Bay Psychiatric
A Group of Independent Practitioners

PLEASE SIGN*
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 evalnate and promote quality to insure that our practice is meeting state and federal guidelines and laws designated 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 rights 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 filling a complaint.

1728 West Marine View Drive, Suite 109
Everett, WA 98201
(425) 252-9216, ext. 402

You may also contact the Dept. of Health and Human Services Directly at:

200 Independence Ave. SW
Washington, D.C. 20201
Toll Free: 1-877-696-6775

Bay Psychiatric

A Group of Independent Practitioners

1728 West Marine View Drive, Suite 109
Everett, WA 98201
Phone 425-252-9216
FAX 425-252-8637

** Robert I. Fink, M.D. * Maryanne Godfrey, A.R.N.P., MN. * Stephen Greenhouse, Psy.D.* William Heusler, Ph..D **
** Tyson Bailey, Psy.D.* Nina Merendino, RN. MA. LMHC * Janice Katt, LMHC * Colleen Lawson, LMHC **

INDIVIDUAL INTAKE

YOUR COOPERATION IN COMPLETING THIS QUESTIONNAIRE WILL BE HELPFUL IN PLANNING OUR SERVICES FOR YOU. PLEASE ANSWER EACH ITEM CAREFULLY OR ASK FOR CLARIFICATION IF YOU DO NOT UNDERSTAND AN ITEM.

NAME:_____ TODAY'S DATE:_____
First MI Last

PHYSICAL ADDRESS:_____
STREET NUMBER

_____
CITY STATE ZIP

MAILING ADDRESS (IF DIFFERENT FROM PHYSICAL ADDRESS:_____
PO BOX OR STREET NUMBER

_____
CITY STATE ZIP

HOME #:_____ CELL:_____ WORK:_____

AGE:_____ BIRTHDATE:_____ SSN:_____ DRIVERS LICENCES#:_____

MARITAL STATUS (CIRCLE ONE): MARRIED DIVORCED SINGLE SEPARATED OTHER:_____

EMPLOYER:_____ OCCUPATION:_____

YEARS EMPLOYED:_____ EDUCATION:_____

REFERRED BY:_____ PHONE:_____

PERSON NOT LIVING WITH YOU TO CONTACT IN AN EMERGENCY:

_____
NAME RELATIONSHIP PHONE

TO BE COMPLETED BY THERAPIST

PRIMARY DIAGNOSIS:_____ SECONDARY DIAGNOSIS:_____ TERTIARY DIAGNOSIS:_____

CONCERNS AND GOALS:

PLEASE DESCRIBE WHY YOU HAVE COME IN:_____

_____

DESCRIBE GOALS YOU WANT TO ACCOMPLISH BY COMING HERE:_____

_____

_____

PLEASE **CIRCLE** INDIVIDUAL ITEMS YOU WANT TO ADDRESS. PLEASE **UNDERLINE** THE **TWO MOST IMPORTANT**, TO ADDRESS FIRST:

CONCENTRATION
HOPELESSNESS
DEPRESSED
HARM TO SELF
SUICIDAL CONCERNS
HIGH ENERGY
LOW ENERGY
ANGER
TEMPER
NERVOUSNESS
ANXIETY
STRESS
PANIC

FEARS
GUILT
SELF-CONTROL
HARM TO OTHERS
IMPULSIVITY
HYPERACTIVE
ATTENTION DIFFICULTIES
SLEEP PROBLEMS
DREAMS
NIGHTMARES
HEALTH PROBLEMS
APPETITE/WEIGHT
EATING/FOOD TROUBLE

BOWEL TROUBLE
STOMACH TROUBLE
SEXUAL PROBLEM
DRUG USE
ALCOHOL USE
HEADACHES
MEMORY
THOUGHTS
ABUSE
TRAUMA
SHYNESS
CRYING SPELLS
UNHAPPINESS

SELF-ESTEEM
TEMPER
RELAXATION
FINANCES
WORK
MOTIVATION
LEGAL MATTERS
CAREER CHOICES
EDUCATION
MAKING DECISIONS
MEANINGLESSNESS
UNRESOLVED GRIEF
SPIRITUAL CONCERNS

PLEASE **CHECK** RELATIONSHIP ITEMS YOU WANT TO ADDRESS. **UNDERLINE** THOSE YOU FEEL APPLY TO ANOTHER FAMILY MEMBER. PLEASE **CIRCLE** THE **TWO MOST IMPORTANT** TO ADDRESS FIRST.

MARRIAGE
SEPARATION
DIVORCE
INTIMACY
IN-LAWS
RELATIVES
JEALOUSY
USE OF TIME

PARENTING
CHILDREN
HOUSING
FINANCES
SEXUAL DESIRE
AGREEING ON CHORES
SEXUAL PERFORMANCE
SPOUSE'S CLEANLINESS

RECREATION
INFIDELITY/AFFAIRS
PHYSICAL FIGHTING
COMMON INTERESTS
SHOWING APPRECIATION
TRUSTING EACH OTHER
AFFECTION
COMMUNICATION

FRIENDSHIPS
HOLDING OTHER DOWN
CONFLICTING SCHEDULES
PROBLEM SOLVING
LONELINESS
COMMON GOALS
VERBAL FIGHTING
HAVING FUN TOGETHER

HEALTH INFORMATION:

LIST ALL CURRENT MEDICATIONS:_____

_____

LIST ALL CURRENT HEALTH PROBLEMS:_____

_____

LIST PAST SIGNIFICANT HEALTH PROBLEMS:_____

_____

HAVE YOU BEEN HOSPITALIZED OR HAD OTHER PSYCHIATRIC CARE RELATED TO YOUR MENTAL HEALTH? **YES** **NO**

IF YOU ANSWERED YES PLEASE PROVIDE DATES AND TREATMENT OUTCOME FOR THOSE EVENTS:_____

_____

LIST PREVIOUS PROFESSIONAL HELP YOU HAVE RECEIVED FOR PERSONAL, MARITAL, OR FAMILY CONCERNS AND DATES:

_____

NAME OF YOUR PRIMARY CARE PHYSICIAN:_____ MAY WE CONTACT? **YES** **NO**

PHONE NUMBER:_____ WHEN WERE YOU LAST SEEN?_____

DRUG AND ACHOHOL ASSESSMENT:

Are drugs or alcohol used by yourself or someone else a significant factor in why you are coming to our office?
_____Yes _____No If yes _____self _____other: Relationship_____

ALCOHOL ASSESSMENT:

Alcohol frequency:
___ Never ___ Less than1 time/month ___ 1-4 times per month ___ 2-3 times per week ___ Daily

Usual Alcohol Consumption:
___ None ___ 1-2 drinks per sitting ___3-4 drinks per sitting ___ 5 or more drinks per sitting

Intoxication Frequency:
___ never ___ less than 1 time/month ___ 1-4 times per month ___ 2-3 times per week ___ Daily

Please describe any alcohol-related problems (e.g. legal, job, physical, or social):_____

Self-perception of **Alcohol Use**: (please check)
___ Occasional or social ___ Problem use ___ Psychological dependence
___ Addicted-cannot stop ___ Does not want to stop ___ Motivated to stop

History of treatment attempts: (check all that apply)
___ None ___ Stopped on own ___Attended AA/ other 12 step program
___ Attended outpatient program ___ Attended inpatient program ___ Attended community-based program

OTHER SUBSTANCE USE ASSESSMENT: (Check Frequency and Duration for each drug used in the last 6 months)

	Frequency			**Duration**	
	Daily	Weekly	Monthly Or less	Less than one year	More than one Year
Marijuana	____	____	____	____	____
Sedative	____	____	____	____	____
Stimulant	____	____	____	____	____
Cocaine	____	____	____	____	____
Opiates	____	____	____	____	____
Inhalants	____	____	____	____	____
Hallucinogens	____	____	____	____	____
Prescription Drugs	____	____	____	____	____

Caffeine _____ Number of cups per day _____ Tobacco____ if cigarettes-number per day _____

Please describe any drug-related problems (e.g. legal, job, physical, or social):_____

Self-perception of **Drug Use:** (please check)
___ Occasional or social ___ Problem use ___ Psychological dependence
___ Addicted-cannot stop ___ Does not want to stop ___ Motivated to stop

History of treatment attempts: (check all that apply)
___ None ___ Stopped on own ___ Attended NA/ other program
___ Attended outpatient program ___ Attended inpatient program ___ Attended community-based program

LEGAL INFORMATION:

DO YOU HAVE A PROBATION OFFICER OR CASE WORKER? **YES NO** MAY WE CONTACT THEM? **YES NO**

WHAT IS HIS/HER NAME?_____

PHONE NUMBER:_____ADDRESS:_____

DO YOU HAVE AN ATTORNEY? **YES NO** IF YES, WHAT IS HIS/HER NAME?_____

PHONE NUMBER:_____ ADDRESS:_____

MARITAL INFORMATION:

MARRIED: _____ DIVORCED: _____ LIVING TOGETHER: _____ SEPARATED: _____ SINGLE: _____ OTHER: _____

IF YOU CHECKED "OTHER" PLEASE EXPLAIN:_____

_____

LIST DATES AND LENGTHS OF ANY PREVIOUS MARRIAGES:_____

_____

FAMILY HISTORY:

LIST THE NAMES, AGES, AND RELATIONSHIP, OF ALL PERSONS LIVING IN YOUR HOME:

_____

_____

_____

LIST THE NAMES, AND AGES OF ANY IMMEDIATE FAMILY MEMBERS THAT ARE NOT LISTED ABOVE

_____

_____

_____

_____

RELIGOUS HISTORY:

ARE SPIRITUAL OR RELIGOUS ISSUES A CONCERN TO YOU _____YES _____NO

WHAT IS YOUR RELIGIOUS AFFILIATION, IF ANY?_____

IF YES, WHAT IS THE NAME OF THE CONGREGATION YOU BELONG TO?_____

REATMENT AGREEMENT:

LEASE INITIAL:

:O-PAYMENTS ARE DUE AT THE TIME OF SERVICE. _____

BAYPSYCH. BAY PSYCH.

HEREBY ASSIGN PAYMENT OF INSURANCE BENEFITS DIRECTLY TO [redacted] WHILE [redacted] WILL BILL MY NSURANCE COMPANY, I WILL BE RESPONSIBLE FOR ANY CHARGES INCURRED IF MY INSURANCE COMPANY DOES NOT 'AY. _____

' IS MY RESPONSIBILITY TO CONTACT MY INSURANCE COMPANY TO OBTAIN THE PROPER AUTHORIZATIONS IF REQUIRED. : I FAIL TO DO THIS AND CHARGES ARE DENIED I WILL BE RESPONSIBLE FOR ALL CHARGES. _____

: YOUR PORTION OF THE BILL IS OVER 90 DAYS OLD YOU WILL BE SENT TO COLLECTIONS, UNLESS OTHER ARRANGEMENTS ARE MADE WITH OUR BILLING OFFICE. _____

$225.00 $175.00

ARE FEES ARE AS FOLLOWS $[redacted] FOR INTIAL SESSION, INDIVDUAL SESSIONS ARE $[redacted], FAMILY/MARITAL SESSIONS ARE $[redacted], FAMILY SESSIONS (PATIENT NOT PRESENT) ARE $[redacted], AND GROUP SESSIONS ARE $60.00. _____

200.00 $175.00 $200.00

'OU WILL BE CHARGED $[redacted] FOR MISSING AN APPOINTMENT WITHOUT CANCELLATION NOTICE. _____

$175.00

'OU WILL BE CHARGED $[redacted] FOR NOT GIVING 24 HOURS NOTICE, WHEN CANCELING AN APPOINTMENT. _____

HAVE READ THROUGH THE TREATMENT AGREEMENT THOROUGHLY AND UNDERSTAND AND AGREE TO ABIDE BY MY FINANCIAL RESPONSIBILITIES. I UNDERSTAND THAT INFORMATION WILL BE RELEASED TO MY INSURANCE COMPANY IF NECESSARY, AND ANY CHARGES THAT MY INSURANCE COMPANY WILL NOT COVER I AM RESPONSIBLE FOR.

CLIENT SIGNATURE:_____ **DATE:**_____

TO ENABLE OUR STAFF WITH ACCURATE AND CONFIDENTIAL SERVICES PLEASE COMPLETE THE FOLLOWING:

PLEASE BE AWARE THAT EMAIL AND FAX TRANSMISSIONS ARRIVE AT A GENERAL FOUNTAINGATE SITE AND ARE DISTRIBUTED TO THE INDIVIDUAL PRACTITIONER CONFIDENTIALITY IS MAINTAINED WITH THESE RECORDS, AS WITH ALL RECORDS IN OUR OFFICE.

MESSAGES REGARDING APPOINTMENTS MAY BE LEFT ON MY ANSWERING MACHINE.

_____YES _____NO

THE FOLLOWING INDIVIDUALS MAY SCHEDULE AND OR CONFIRM APPOINTMENTS:

_____

_____

THE FOLLOWING INDIVIDUALS MAY DISCUSS MY ACCOUNT WITH THE BILLING DEPARTMENT:

_____

(INTENTIONALLY LEFT BLANK)

Read each item carefully and circle the number next to the answer that best reflects how you have been feeling during the past few days.

1.	0	I do not feel sad.
	1	I feel sad.
	2	I am sad all of the time and I can't snap out of it.
	3	I am so sad or unhappy that I can't stand it.
2.	0	I am not particularly discouraged about the future.
	1	I feel discouraged about the future.
	2	I feel I have nothing to look forward to.
	3	I feel that the future is hopeless and that things cannot improve.
3.	0	I do not feel like a failure.
	1	I feel I have failed more then the average person.
	2	As I look back on my life, all I can see is a lot of failures.
	3	I feel I am a complete failure as a person.
4.	0	I get as much satisfaction out of things as I used to.
	1	I don't enjoy things the way I used to.
	2	I don't get real satisfaction out of anything anymore.
	3	I am dissatisfied or bored with everything.
5.	0	I don't feel particularly guilty.
	1	I feel guilty a good part of the time.
	2	I feel quite guilty most of the time.
	3	I feel guilty all of the time.
6.	0	I don't feel I am being punished.
	1	I feel I may be punished.
	2	I expect to be punished.
	3	I feel I am being punished.
7.	0	I don't feel disappointed in myself.
	1	I am disappointed in myself.
	2	I am disgusted with myself.
	3	I hate myself.
8.	0	I do not feel I am any worse than anybody else.
	1	I am critical of myself for my weakness or mistakes.
	2	I blame myself all the time for my faults.
	3	I blame myself for everything bad that happens.
9.	0	I don't have any thoughts of killing myself.
	1	I have thoughts of killing myself, but I would not carry them out.
	2	I would like to kill myself.
	3	I would kill myself if I had the chance.
10.	0	I don't cry any more then usual.
	1	I cry more now than I used to.
	2	I cry all the time now.
	3	I used to be able to cry, but now I can't cry even though I want to.
11.	0	I am no more irritated by the things than I ever am.
	1	I am slightly more irritated now than usual.
	2	I am quite annoyed or irritated a good deal of the time.
	3	I feel irritated all the time now.
12.	0	I have not lost interest in other people.
	1	I am less interested in other people than I used to be.
	2	I have lost most of my interest in other people.
	3	I have lost all of my interest in other people.

13. 0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions than before.
3 I can't make decisions at all anymore.

14. 0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel that there are permanent changes in my appearance that make me look unattractive.
3 I believe that I look ugly.

15. 0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.

16. 0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.

17. 0 I don't get more tired then usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.

18. 0 My appetite is no worse then usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3. I have no appetite at all anymore.

19. 0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20. 0 I am no more worried about my health than usual.
1 I am worried about physical problems such as aches and pains, or upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think about anything else.

21. 0 I have not noticed any recent changes in my interest in sex.
1 I am less interested in sex than I used to be.
2 I am much less interested in sex now.
3 I have lost interest in sex completely.