Regional Psychiatry
9100 Conroy Windermere Rd, Suite 269, Windermere FL, 34786
Tel: 407-462-1254 / Fax: 407-604-6614

Practice Policies and Agreement (08/15/2020)

Confidentiality

Patients who are 15 and older have the right to confidentiality under Florida State law.

For those who have requested that records be kept confidential, information can be disclosed without consent in cases in which a patient is deemed to be an acute danger to self or to others, and unable to care for self. Additional causes for disclosure of information without consent include suspected child/ elder/vulnerable person abuse and a court order/subpoena.

Your provider may use or disclose health information in order to provide and coordinate your health care.

Please note that if you choose to use your insurance for reimbursement your information will be shared in accordance with the agreement and policies set forth by your insurance company. Insurance companies always require type of service and diagnosis codes.

Appointments

At the end of a visit your physician, or staff member, will provide you with a follow-up appointment within a specific time frame appropriate to your condition upon checking out. If any unforeseen issues arise, please contact our Scheduling Department at 407.462.1254 to be seen sooner.

Cancellation Policy / Late Cancellations/ No Shows and Fees

Appointments that are missed without having notified our office at least 24 hours in advance will be charged at 50 percent of the full fee. Monday appointments must be cancelled by 4 p.m. the preceding Friday. Please note that insurance will not reimburse missed visits. If you show up late to an appointment, extra time will not be added to the end of the sessions. More than three missed appointments or late cancellations may be grounds for termination of treatment.

Voicemail/Messages

We will do our best to respond to messages within 48 hours. Calls left late on Friday will most likely be processed on Monday morning.

Emergencies

For life-threatening medical emergencies, psychiatric crisis, or if you are at risk of harming yourself or others, **CALL 911** or go to your nearest emergency room. Additionally **Central Florida Behavioral Hospital** has a 24/7 walk in clinic **321-247-7275 or 407-370-0111** located at 6601 Central Florida Parkway, Orlando, FL 32821. You should instruct the emergency room to notify your treating physician. For the sake of continuity of care we ask that you bring any discharge instructions or medication adjustments to your next appointment.

Additional Behavioral Health services is performed at the following facilities:

-Doctor P Phillips Hospital 407-351- 8500 located at 9401 Turkey lake Rd, Orlando, FL 32819

- South Seminole Hospital 407-767-1200 located at 555 W FL-434, Longwood FL, 32750

- Orlando Regional Medical Center 321-841-5111 located at 52 W. Underwood Street, Orlando FL, 32806

Telephone Calls

We provide face-to-face care but urge patients/family members/significant others to call us regarding medication interactions or any new behaviors that may be causing concern. In most cases, issues that cannot be handled with brief management or recommendations will require an office visit.

Virtual Sessions

We offer virtual sessions using a HIPAA compliant software (doxy.me). We require you notify our receptionist (407-462-1254) at least 15 minutes prior to your appointment that you wish to do a virtual session to ensure your treating physician will be logged into the virtual portal. A credit card or debit card must be left on file prior to your virtual session. Any payment that is owed at the end of session (including co-pay) will be processed via the card you left on file. Make sure to be in a setting with strong wifi connection. Session may be performed via your desktop computer, laptop , tablet or smart phone. Although rare, it is possible to have a connectivity (internet) issue during a virtual session. In the event that there is a connection issue interfering with the session, the remainder of the session will be carried out via telephone.

***Virtual Login Instructions:** open web browser. Type in URL provided to you by our Receptionist (407-462-1254). Enter your first and last name and click “check in.” Click on button allowing your browser to use your webcam and microphone. Wait for your provider to log in and connect. *Save the URL as it will be the same URL for future sessions.

As with any medical procedure, there are potential risks associated with the use of telemedicine/ teletherapy. These risks include, but may not be limited to:
● In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s);
● Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment;
● In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information;
● In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

By signing this Policy Form Below, you attest to and understand the following:
1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine/teletherapy, and that no information obtained in the use of telemedicine/ teletherapy which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine/ teletherapy in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. My clinician has explained the alternatives to my satisfaction.
4. I understand that I may expect the anticipated benefits from the use of telemedicine/teletherapy in my care, but that no results can be guaranteed or assured.

Refills

In general, your physician will provide as many refills as believed to be reasonable given the stability of your condition and frequency of monitoring needed. If your condition requires monitoring, and we have not seen you recently, we may insist on a new appointment. We will typically provide you with enough medication until the next appointment. We do this to provide safe and appropriate care for you.

If you are in need of a remaining refill, please contact your pharmacy. Your pharmacy will contact our office if authorization is required. Your requests will be processed within 1-2 business days after receipt of your pharmacy's requests so please plan accordingly. We reserve the right to decline issuing prescription refills if medications have been lost or stolen, or if you have missed an appointment. **For an urgent immediate refill, you may go to your nearest Emergency room**

Scheduling

In most cases, visits are frequent upon treatment initiation, with the time between appointments lengthening, as stability is achieved. Refills often follow that pattern as well. For safety, our standard of care is to see long term patients a minimum of every three months. Since active psychiatric conditions require monitoring as they evolve, if you miss appointments or fail to schedule resulting in you not receiving treatment by me in 6 months, your file will be formally closed and your provider at Regional Psychiatry will no longer be your psychiatrist of record. If you wish to return as a new patient, a new initial intake appointment would have to be scheduled.

Hours of Operation:

Standard hours are Monday-Friday 9am-5pm. Some evening and weekend availability may be available on request.

Our Office will be closed on the following holidays: 4th of July, Labor Day, Columbus Day, Veterans Day, Thanksgiving, Christmas Day, New Years Day, Martin Luther King Jr. Day, Presidents Day, Easter Monday. If any of these holidays falls on a weekend, our office will be closed on the subsequent Monday.

Patient Records

You may request copies of your medical records at your own discretion and ask that factual errors be corrected. Depending on the amount of records requested, a nominal service fee can be applied. Parts of your record that could potentially be more detrimental than helpful to your psychological well-being may be withheld. You may also authorize in writing that copies of your records be released to entities you designate.

All charts and records are generated and stored using the electronic medical record platform Luminello. Patient will be sent via email a link to generate a portal account to Luminello where you will be able to access your account and receive notifications from our clinic.

Requesting Written Letters / Paperwork

For simple letters stating you are currently in treatment with your provider and / or was present at our clinic on a particular date will be provided at no cost. For detailed letters such as Disability claims , FMLA , work / school accommodations, Clearance for medical procedures, military clearance, or any letter that will require a blocked period of time during work hours will come with a fee ranging between $75.00 - $125.00 depending on length of time needed to complete. This fee is per Letter / paper work package. If additional paper work /forms are required to be filled out (or additional letters needed) at a later time, an additional $75 - $125.00 fee will be applied.

Messaging

You can send messages through luminello, or text message to your physician or the administrative team. Messages can be used for non urgent matters such as appointment reminders, medication refill, insurance questions. You should **NOT** use the Luminello messaging software for any **urgent** questions including symptoms of medication side effect, experiencing desire to harm yourself or others, or are in need of an **Immediate** response. Please refer to the Emergency section above for management of urgent issues. Messages will not be read after 5pm on business days, nor will they be read on weekends. We will try our best to response to messages within 48 ours. Any messages left late on Friday will most likely be processed on Monday morning.

Social Media

In order to maintain HIPAA and confidentiality, it is our practice to refrain from engaging in social media with our clients (such as facebook, twitter, Instagram).

Weapons

To ensure a safe and productive treatment setting, Dr. Andrew Pleener's office prohibits weapons of any kind, with or without a permit to carry, in the office or on office property. Examples include, but are not limited to firearms, edged weapons, and chemical agents. With the exception of on-duty law enforcement officers, anyone found to be in violation of this policy will be asked to leave the premises.

Fees (as of 08/15/2020): Below are some of the typical fees and associated codes (these are subject to change)

Psychiatric Initial Diagnostic Evaluation (Approximately 60 minutes) $250.00
(CPT code 90792, 99204, or 99205)

Typical follow-up medication management visit (Level 4 or 3 complexity) $125.00
(CPT code 99214 or 99213 respectively)

Psychotherapy (Approximately 15-30 minutes) - $80.0
(CPT code 90833)

Card on File

We require that a credit card / debit card be left on file and authorized to use by Regional Psychiatry physician, staff and our billing partner Blue Sky Billing Solutions, to cover any outstanding balance including cancellation / no show fees, copayments, deductibles. If your bank account or credit card information in the future changes for any reason, it is your responsibility to notify Regional Psychiatry physicians and / or staff team, and the information will be updated. Authorization to use

card on file to collect outstanding payments, shall remain in effect until the patient doctor relationship between yourself and Regional Psychiatry provider has ended, or when your provider has received written notification from you of its termination.

Please refer to our credit card on file authorization form for further details.

Insurance and Payment

For In Network Provider:
-We Currently Accept Aetna, Cigna, & United Health Care. Copayments are due at the time of service. Payment is due no later then the end of 31 days from the statement date.

For Out of Network Providers:
-We Accept Out of Network Providers (Except Medicaid). Payment for out of network is due at time of service. At the end of the session, you will be provided with a superbill containing the CPT diagnostic codes for you to submit yourself, to your insurance for reimbursement. Contact the membership number on the back of your insurance card. An insurance representative will direct you to the area on the insurance website where a reimbursement form can be printed out. You will complete that form, in addition to providing the CPT codes from the superbill. The form will then be submitted to your insurance company by either mail or fax to receive reimbursement.

Late Payments:

If payments are >31 days late without notice to us, accounts may be forwarded to collections. If outstanding balances are not paid and not addressed, treatment information may be released for collection agency involvement. If the undersigned fails to pay for services rendered and collection efforts become necessary, the undersigned agrees to be responsible for all collection costs, court fees and including attorney's fees.

Billing

I automatically bill face-to-face (including virtual) services on the day they are rendered.

Insurance Codes

Below are CPT codes (standard insurance descriptors) that we commonly bill. We are knowledgeable about reimbursements and bill for the highest level that is appropriate; however, variations exist depending on specific insurances. The most common codes are below. If you wish to ask your insurer what they will reimburse for, they may wish to know our Tax Identification Number (84-1951129) and NPI (1255979449). A common "diagnosis" code used is unspecified episodic mood disorder

(F39), attention deficit hyperactivity disorder (F90.9) or anxiety disorder unspecified (F41.9). That information should be sufficient for your insurance to advise you.

Most commonly used codes

90792 , 99204, 99205 (Initial Diagnostic Evaluations), 99213, 99214, (follow up med management office visit L3-L5 complexity) with or without 90833 (Psychotherapy with L3-L5 visit).

I have read the above practice policies and have had the opportunity to have my questions answered. I understand that policies and fees change over time and that I will be updated regarding any major adjustments. I have read and acknowledge receipt of Regional Psychiatry's notice of privacy practices (can be found at www.RegionalPsychiatry.com) and have had my questions answered.
I consent to evaluation and treatment by a Regional Psychiatry provider and agree to be responsible financially for services rendered.

Print Patient Name Date

Signature of Patient

Regional Psychiatry
9100 Conroy Windermere Rd, Suite 269, Windermere FL, 34786
Tel: 407-462-1254 / Fax: 407-604-6614

PATIENT NAME:

_____

Last First Middle

Home address: _____City: _____

Home telephone: _____ Date of Birth: _____

I authorize my provider Dr._____ and the named party below to exchange written and verbal information including my protected health information, including medical treatment, mental health treatment, educational information for the purpose of providing psychiatric assessment, diagnosis, treatment or coordinating care unless specified otherwise below.

Name/Facility:

_____

Address:

_____

_____

State:_____

Zip:_____Phone:_____Fax:_____

INFORMATION COVERED UNDER THIS RELEASE

____ Entire medical record (Examples include discharge summaries, medical assessments, lab data and information from a primary care physicians office)

____ Ongoing communication regarding psychiatric or mental health care (Examples include ongoing care with a primary care physician or mental health provider)

____ Individual Education Plan, school psychological testing, and information relating to the academic performance and behavior of child in a school setting.

____ Psychological testing

____ Information for referral purposes

____ Other (please specify)_____

____ Specific authorization for information related to testing, diagnosis and treatment for drug or alcohol use.

____ Specific authorization for information related to testing, diagnosis and treatment of sexually transmitted diseases or HIV

The purpose of this disclosure is: Medical care_____ Legal Matter_____ Insurance_____ Personal:_____

TERM: Unless otherwise specified this authorization will expire on termination of treatment with Dr Pleener .
This authorization expires:
_____ Termination of treatment with Dr Pleener
_____ 90 days from the date signed
_____ on other date, reason or event (specify)
_____

By my signature below, I hereby authorize my Regional Psychiatry Provider as written above to obtain, use and/or disclose my health information for the term of this Authorization for the specific purposes listed ("At the request of the patient" is sufficient if the patient is initiating this Authorization). I understand that once my provider discloses my health information to the recipient, my provider cannot guarantee that the recipient will not re-disclose my health information to a third party. Any such third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information. I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation, or quality of my providers treatment of me; except, however, if my treatment with my provider is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case my provider may refuse to treat me if I do not sign this Authorization. I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my provider. The revocation will be effective immediately upon my providers receipt of my written notice, except that the revocation will not have any effect on any action taken by my provider in reliance on this Authorization before it received my written notice of revocation. I have read and understand the terms of this authorization and have had an opportunity to ask questions about obtaining, using and disclosing my health information. By my signature below, I hereby, knowingly and voluntarily authorize my provider as written above to obtain use and/or disclose my health information in the manner described

X_____X_____X_____

Signature of Patient or Personal Representative Relation to patient (self, guardian, parent etc) Date

Regional Psychiatry
9100 Conroy Windermere Rd, Suite 269, Windermere FL, 34786
Tel: 407-462-1254 / Fax: 407-604-6614

PLEASE COMPLETE THE BELOW INFORMATION TO PLACE A CREDIT CARD ON FILE FOR PAYMENTS

Patient Name:_____ Date of Birth: _____

Billing Information:

Accountholder Name:_____

Account Billing Address _____
_____

City_____ State_____ Zip _____

Account Phone _____

Card #
_____
Exp: _____/ _____ Security Code on Back of Card (3 or 4 digit) _____

Email if you would like receipts:
_____

I hereby authorize Regional Psychiatry physician and staff to keep my account information on file for payment and to initiate debit or charge entries on this account as amount are owed for the Patient Account listed above. I acknowledge that the origination of ACH or credit card transactions to my account must comply with the provisions of U.S. law. I understand that a debit or charge may be made to my bank account or credit card account periodically to pay for amounts owed including cancellation no show fees, copayments, deductibles. If my bank account or credit card information listed above changes for any reason, I will notify my Regional Psychiatry physician and / or staff team. This authorization shall remain in effect until the patient doctor relationship between myself and my Regional Psychiatry provider has ended, or when my provider has received written notification from me of its termination.

X_____ Date: _____
Cardholder

Regional Psychiatry
9100 Conroy Windermere Rd, Suite 269, Windermere FL, 34786
Tel: 407-462-1254 / Fax: 407-604-6614

Adult Intake Form

***DEMOGRAPHICS**

Name _____ _____
_____
Last First Middle

Date of Birth _____ Age _____ Sex _____ Birthplace
_____

Home Address _____ _____ _____
_____
Street City State Zip

Mailing Address_____ _____ _____
_____ (If Different) Street
City State Zip

Phone / (Self / Emergency Contact) Phone / (Self / Emergency Contact) Type of Phone
Okay to leave message?
(Home / Work / Cell) (Non-Emergencies /
Routine)

_____ ⏮ Yes ⏮ No

_____ ⏮ Yes ⏮ No

_____ ⏮ Yes ⏮ No

_____ ⏮ Yes ⏮ No

_____
Email address (for emergencies only)

Please note, due to privacy, we do not use email routinely but under emergent circumstances may need to send you a “we cannot reach you by phone, please call our office” message if a scheduling issue comes up or you elect to receive reminders.

Please select how you would like to receive appointment reminders. You may choose multiple options:
Text _____ Email _____ Phone Call _____

Please note, automated reminders are provided as a courtesy. Missed appointments are under 24 hour cancellations will incur a cancellation / no-show fee.

Who Referred You to Me? _____

Briefly, what is the primary reason for consultation / evaluation?

_____

PAST PSYCHIATRIC HISTORY

HOSPITALIZATIONS FOR PSYCHIATRIC REASONS (if applicable)

None Please list all hospitalizations you have had, dates, where and what for:

COUNSELING OR THERAPY SERVICES (if applicable)

None Please indicate any current or past counseling or therapy sessions you have had, and if so, with whom, when, for how long, and what for? Are you happy with the treatment?

PAST PSYCHIATRIC MEDICATIONS (if applicable)

None **Please list any psychiatric medications you have taken**

Name	Dose (if known)	What for ?	Effective?	Side effects?

Please indicate any other mental health treatment outside the usual scope of usual 'medical' practice (holistic treatments, church counseling, alternative treatments, dietary treatments etc.) ⏮ **None**

Have you been physically, sexually, or verbally abused? ⏮ **Yes** ⏮ **No** ⏮ **Prefer to discuss in person** Details (if applicable)

_____

Have you ever attempted suicide or are spending time thinking about it? ⏮ **Yes** ⏮ **No** ⏮ **Prefer to discuss in person** Details (if applicable)

_____

Have you ever engaged in cutting or other self-injurious behaviors? ⏮ **Yes** ⏮ **No** ⏮ **Prefer to discuss in person** Details (if applicable) _____

Have you ever had hallucinations ⏮ **Yes** ⏮ **No** ⏮ **Prefer to discuss in person**
(hearing voices that others do not or seeing things that other people do not)
Details (if applicable)

_____

MEDICAL INFORMATION

Please list allergies_____ ⏮ No Known Allergies

Primary Care Physician _____City/State_____

Please list all medical problems (including history of seizure, loss of conscious, or head trauma), medical hospitalizations and surgeries:

Please list your current medications:
Name Dose How many times a day What for ? Side effects?

SOCIAL HISTORY

You are: ⏮ Partnered/Married ⏮ Single ⏮ Separated ⏮ Divorced ⏮ Widowed

How far did you go in school? (degree) _____

Current occupation:_____

FAMILY MENTAL HEALTH HISTORY ⏮ **No known**

Has anyone in your immediate or extended family ever been diagnosed with a psychiatric illness, had a psychiatric hospitalization, suicide attempt, or struggled with issues around drugs or alcohol? Please provide information on psychiatric medications taken if known. (Examples of conditions are depression, anxiety, PTSD, ADHD, autism, OCD, schizophrenia, bipolar, alcohol or other substance dependence.) Please indicate relation, condition, treatments and medications taken if known:

Substance Use

Smoking: Current packs per day _____ Former Smoker last smoked _____(mo/yrs) ⏮ Nonsmoker

Alcohol: Current drinks a week _____ Choice and size of drink ____ Occasional ⏮ Do not drink

Have you ever tried to cut back? ⏮ Yes ⏮ No
Have you ever felt annoyed at someone for commenting on your drinking? ⏮ Yes ⏮ No
Do you feel guilty about anything you have done while drinking? ⏮ Yes ⏮ No
Do you ever have to have a drink to get you "going in the morning" ⏮ Yes ⏮ No

Caffeine: Current caffeinated beverages a day _____What type? _____ ⏮ No caffeine

Other substances_____

⏮ **Yes** ⏮ **No** ⏮ **Prefer to discuss in person**

Are there any other considerations not addressed in this intake form or specifically highlight that you want to talk about during our consultation? If so, please write them down.

Psychiatric Review of Systems

1. Have you had periods of feeling sad, despondent or hopeless?	⏮ Yes ⏮ No
2. Have you noticed a change in your interest in things you normally enjoy?	⏮ Yes ⏮ No
3. Have you been feeling down on yourself? Guilty about anything?	⏮ Yes ⏮ No
4. Have you tended to feel more tired than usual? As if all your energy is drained?	⏮ Yes ⏮ No
5. Have you had trouble concentrating? Making decisions?	⏮ Yes ⏮ No
6. Have you had any changes in your appetite? Lost or gained weight?	⏮ Yes ⏮ No
7. Have you felt restless or agitated? Have you been feeling slowed down?	⏮ Yes ⏮ No
8. Have you had trouble sleeping?	⏮ Yes ⏮ No
9. Have you ever felt that life isn't worth living? Thought about taking your own life?	⏮ Yes ⏮ No

_____

1. Have you ever experienced a sudden attack of panic or fear? ⏮ Yes ⏮ No

2. Did you feel as if you were going to die or go crazy? ⏮ Yes ⏮ No

3. Ever been afraid of going outside, so that you tended to stay home all the time? ⏮ Yes ⏮ No

4. Are you ever bothered by persistent ideas that you can't get out of your head, such as being dirty or contaminated? ⏮ Yes ⏮ No

5. Is there anything you have to do over and over, such as washing your hands or checking the stove? ⏮ Yes ⏮ No

---

_____

1. Have you ever felt extremely good or high, clearly different from your normal self? ⏮ Yes ⏮ No

2. Have you felt your thoughts are racing through your mind? ⏮ Yes ⏮ No

3. Did you need less sleep than usual to feel rested? ⏮ Yes ⏮ No

4. Have you done anything that caused trouble for you or your family/friends? ⏮ Yes ⏮ No

5. Have you had periods of excessive involvement in pleasurable activities? ⏮ Yes ⏮ No

6. Did people say you talked too fast or excessively? ⏮ Yes ⏮ No

---

_____

1. Are you a moody person? ⏮ Yes ⏮ No

2. Do you often feel empty inside? ⏮ Yes ⏮ No

3. When something goes really wrong in your life, like getting rejected, do you ever do something to hurt yourself, like cutting yourself or overdosing? ⏮ Yes ⏮ No

When you're under stress, do you feel like you lose touch with your environment or with yourself? ⏮ Yes ⏮ No

4. During those times, do you feel like people are ganging up against you? ⏮ Yes ⏮ No

5. When someone abandons you or rejects you, do you feel terrified? ⏮ Yes ⏮ No

6. Do you ever get really impulsive and do crazy things, like going on spending sprees, having a lot of sex, driving like a maniac and so forth? ⏮ Yes ⏮ No

7. Do your relationships tend to be stormy with lots of ups and downs? ⏮ Yes ⏮ No

8. Do you make yourself sick (induce vomiting) because you feel uncomfortably full from eating? ⏮ Yes ⏮ No

9. Do you worry that you have lost control over how much you eat? ⏮ Yes ⏮ No

10. Have you recently lost more than 15lbs in a three-month period? ⏮ Yes ⏮ No

11. Do you think you are too Fat, even though others say you are too thin? ⏮ Yes ⏮ No

12. Would you say that Food dominates your life? ⏮ Yes ⏮ No

_____

1. Have you felt that people are against you? Trying to harm you in any way? ⏮ Yes ⏮ No

2. Do you have any special powers, talents or abilities? ⏮ Yes ⏮ No

3. Have you heard your own thoughts out loud, as if they were a voice outside your head? ⏮ Yes ⏮ No
4. Have you felt that your thoughts were broadcast so that other people could hear them? ⏮ Yes ⏮ No

Medical Review of Systems:

Please check if you have recently had any of the following:

Fatigue?	⏮ No ⏮ Yes:
Changes to vision?	⏮ No ⏮ Yes:
Changes to hearing?	⏮ No ⏮ Yes:
Palpitations/Chest Pain/Dizziness?	⏮ No ⏮ Yes:
Shortness of breath?	⏮ No ⏮ Yes:
Nausea or vomiting?	⏮ No ⏮ Yes:
Frequent urination?	⏮ No ⏮ Yes:
Muscle or joint pain?	⏮ No ⏮ Yes:
Rashes?	⏮ No ⏮ Yes:
Dry mouth?	⏮ No ⏮ Yes:
Headaches?	⏮ No ⏮ Yes:
Numbness/Tingling/Weakness?	⏮ No ⏮ Yes:
Increased or decreased sweating?	⏮ No ⏮ Yes:
Easy bruising or bleeding?	⏮ No ⏮ Yes: