exchange is an available service, and that Dr. Cook will try to return calls in a reasonable time frame, but that if I am in grave danger of harming myself, I won't wait for a returned call but will immediately go to an emergency room. I realize all electronic communication is neither an efficient nor a rapid means of communication, and it is neither my understanding, nor my expectation, that electronic text/email communications with Dr. Cook's Office will pertain to, or be intended to address, any urgent matters whatsoever.

Confidentiality - I understand my medical information may be shared with certain insurance carriers to assess the necessity of treatment, and that the policy of Dr. Cook's Office is to share with them no more information than they need to know to accomplish that task. I may consult my insurance documents to determine what level of access to my records I have authorized my insurance carrier to receive. I understand that my medical information may be shared with pharmacists and their assistants, and I give consent for Dr. Cook's Office to look up my Rx history with the Hawaii Prescription Drug Monitoring Program. I realize and consent to the fact that all ancillary staff working in Dr. Cook's Office may need to access my detailed medical records. If I request a sick leave notification from Dr. Cook, I understand that this may entail my boss or other officials at my place of work knowing full well that I am under the care of a psychiatrist and may have a mental health diagnosis.

Pregnancy - I understand that if I am pregnant, if I become pregnant, or if I intend to become pregnant while a patient of Dr. Cook's Office, I must disclose this information to Dr. Cook's Office. Failure to do so will result in a termination of this contract and the doctor-patient relationship.

Release of Specially Protected Health Information - If my medical record contains any information related to HIV or AIDS, mental health diagnosis and treatment, or federally funded substance abuse treatment programs, I consent to release such health information for the purpose of treatment for obtaining authorization or payment from my insurers and other payers and for other specific insurer/payor requirements, within the limits of the law. I understand that I may choose to pay for treatment in which case my health information will not be provided to my insurance company, but that I must make arrangement for payment before services are provided, or on the day services are provided, and that if I fail to make payment within 30 days (or as otherwise agreed in writing), the health information may be disclosed to my insurance company.

Eligibility - I understand that it is my responsibility to keep track of my eligibility status. If I consent to see Dr. Cook for a clinical visit, thinking I am eligible, when I am not in fact eligible for services, I will incur the self-pay rate for the visit.

Self Pay - If I do not have active medical insurance, or if my insurance does not cover outpatient behavioral health services, I understand that self-pay forms accepted may include cash, credit card, debit card, or check. I understand the charge for an evaluation is $300, and for a follow up visit is $150. I understand co-payment may be made by the same means. I understand that if I authorize Dr. Cook to make lengthy phone calls (e.g., longer than 10 minutes) for my care, e.g. to gather history, update other individuals about my treatment, or for other purposes, I may incur a self-pay charge between $50 -$150.

Financial Agreement - I understand that all copays are due at time of visit, and that I am responsible for all deductibles, copays, and non-covered benefits, and that I will pay Dr. Cook's Office in full, within 30 days (or longer if required by law) unless I make other arrangements with Dr. Cook's Office. I realize if my check bounces, and the bank charges Dr. Cook's Office a fee, I will be responsible for that fee. Bill Collection: a late payment charge of 1% per month, calculated at simple interest, may be assessed on my account if not paid in full within 30 days (or longer if required by law). If the bill is not paid in full within 30 days (or longer if required by law) I understand that Dr. Cook's Office may refer the matter to an attorney and/or collection agency, and that I will be responsible for paying all legal fees and other costs incurred to collect my bill.

Medicare / Medicaid - If I have Medicare or Medicaid coverage, I certify that the information given by me in applying for payment is correct. I understand that the Social Security Administration may release information on my Medicare effective dates and Medicare claim number to Dr. Cook's Office. I request that payment of benefits be made to Dr. Cook's Office on my behalf. I consent to the release of my information related to Medicare and Medicaid coverage as needed for payment of this claim and related claims. I understand that I am responsible for paying my bill in full. If I am entitled to any insurance benefits, I assign all of these benefits to Dr. Cook's Office toward payment of my bill and I direct my insurance carrier to pay these benefits to Dr. Cook's Office. I understand that Dr. Cook's Office will bill my insurance carrier if I provide benefits information in a timely fashion.

Termination - I understand the physician-patient relationship is a voluntary one, and that I may be terminated as a patient for any reasonable reason, including, but not limited to, if I do not return calls or mail, if I stop medication without notifying a provider, if I do not take medications as prescribed, if I am unruly, rude, threatening, inappropriate, or harassing to any office staff, if I am disruptive, if I exhibit poor boundaries with staff or with other patients in the waiting area, if Dr. Cook concludes that my problems would be better addressed by another physician, or if there is any indication that I am not reliably honest in the information I give to Dr. Cook's Office.

By signing below, I certify that I have read the Terms and Conditions of Service above and that I understand that I am responsible for all charges, regardless of insurance coverage. By signing below, I also certify that I consent in full to the privacy statement above, as well as the privacy practices of Dr. Cook's Office, and that I agree to be bound by them, and that I am the patient, or the patient's authorized representative. I am aware that a copy of the Privacy Notice for Dr. Cook's Office is readily available in the office for anyone to read. I hereby acknowledge that I may obtain a copy of the Privacy Notice from the receptionist, or from Dr. Cook, if I wish.

What is a Guarantor? A guarantor is the person responsible for payment. If guarantor is NOT the patient, then both patient AND guarantor must sign.

As the guarantor, I hereby acknowledge and accept financial responsibility for any charges incurred by the above named patient while under the care of Thomas Cook, M.D.

Guarantor signature:

Print Name: DOB: hone#:

Signature: Date: / /

Place: 1401 S. Beretania St. Suite 450, Honolulu, HI 96814

SIGN HERE:

Print: _____

Sign: _____

Date: ___/___/ 20___

MEDICATION & PSYCHOTHERAPY CONSENT

Please read this form carefully and review as necessary. If you have problems reading it, ask to have it read to you.

I have voluntarily entered into the healthcare decision making process with Thomas Cook, MD ("Dr. Cook"), and have spoken with Dr. Cook, who has recommended that I (my child) receive(s) medication(s) and/or psychotherapy. Dr. Cook has advised me of the medications that are known to be of help in treating symptoms such as mine, and the reasons for taking them. Dr. Cook discussed the risks and benefits of such medications and the likelihood of improvement or no improvement with or without medication. Reasonable treatment alternatives, if any, have been discussed. No promise or guarantee has been made to me as to a resulting cure. Dr. Cook advised me of the potential side effects of the medications prescribed to me from the groups below. I understand that I have the right to accept or refuse medications recommended to me. I understand that my consent to treatment may be withdrawn at any time by stating such intention in writing to Dr. Cook's Office. I understand that medications may have side-effects that are unexpected or that are not on this list, and that if I have any further questions or want to know more about my medications I can ask for more information. The side effects include, but are not limited to:

Antipsychotics - (e.g., Abilify, Risperidone, Seroquel, Geodon)
Drowsiness, stiffness, muscle spasms, tremors, restlessness, dry mouth, constipation, blurry vision, uncontrollable movements or development of tardive dyskinesia, weight gain, increased risk for diabetes or elevated lipids or cholesterol, lightheadedness, drooling, worsening seizures, changes in blood pressure, difficulty with discontinuation.

Antidepressants - (e.g., Celexa, Zoloft, Lexapro, Prozac, Selegiline, Remeron, Cymbalta, Wellbutrin, Emsam)
Dry mouth, constipation, drowsiness, lightheadedness, heart arrhythmia, nausea, diarrhea, decreased sex drive and function, headache, shakiness, restlessness, unsteadiness, weight gain, worsening seizures, changes in blood pressure, development of tolerance, psychological or physical dependence, difficulty with discontinuation.

Mood Stabilizers / Anticonvulsants – (e.g., Lithium, Depakote, Tegretol, Lamictal, Topamax, Gabapentin, Lyrica)
Sedation, slowed thinking, unsteadiness, nausea, diarrhea, constipation, drooling, increase in liver enzymes, lowering of blood count, severe rash, changes in blood pressure, increased thirst and urination, decrease in thyroid function, lowered blood pressure, numbness and tingling in limbs, kidney stones, development of tolerance, psychological or physical dependence, difficulty with discontinuation.

Sedatives / Anxiolytics – (e.g., Ativan, Xanax, Klonopin, Valium, Restoril, Ambien, Lunesta, Sonata)
Sleepiness, lightheadedness, unsteadiness, confusion, learn vision, slurred speech, nasal congestion and dryness, dry mouth, constipation, development of tolerance, psychological or physical dependence, difficulty with discontinuation.

Stimulants - (e.g., Adderall, Ritalin, Concerta, Vyvanse)
Constipation, coughing, diarrhea, dizziness, drowsiness, dry mouth, flushing, headache, loss of appetite, nausea, nervousness, restlessness, stomach pain or upset, sweating, trouble sleeping, unpleasant taste, vomiting, weakness, weight loss, development of tolerance, psychological dependence, difficulty with discontinuation.

Anti-Parkinson's Drugs - (e.g., Cogentin, Artane)
Dry mouth, constipation, worry vision, slow urination, excitation.

Beta Blockers - (e.g., Propranolol, Metoprolol)
Dizziness, lightheadedness, tiredness, stomach pain, intense dreams, insomnia, slow heartbeat, fainting, impotence.

Muscle Relaxants - (e.g., Zanaflex, Baclofen, Flexeril, Gabapentin, Lyrica)
sleepiness, lightheadedness, unsteadiness, confusion, learn vision, slurred speech, nasal congestion and dryness, dry mouth, constipation, acid reflux, development of tolerance, psychological or physical dependence, difficulty with discontinuation.

Xyrem / Sodium Oxybate
Nausea, vomiting, memory problems, depression, bedwetting, sleepwalking, headache, nasal congestion, physical discomfort, development of tolerance, psychological or physical dependence, difficulty with discontinuation.

I understand the dosage(s) and when to take the medication(s), and for how long, and that any changes in medication dosage and/or frequency during the course of treatment will be discussed with me. I recognize that unforeseen events and conditions arising during the course of treatment may necessitate surgical or medical care, restriction of activity, physical control, or seclusion. I authorize Dr. Cook and *Happy Happy Happy, LLC* (collectively, "Dr. Cook's Practice"), to carry out such emergency measures. I understand that I should promptly inform my psychiatrist about possible adverse reactions or alarming changes in my condition, e.g., *sudden suicidal or violent thoughts or tendencies, dizziness, severe sedation, fever, swollen lymph nodes, rash, abdominal pain and confusion, loose stools and hyperthermia, lightheadedness and confusion.* If I (or the patient) am over 65 yrs old, and taking benzodiazepines, I understand Dr. Cook's policy that this entails certain risks, and may usually only occur at low doses, and by my consenting to the small increased risks of falling down, or developing dementia.

No matter if I (or the patient) am elderly or not, I understand that Dr. Cook's recommendation is not to drive, drink alcohol, or operate machinery while taking benzodiazepines or other sedatives. I understand that if the patient is a minor, and taking stimulants for long periods, there may be an effect on growth height. I understand that SSRI's may lower platelets, and thereby increase the risk for bleeding, and that valproate as well as SSRI's have been linked to low bone density and hair loss. I understand that I should inform my psychiatrist if I become pregnant, and/or if I am given any new medications prescribed for other conditions. I understand that mood stabilizers in particular may cause severe birth defects, and other medicines such as SSRI's, may cause rare birth defects. With some anti-psychotics, I understand that there is a possible side effect, tardive dyskinesia, which may cause involuntary movement of the tongue, face, neck, limbs, or torso, and may persist even after stopping the medication. If I (or the patient) am over 65 yrs old and taking antipsychotics, I understand that such medicines may carry a small increased stroke risk.

I understand that the decision to take medication is up to me, but that I should always first discuss with my psychiatrist any decision to stop taking medication. I understand that when Dr. Cook orders refills of any medication for several months or more, this does ***not*** mean I do not need to be seen until they have all run out. I agree to take medication(s) only as prescribed, and I understand medications can only be prescribed reasonably and safely if I take them exactly as ordered by Dr. Cook, and that if I persistently and intentionally take medications prescribed by Dr. Cook in an irresponsible or dangerous way, I may be terminated as a patient in his practice.

Consent: my signature below confirms that the information on the form has been explained to me, I have received all the information I wanted about medication and treatment, and I give Dr. Cook's Office permission to provide medication and treatment

SIGN HERE:

Print: _____

Sign: _____

Date: ___/___/ 20___

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