Maryanne Godfrey, A.R.N.P., M.N.

Advanced Registered Nurse Practitioner
Adult Psychotherapy and Pharmacology
1728 West Marine View Dr., Suite 109
Everett, WA 98201
Phone (425) 252-9216
Fax (425) 252-8637

DX:_____ DATE:_____

PATIENT REGISTRATION

Patient:_____M/F DOB:_____

Home Address:_____City:_____State:_____Zip_____

Home Phone:_____ Cell:_____Work:_____

_____ *Please check if it is alright to leave messages on message machines or with family members.*

Email Address: _____

Social Security #:_____ Employer:_____

Name of Spouse:_____ SS#:_____ DOB:_____

Referred By:_____ Phone _____

Family Physician:_____ Phone #:_____

Emergency Contact:_____ Phone #:_____

Address:_____City:_____ State: _____Zip:_____

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INSURANCE INFORMATION

Insurance Company:_____ID#:_____

Policy Holders Name:_____DOB:_____ Group#:_____

Employer:_____Phone#:_____

Responsible Party Name: _____SS#:_____DOB:_____

Address:_____ Phone#:_____

Secondary Insurance:_____ID#:_____

Policy Holders Name:_____Group#:_____

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 **24 HOURS** prior to the scheduled appointment will be charged at 50% of my regular fee. 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 Maryanne Godfrey, A.R.N.P., M.N. 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 Maryanne Godfrey, A.R.N.P., M.N. benefits otherwise payable to me for therapy/medical visits by Maryanne Godfrey, A.R.N.P., M.N., but not to exceed the regular charges for therapy/medical visits commencing on the _____ day of _____, 20____.

I HEREBY AUTHORIZE that Maryanne Godfrey, A.R.N.P., M.N. 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 Maryanne Godfrey, A.R.N.P., M.N. to exchange necessary information with my referring physician/therapist.

_____ _____ _____

Signature Date Parent/Guardian

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 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

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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

Name _____ Date _____

Family History

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
Alcoholism	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Bleeding Disorder	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Epilepsy/Convulsions	☐	☐	☐	☐	☐	☐
Glaucoma	☐	☐	☐	☐	☐	☐
Hair Loss	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐

	Father	Mother	Children	Siblings	Father's Parents	Mother's Parents
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Migraine	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐
Thyroid Disease	☐	☐	☐	☐	☐	☐
Other	☐	☐	☐	☐	☐	☐
	☐	☐	☐	☐	☐	☐

Habits

☐ Alcohol: Type _____ Amount _____	☐ Diet: Salt Intake _____	☐ Sleep:Difficulty Falling Asleep	☐ Other _____
☐ Coffee: Cups Daily _____	☐ Fat Intake _____	☐ Early Morning Awakening	☐ Smoke: Pack Daily ____ How Long _____
☐ Other Caffeine _____	☐ Exercise Routine _____	☐ Daytime Drowsiness	☐ Interested in Stopping

Medical History

☐ Abdominal Pain-Chronic	☐ Diptheria	☐ Jaundice/Hepatitis	☐ Sinus Troubles	**Females-Please Complete**
☐ Allergies/Hayfever	☐ Diverticulosis	☐ Kidney Stones	☐ Stroke	Pregnant? ___Yes ___No
☐ Anemia/Bruise Easily	☐ Crohn's/Colitis	☐ Memory Loss	☐ Tetanus	Planning Pregnancy? ___Yes ___No
☐ Ankles-Swollen	☐ Dizziness/Fainting	☐ Mental Illness	☐ Thyroid Disease	Menstrual Flow: ___Regular ___Irregular
☐ Appetite-Loss of	☐ Ear Infections-Frequent	☐ Moodiness-Excessive	☐ Tremor/Hands Shaking	___Pain/Cramps
☐ Arthritis/Rheumatism	☐ Ear-Ringing in	☐ Muscle Weakness	☐ Ulcers	Number of: ___Pregnancies ___Abortion
☐ Asthma/Wheezing	☐ Eye Infections	☐ Nausea/Vomiting-Persistent	☐ Varicose Veins/Phlebitis	___Miscarriages
☐ Back Pain-Recurrent	☐ Fatigue-Chronic	☐ Nervousness	☐ Venereal Disease	___Live Births
☐ Bone Fracture/Joint Injury	☐ Foot Pain/Cold/Numb	☐ Depression	☐ Vision-Failing	Date of Last Pap Test _____
☐ Bowel Habits-Change In	☐ Gall Bladder Trouble	☐ Nose Bleeds	☐ Weight Loss-Recent	___Normal ___Abnormal
☐ Bronchitis/Chronic Cough	☐ Gout	☐ Numbness/Tingling Sensation	☐ Chicken Pox	Date of Last Mammogram _____
☐ Cancer	☐ Hair Loss	☐ Osteoporosis	☐ Polio	___Normal ___Abnormal
☐ Chest Pain	☐ Headaches-Frequent	☐ Phobias	☐ Mumps ___Measles ___Rubella	
☐ Convulsions/Seizures	☐ Heart Murmur	☐ Pneumonia	☐ Rheumatic Fever/Scarlet Fever	
☐ Diabetes	☐ High Blood Pressure	☐ Prostate Disease	☐ Tuberculosis	
☐ Diarrhea	☐ Indigestion/Heartburn	☐ Rashes/Hives	☐ Other _____	
☐ Constipation	☐ Infections-Frequent	☐ Sexual/Menstrual Dysfunction	☐ Other _____	

Medication History

Patient Name _____ DOB _____ Date _____

Current Medication

Allergies