Mind & Behavior Center
Adult Mental Health Intake Forms

Patient Name	DOB	Age	Gender

Address ______________________________

Home Phone ______________ Cell ______________ Work ______________

Email Address ______________ Preferred method of contact ______________

SSN ______________ Emergency Contact ______________

Did the receptionist copy your insurance card? ______________

Insurance Company ______________ ID # ______________

Policy Holders Name ______________ DOB ______________ Group # ______________

Responsible Party Name & Address ______________

Secondary Insurance ______________ ID # ______________

Ethnicity: ☐White ☐African American ☐Native American ☐Hispanic ☐Asian ☐Middle Eastern ☐Other

Relationship status: ☐Married ☐Domestic partner ☐Single ☐Divorced ☐Separate ☐Widowed ☐Other

Employment status: ☐Employed full-time ☐Employed part-time ☐Unemployed ☐Disabled ☐Retired ☐Homemaker ☐Other

Do you have any special/disability needs we need to be aware of? ______________

Height: ________ Weight: ________ Last Recorded Blood Pressure: ______________

Date of Last Physical ______________ Name of Primary Care Physician ______________

Location ______________

List any allergies/reactions (plants, animals, medications) ______________

____

Who referred you to us : ______________________________

Psychiatric and/or Alcohol and Drug Abuse History:

Do you currently have a psychiatrist, psychologist, social worker or counselor?	☐Yes	☐No
If yes, name(s)		

List and describe all past treatment for psychological/psychiatric concerns or alcohol/drug problems:

Year	Doctor/Therapist	Inpatient/ Outpatient	Type of Treatment Name & Location of Treatment Facility (Include medication, psychotherapy, counseling, alcohol or drug counseling, psychological testing, ECT, etc.)

Past Medical History

Describe surgeries, major illnesses, accidents or hospitalizations for medical problems: ☐ None

Year	Where Treated	Type of Illness/Operation	Doctor/Therapist

Describe any current medical problems: ______________________________

____

____

Current Medication and Dose	Prescription	How Often	Non-Prescription	What For

Substance Use:

	Tobacco	Caffeine	Alcohol	Street Drugs
Date last used				
Type				
Amount per day				
Tried to Quit	☐Yes ☐No	☐Yes ☐ No	☐Yes ☐ No	☐Yes ☐No

Family Psychiatric History:

Describe any family history of psychological difficulties, psychiatric illness, alcohol or drug abuse, history of violence or suicidal behavior:

☐Psychiatric ☐Alcohol/Drug ☐Suicidal ☐Violent behavior

Social History:

	Type of Work	Age or Date of Death	Physical Illness
Father			
Mother			
Brother/ Sister			
Spouse/ Partner			
Children/ Stepchildren			

Any previous primary relationships and/or marriages? ☐Yes ☐No If yes, explain ________________

____

____

What was your birth order and number of children in family (for example: oldest of 3, etc.)? ________________

____

Graduated from high school: ☐Yes ☐No If yes, what year

Education after high school: ☐Yes ☐No If yes, describe

Describe any school problems ____

Where are you employed? ____

How long have you been there? ____________________ Job title ____________________

Describe any job problems/concerns ____

Any legal or arrest history? ☐Yes ☐No Probation/Parole: ☐Yes ☐No

If yes, what type: ☐Traffic offenses ☐Alcohol/Drug ☐Property/Financial ☐ Assault/Violence/Weapons

Any armed services history? ☐Yes ☐No If yes, how long __________ Years

Discharge: ☐Honorable ☐Other Branch of service ____________________

Active religious practice: ☐Yes ☐No If yes, what religion

Who lives with you now in your household? ____

Hobbies and leisure activities ____

____

____

Any other comments or concerns you want to share? ________________________________

____

____

____

________________________________ ____________________ ____________________

Patient signature or Patient's legal representative **(Relationship)** **(Date)**

Have you ever taken any psychiatric medication? ☐ yes ☐no ☐ unsure

Please check all that apply:	Name of medication, if known
☐Antidepressants	
☐Antipsychotic	
☐ADHD Meds	
☐Mood stabilizing Meds	
☐Side Effect Meds	
☐Anti-anxiety Meds	
☐Other:	

Family History

(see familial Medical & Psychiatric History form & genogram attached)

Has anyone in your immediate or extended family taken psychiatric medicines?

☐ **NO** ☐ **YES** **if yes**

comment:________________________________

Has anyone in your immediate or extended family had s psychiatric hospitalization?

☐ **NO** ☐ **YES** **if yes**

comment:________________________________

ADDITIONAL family information (added by psychiatrist):

SLEEP: ☐ **No problem** ☐ **Wakes up during the night** ☐ **Nightmares**
☐ **Can't fall asleep** ☐ **Can't wake up in the morning** ☐ **Anxious**
☐**Other:**____________________

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ________
Somewhat difficult ________
Very difficult ________
Extremely difficult ________

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	Not at all	Several days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + ____ + ____ + ____

=Total Score: ____

If you checked off <u>any</u> problems, how <u>difficult</u> have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

	Never	Rarely	Sometimes	Often	Very Often
7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

Office Policy

COMMITMENT TO CHANGE: An effective therapy program requires openness, commitment to change, and an attitude of collaboration between client and therapist. Since many of the aspects of these requirements are intangible, the success of any therapy cannot be guaranteed by your efforts.

FEE FOR SERVICE APPOINTMENT: The fee for therapy appointments is based upon the type of appointment you have scheduled. A staff person will discuss what your fee is at the time that you schedule an appointment. Your session begins at the scheduled time, not when you arrive.

PAYMENT: Payment will be requested at the time of your appointment. This office reserves the right to send a bill for collection, after 90 days without a payment. Any questions regarding payment needs to be directed to your provider.

MISSED APPOINTMENTS AND CANCELLATIONS: Not made at least **48 HOURS** prior to the scheduled appointment will be charged $75.00 per incident. This is not covered by insurance. A list of my fees is available upon request.

INSURANCE COVERAGE: Some insurance plans cover psychiatric services. If you are unsure about your coverage, call your insurance company to inquire if your plan covers outpatient mental health services. In most instances I will provide billing for mental health services. Your co-payment or co-insurance (the amount not paid by your insurance carrier), as well as any amounts credited toward a deductible are due at the time service is rendered.

Payment for services is your responsibility, so please keep track of billings and payments. If you have questions, do not hesitate to contact me. In the event that you submit your own claim, I will provide you with a statement of diagnosis, services provided, and payments made to submit to your insurance company. Insurance companies may require more detailed information, such as progress notes or treatment summaries. Attached is a Consent Form allowing me to release the necessary information for processing your claim.

Most managed care companies require pre-authorization before you see a therapist. The responsibility for assuring that this happens lies with the client.

If you have a change in your insurance carrier please notify me immediately. Coverage may not be the same if you switch companies and it is essential that we discuss this issue in the case of a change in insurance. Please do not assume that since your care was paid for with your previous insurance that it will be paid for in a similar manner (or at all) by your new carrier.

CONFIDENTIALITY: All information discussed in the course of therapy is strictly confidential. By law, information can only be released with the written consent of the person treated, or such person's parent or guardian. However, the law requires the release of confidential information in three situations: suspected child or elder abuse, potential suicidal behavior, or threatened harm to another. In addition, in certain select circumstances, the court may subpoena treatment records. The law also allows me to consult with other health care providers without your written permission if I deem that it is in your best interest for me to do so.

ETHICS AND PROFESSIONAL STANDARDS: As a licensed nurse practitioner and a member of the Washington State Nurses Association, I am accountable for my work with you. If you have any concerns about the course of treatment, please discuss them with me. Should you feel that I have been unethical or unprofessional, you may contact the Licensing Department in Olympia at 206-753-6981.

EMERGENCY AVAILABILITY: A psychiatrist or nurse practitioner is available 24 hours per day in case of emergency by calling our regular office number. Emergencies are defined as "life threatening" problems that cannot wait to be resolved on the next working day. If our emergency system fails for any reason, please use good judgment and obtain emergent care through a local hospital emergency room, your primary care physician, or a crisis line. Non-emergent issues should be brought up at scheduled appointments.

MEDICATION REFILLS: I endeavor to provide enough medication to get to the next scheduled appointment. If called for refills in non-business hours, I generally do not have access to the patient file and do not have adequate information on which to determine appropriate action. It is expected that patients will make appointments to discuss medication changes, or refills and is your responsibility to make sure you schedule an appointment for discussion of medications issues. It is for this reason that **NO MEDICATION REFILLS will be called in outside of normal business hours. If refills are necessary and you have failed to schedule an appointment to address these issues, enough medication will be called into the pharmacy to allow you to make it to your next appointment. Office policy requires that you please allow 72 business hours for prescription request.**

I HEREBY AUTHORIZE Hyesoon Choi PMHNP-BC to render psychiatric services to ______________________. This authorization constitutes informed consent without exception. I have read and understand this Office Policy and am in agreement, and have received a copy for myself.

Signature	Date	Parent/Guardian

ASSIGNMENT OF BENEFITS

I HEREBY AUTHORIZE directly to Hyesoon Choi PMHNP-BC benefits otherwise payable to me for therapy/medical visits by Hyesoon Choi PMHNP-BC but not to exceed the regular charges for therapy/medical visits commencing on the ________ day of _____, 20____.

I HEREBY AUTHORIZE that Hyesoon Choi PMHNP-BC may be in receipt for any such payment and that it's receipt shall be a conclusive acknowledgement by me that I have received benefits from the insurance company in the sum specified in such receipt, and agree that such payment shall discharge the said insurance company of any and all obligations under the policy to the extent of such payment, and for the purpose I understand that I am financially responsible to the provider for charges no covered by this agreement.

Signature	Date	Parent/Guardian

I HEREBY AUTHORIZE Hyesoon Choi PMHNP-BC to exchange necessary information with my referring physician/therapist.

Signature	Date	Parent/Guardian

Bay Psychiatric
A Group of Independent Practitioners

Financial Policy

Insurance Verification. Before the initial visit our office will contact the patient's insurance company to determine specific benefits. We will inquire if there is a deductible, what services are covered, whether or not a referral is necessary and what the estimated copayment is. The information we receive is not a guarantee of the patient's actual benefit and is subject to final processing by the patient's insurance company. The patient is responsible for fees not covered by his or her insurance company.

Private Billings. For patients without insurance coverage, full payment is due at the time of service. All new patients are quoted a fee for the office visit and are expected to pay at the time they are seen.

We kindly accept Visa and MasterCard for payment of services.

Should patients need to make special payment arrangements, arrangements may be made with our billing service or at the time of the scheduled appointment. Payment arrangements are based on total balance due. Any and all accounts that become 90 days delinquent are subject to collections.

I certify that I am eligible for benefits under this prepaid health benefit plan.
In the event that I am later found to be ineligible, or as consideration for being treated without proof of eligibility, I agree to pay for any and all services provided by an individual practitioner at his or her regular fees then in effect.

I have read and understood the above information and have received a copy.

____ Signature

____________________ Date

A Group of Independent Practitioners

I acknowledge receipt of Medical Records Privacy Policy.
Signature ______________________________ Date __________

NOTIFICATION OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Uses and Disclosures

Treatment. Your health information may be used by our physicians and staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment.

Payment. Your health information may be used to seek payment from your health plan, other sources of coverage such as an automobile insurer, or credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of service, the services provided, and the medical condition being treated.

Health Care Operations. Your health information may be used as necessary to support the day-to-day activities and management of Bay Psychiatric. For example, information on the services you received may be used to support budgeting and financial reporting and activities to evaluate and promote quality to insure that our practice is meeting state and federal guidelines and laws designed to protect your health care information.

Law Enforcement. Your health information may be disclosed to law enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting. Your health information may be disclosed to public health agencies as required by law. For example, our practice is required to report certain communicable diseases to the State of Washington Department of Health.

Other uses and disclosures require your authorization. Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure that occurred before you notified us of your decision.

Additional Uses of Information

Appointment reminders. When applicable, your health information will be used by our staff to call/send you appointment reminders.

☐ Please check here if it is OK to leave messages at your home.

Information about treatments. Your health information may be used to send you information on the treatment and management of your medical condition that you may find of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Individual Rights

You have certain right under the Federal Privacy Standards. These include:

- The right to request restrictions on the use and disclosure of your protected health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information.
- The right to request an amendment or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Bay Psychiatric Duties. We are required by law to maintain the privacy of your protected health information and to provide you with this notice of privacy practices. We are also required to abide by the privacy policies and practices that are outlined in this notice.

Right to Revise Privacy Practices. As permitted by law, we reserve the right to amend or modify our privacy policies and practices, these changes in our policies and practices may be required by changes in federal and state laws and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Requests to Inspect Protected Health Information. As permitted by federal regulation, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting your individual practitioner.

Complaints and Contact Person. If you would like to submit a comment or complaint about our privacy practices, or obtain additional information about our privacy practices, you can do so by sending a letter outlining your concerns to the person listed below. You will not be penalized or otherwise retaliated against for filing a complaint.

Maryanne Godfrey, A.R.N.P., M.N.
1728 West Marine View Drive, Suite 109
Everett, WA 98201
(425) 252-9216 ext. 208

You may also contact the Department of Health and Human Services directly at:

200 Independence Ave SW
Washington, DC 20201
Toll Free: 1-877-696-6775

MIND AND BEHAVIORAL CENTER

178 W Marine View Drive Suite 109•Everett, WA 9820•425-252-9216•Fax 425-252-8637

AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Please read all information and instructions before completing the authorization form

Patient's Name_______________________________________ DOB ______________

(PLEASE PRINT) LAST FIRST MI

Are medical records filed under another name?_________________________Phone Number:

INFORMATION TO BE RELEASED BY: Organization/Person/Address/Phone/Fax (please print name):

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

______________________________ ______________________________

TYPE OF MEDICAL INFORMATION REQUESTED

☐ Complete medical records(include 3 years of chard notes, most recent labs/pathology & diagnostic imaging reports) ☐ Behavioral Health records only ☐Pharmacy

☐ My health information related only to the following condition or treatment:

☐ My health information only for the following date(s): ______________________________

☐ Other: ____

REASON FOR REQUEST: ☐ Personal ☐ Transfer of care ☐ Disability ☐ Insurance ☐ Legal View ☐ Other:

THERE MAY BE A CHARGE FOR COPIES OF YOUR MEDICAL RECORDS UNLESS YOUR COPIES ARE BEING SENT TO ANOTHER PHYSICIAN OR HEALTH CARE FACILITY.

SENSITIVE INFORMATION: This authorization includes the released of the following sensitive information unless specifically excluded. **Please check if you do not want this released:** ☐ HIV/AIDS ☐ Sexually Transmitted diseases ☐ Drug and alcohol treatment ☐ Reproductive care (minors only) ☐ Self-paid services

I hereby consent to release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my consent. I acknowledge I have fully reviewed and understand the contest of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. You have the right to revoke or cancel this authorization, in writing at any time.

This authorization expires ____________________(date of event). Authorization with expire 90 days if not otherwise specified: ______________________________

Patient Signature ______________________________ Date ______________

Parent or Legal Guardian ______________________________ Date ______________

Relationship to patient, if other than parent ______________________________

Federal laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent the person to whom it pertains or as otherwise permitted by 42 CFR Part 2