Mind & Behavior Center

Child/Adolescent Psychiatric & Medical History

Patient Name	DOB	Age	Gender
Address			
Height	Weight	Date of Last Physical	Last Recorded Blood Pressure /
School			Grade

Class arrangement: ☐ Special ☐ Regular ☐ Combination ☐ Chapter 1 ☐ Individual educational plan evaluation

Current living arrangement:

Parent home	Foster home	Residential facility

Other

Caretaker/Relationship	Caretaker/Relationship
Name	Name
Address	Address
Home phone number	Home phone number
Work phone number	Work phone number

Parent or legal guardian (person legally authorized to sign for medication and treatment)

Address and phone number, if different than above

Referral Source :

Referred by	

Child's primary physician:

Address:

Would you like a copy of the evaluation from this appointment sent to the child's doctor? ☐ Yes ☐ No

Would you like a copy of the evaluation from this appointment sent to someone else? ☐ Yes ☐ No

If yes, specify to whom

Reason for appointment (Please explain)

HISTORY FOR CHILD/YOUTH MEDICATION CONSULTATION

Client Name:	DOB:	ID:
Form Completed by:	Relationship to Client:	Date:

1. ***Reason for seeking services:***

Why will this child be seeing a child psychiatrist at this time?
What are some of your hopes regarding this meeting with the psychiatrist?

2. ***Mental Health History:***

Has this child received outpatient mental health services before?	☐ yes ☐ no
How old was this child at that time?	

Names of clinics or providers:	Phone	Date / Reason	Records Requested?
			☐ no ☐ yes
			☐ no ☐ yes
			☐ no ☐ yes
			☐ no ☐ yes
			☐ no ☐ yes
			☐ no ☐ yes

HISTORY FOR CHILD/YOUTH MEDICATION CONSULTATION

Has this child ever taken any psychiatric medications? ☐ no ☐ yes ☐ 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:	

Please comment on **PAST psychiatric medications** below:

Medication	Comments (why taking? side effects, benefits, why stopped)

Has this child been in a psychiatric hospital? ☐ no ☐ yes How many times?

What year was this child last hospitalized?

Where?

Why?

Please Comment on **Past hospitalizations** below:

Hospital / Location	**phone**	**Date / Reason**	**Records requested?**
			☐ no ☐ yes
			☐ no ☐ yes
			☐ no ☐ yes
			☐ no ☐ yes

Has this child talked about suicide? ☐ no ☐ yes

Has this child ever attempted suicide? ☐ no ☐ yes When?

If yes, discuss:

ADDITIONAL mental health history information (added by psychiatrist):		

3. *FAMILY HISTORY*

(see Familial Medical & Psychiatric History form & genogram attached)
Has anyone in your immediate or extended family taken psychiatric medicines? ☐ no ☐ yes Comment:
Has anyone in your immediate or extended family had a psychiatric hospitalization? ☐ no ☐ yes Comment:
ADDITIONAL family history information (added by psychiatrist):

4. *DEVELOPMENTAL & MEDICAL HISTORY, ALLERGIES AND CURRENT MEDICATIONS*

Does this child have a Primary Medical Provider?	☐ no ☐ yes
Provider Name:	
Phone Number:	
Address:	
Date of last well child exam?	
Date release with PCP signed:	
Problems during pregnancy with this child? ☐ no ☐ yes	If yes, explain:
During pregnancy did mother take:	
☐ Medications ☐ Alcohol ☐ Drugs ☐ Tobacco	
Problems at birth with this child? ☐ no ☐ yes	If yes, explain:

HISTORY FOR CHILD/YOUTH MEDICATION CONSULTATION

Did mother experience post-partum depression? ☐ no ☐ yes	If yes, explain:
In infancy was this child: ☐ Fussy baby? ☐ Easy baby? ☐ Health problems?	Explain:
Toddler/preschooler: ☐ No concerns ☐ Extremely active? ☐ Trouble getting along w/ other kids?	
☐ Delayed developmental milestones? (talking, walking, toileting) Explain:	

Child has experienced:	Check those that apply and give brief explanation
☐ head injury?	
☐ seizures?	
☐ loss of consciousness?	
☐ physical abuse?	
☐ neglect?	
☐ sexual abuse?	
☐ Allergies to:	
☐ Medications	
☐ Foods	
☐ Other:	

Current and ongoing medical problems? Please explain:

Past medical problems, surgeries, accidents or injuries? Please explain:

HISTORY FOR CHILD/YOUTH MEDICATION CONSULTATION

Please list **CURRENT** medications below. Include all prescription, over-the-counter and herbal medications, using back of this sheet if necessary)

Medication	Reason	Prescribed by

Has this child had an **ALLERGIC REACTION TO ANY MEDICATIONS?** ☐ no ☐ yes
If yes, give name of med and describe what happened:

ADDITIONAL medical information (added by psychiatrist):

5. ***ATTITUDE / BEHAVIOR: (check all that apply)***

Mood:	Comments:
☐ Happy	
☐ Depressed	
☐ Crying spells	
☐ Irritable / angry	
☐ Talk of death / suicide	
☐ Bored	
☐ Anxious	
☐ Other:	

HISTORY FOR CHILD/YOUTH MEDICATION CONSULTATION

Sleep:	☐ No problem	☐ Can't fall asleep	☐ Other:
	☐ Wakes up during night	☐ Can't wake up in the morning	
	☐ Nightmares	☐ Anxious	
Comments:			
Appetite:	☐ No problem	☐ Picky	☐ No appetite ☐ Overeats
	☐ Eats primarily junk food	☐ Hoards food	☐ Other
Comments:			
ADDITIONAL behavioral Information (added by psychiatrist):			

6. ***SCHOOL***

Information marked by ** will be completed by therapist:			
**Release of information signed with school?	☐ no ☐ yes	Date signed:	
**Records requested?	☐ no ☐ yes	Date done:	
**Which records?	☐ IEP ☐ 504 ☐ Other: (specify)		
This child:	☐ Likes school	☐ Doesn't like school	When did this start?
	☐ Teased/ Bullied	☐ Sees/ has seen school counselor	When?
Academics:	☐ Does Well	☐ No academic concerns	☐ Passing classes
	☐ Special Ed-	☐ IEP/ 504 Plan	☐ Repeated grade? Which one?

Behavior:	☐ No problem	☐ Doesn't complete school work	☐ Doesn't stay in seat
	☐ Truant--Grade?	☐ Suspended--Grade?	☐ Expelled--Grade?
	☐ Talks during class	☐ Needs 1:1 help to do homework	
	☐ Difficulty focusing	☐ Loses things	☐ Forgets/doesn't hand in homework
Non-academic activities:	☐ Sports	☐ Band	☐ Drama
	☐ Other:	☐ Choir	☐ Art:

Name of school:		
Current grade:		
Current Teacher(s):		
Schools attended (include Early Intervention, Headstart, preschool/daycare)		
Previous schools: (most recent first)	Location:	Grade
Comments:		
ADDITIONAL school information (added by psychiatrist):		

7. ***SUBSTANCE ABUSE:*** ☐ ***No concerns***

Does this child	☐ Smoke cigarettes	☐ no ☐ yes	How often?
	☐ Drink alcohol	☐ no ☐ yes	How often?
Which drugs?	☐ Illegally use drugs	☐ no ☐ yes	How often?

ADDITIONAL information (added by psychiatrist)

8. ***LEGAL***

Is this child adopted? ☐ no ☐ yes	What age?		
Custody of child held by: ☐ Mother ☐ Father ☐ Both ☐ Parenting Plan? ☐ State of WA ☐ Social Worker			
Protection Orders?	☐ no ☐ yes Explain:		
Has this child been in any trouble with the law?	☐ no ☐ yes		
When / Reason:			
Has this child ever been in juvenile detention?	☐ no ☐ yes		
When / Reason:			
Is this child on probation?	☐ no ☐ yes		
Name of probation officer:			
Is this child on an: ☐ LRA	☐ ARY petition	☐ CHINS	
Explain:			
ADDITIONAL legal information (added by psychiatrist)			

9. *SOCIAL HISTORY*

Are parents

☐ Never married ☐ Married ☐ Divorced ☐ Widowed ☐ Remarried

Child lives with:

☐ Parent ☐ Foster parent ☐ Relative ☐ Other

Any brother or sisters? ☐ yes ☐ no

☐ Full siblings Number:

☐ Half siblings Number:

☐ Step-siblings Number:

Does this child have friendships? ☐ no ☐ yes

When did child last move?

How many moves in past year?

How many moves in past 5 years?

List some of the strengths, talents or positive qualities of this child:

(What is he/she good at? What do you like most about this child?)

ADDITIONAL social information (added by psychiatrist)

HISTORY FOR CHILD/YOUTH MEDICATION CONSULTATION

Signature: _____ _____
Signature of person completing this form Date

Your relationship to this child:

☐ Mother ☐ Father ☐ Relative ☐ Foster parent

☐ Other, please indicate: _____

**** ***This ends the paperwork for client and family to complete.*** ****
Thank you for your responses.

I have reviewed the above history. _____ _____
Doctor's Signature **Date**

****This table will be completed by therapist:**

Past Psychiatric Diagnoses		By Whom	Date
AXIS I			
AXIS II			
AXIS III			
AXIS IV			
AXIS V	CGAS		

Therapist signature: _____ **Date:** _____

SYSTEMS REVIEW HISTORY

FAMILIAL, MEDICAL AND PSYCHIATRIC HISTORY

Psychiatric/Medical history of biologically related family members: ☐ None reported.

Does anyone in your family have any of the following conditions? (Interviewer check all that apply, past or present.)

Condition / Circumstance	Mother	Father	Sibling	Mother's Family	Father's Family
Mental Retardation					
Learning Disorder					
ADD / ADHD					
Alcohol Abuse					
Drug Abuse					
Physical/Emotional Abuse					
Sexual Abuse Victim					
Bipolar Disorder / Mania					
Depression					
Suicide Attempts					
Completed Suicides					
Anxiety Disorders					
Specific Fears or Phobias					
Panic Attacks					
Schizophrenia					
Tics / Tourette's Syndrome					
Arrests / Incarcerations					
Neurological Disorders (eg: Seizures / Epilepsy)					
Chronic Illnesses					
Diabetes					
Thyroid Disorders					
Cardiac / Heart Problems / Sudden Death / High BP					
Obesity					
Other					

Client Name: _____ **Date** _____

Reviewed by: _____ **Date:** _____

SYSTEMS REVIEW HISTORY

Client Name: _____ Date: _____

Born: _____

Person Completing Form: _____

Has your child had abnormal signs or symptoms in any of the following areas?

BODY SYSTEMS	PROBLEMS / CONCERNS
CONSTITUTIONAL ☐ Fever ☐ Fatigue ☐ Swollen Glands ☐ Weight Loss ☐ Weight Gain	☐ Yes ☐ No Problem Identified Explain
NEUROLOGICAL ☐ Headache ☐ Weakness ☐ Stiffness / Tremor ☐ Unusual Spells ☐ Seizures ☐ History of head injury with loss of consciousness ☐ Estimate sleep schedule ☐ School Days: _____ ☐ Weekends: _____	☐ Yes ☐ No Problem Identified Explain
ENDOCRINE ☐ Diabetes ☐ Thyroid Problem ☐ Hormone Problem ☐ Age at first period ☐ Abnormal Menses ☐ Last Menstrual Period Started:	☐ Yes ☐ No Problem Identified Explain
EYES ☐ Pain ☐ Double Vision ☐ Redness ☐ Needs glasses	☐ Yes ☐ No Problem Identified Explain
EAR; NOSE; MOUTH; THROAT ☐ Ear Pain ☐ Drainage ☐ Hearing Loss ☐ Nasal Problem ☐ Sinus Problem ☐ Tooth Pain ☐ Sore Throat ☐ Hoarse Voice	☐ Yes ☐ No Problem Identified Explain
RESPIRATORY ☐ Wheezing ☐ Cough ☐ Asthma ☐ Breathing Problems	☐ Yes ☐ No Problem Identified Explain
CARDIOVASCULAR ☐ Heart Problems ☐ Chest Pains ☐ High Blood Pressure	☐ Yes ☐ No Problem Identified Explain
GASTROINTESTINAL ☐ Nausea ☐ Stomach Aches ☐ Vomiting ☐ Diarrhea ☐ Constipation ☐ Soiling ☐ Appetite changes ☐ Indigestion	☐ Yes ☐ No Problem Identified Explain
GENITOURINARY ☐ Menstrual Discomfort/Moodiness ☐ Discharge ☐ Difficulty with urination ☐ Wetting ☐ Day ☐ Night	☐ Yes ☐ No Problem Identified Explain
MUSCULOSKELETAL ☐ Joint Pain ☐ Muscle Aches ☐ Weakness	☐ Yes ☐ No Problem Identified Explain
HEMATOLOGICAL / LYMPHATIC ☐ Anemia ☐ Bleeding ☐ Jaundice ☐ Swollen Glands	☐ Yes ☐ No Problem Identified Explain
ALLERGIC / IMMUNOLOGY ☐ Allergies ☐ Immunological Disorder ☐ Medication Allergies	☐ Yes ☐ No Problem Identified Explain
INTEGUMENTARY (SKIN AND/OR BREAST) ☐ Rashes ☐ Sores ☐ Swelling ☐ Unusual Spots	☐ Yes ☐ No Problem Identified Explain

Reviewed by: _____ Date: _____

D3 **NICHQ Vanderbilt Assessment Scale—PARENT Informant**

Today's Date: _____ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Directions: Each rating should be considered in the context of what is appropriate for the age of your child. When completing this form, please think about your child's behaviors in the past 6 months.

Is this evaluation based on a time when the child ☐ was on medication ☐ was not on medication ☐ not sure?

Symptoms	Never	Occasionally	Often	Very Often
1. Does not pay attention to details or makes careless mistakes with, for example, homework	0	1	2	3
2. Has difficulty keeping attention to what needs to be done	0	1	2	3
3. Does not seem to listen when spoken to directly	0	1	2	3
4. Does not follow through when given directions and fails to finish activities (not due to refusal or failure to understand)	0	1	2	3
5. Has difficulty organizing tasks and activities	0	1	2	3
6. Avoids, dislikes, or does not want to start tasks that require ongoing mental effort	0	1	2	3
7. Loses things necessary for tasks or activities (toys, assignments, pencils, or books)	0	1	2	3
8. Is easily distracted by noises or other stimuli	0	1	2	3
9. Is forgetful in daily activities	0	1	2	3
10. Fidgets with hands or feet or squirms in seat	0	1	2	3
11. Leaves seat when remaining seated is expected	0	1	2	3
12. Runs about or climbs too much when remaining seated is expected	0	1	2	3
13. Has difficulty playing or beginning quiet play activities	0	1	2	3
14. Is "on the go" or often acts as if "driven by a motor"	0	1	2	3
15. Talks too much	0	1	2	3
16. Blurts out answers before questions have been completed	0	1	2	3
17. Has difficulty waiting his or her turn	0	1	2	3
18. Interrupts or intrudes in on others' conversations and/or activities	0	1	2	3
19. Argues with adults	0	1	2	3
20. Loses temper	0	1	2	3
21. Actively defies or refuses to go along with adults' requests or rules	0	1	2	3
22. Deliberately annoys people	0	1	2	3
23. Blames others for his or her mistakes or misbehaviors	0	1	2	3
24. Is touchy or easily annoyed by others	0	1	2	3
25. Is angry or resentful	0	1	2	3
26. Is spiteful and wants to get even	0	1	2	3
27. Bullies, threatens, or intimidates others	0	1	2	3
28. Starts physical fights	0	1	2	3
29. Lies to get out of trouble or to avoid obligations (ie, "cons" others)	0	1	2	3
30. Is truant from school (skips school) without permission	0	1	2	3
31. Is physically cruel to people	0	1	2	3
32. Has stolen things that have value	0	1	2	3

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Today's Date: ___/___/___ Child's Name: _____ Date of Birth: _____

Parent's Name: _____ Parent's Phone Number: _____

Symptoms (continued)	Never	Occasionally	Often	Very Often
33. Deliberately destroys others' property	0	1	2	3
34. Has used a weapon that can cause serious harm (bat, knife, brick, gun)	0	1	2	3
35. Is physically cruel to animals	0	1	2	3
36. Has deliberately set fires to cause damage	0	1	2	3
37. Has broken into someone else's home, business, or car	0	1	2	3
38. Has stayed out at night without permission	0	1	2	3
39. Has run away from home overnight	0	1	2	3
40. Has forced someone into sexual activity	0	1	2	3
41. Is fearful, anxious, or worried	0	1	2	3
42. Is afraid to try new things for fear of making mistakes	0	1	2	3
43. Feels worthless or inferior	0	1	2	3
44. Blames self for problems, feels guilty	0	1	2	3
45. Feels lonely, unwanted, or unloved; complains that "no one loves him or her"	0	1	2	3
46. Is sad, unhappy, or depressed	0	1	2	3
47. Is self-conscious or easily embarrassed	0	1	2	3

Performance	Excellent	Above Average	Average	Somewhat of a Problem	Problematic
48. Overall school performance	1	2	3	4	5
49. Reading	1	2	3	4	5
50. Writing	1	2	3	4	5
51. Mathematics	1	2	3	4	5
52. Relationship with parents	1	2	3	4	5
53. Relationship with siblings	1	2	3	4	5
54. Relationship with peers	1	2	3	4	5
55. Participation in organized activities (eg, teams)	1	2	3	4	5

Comments:

For Office Use Only

Total number of questions scored 2 or 3 in questions 1–9: _____

Total number of questions scored 2 or 3 in questions 10–18: _____

Total Symptom Score for questions 1–18: _____

Total number of questions scored 2 or 3 in questions 19–26: _____

Total number of questions scored 2 or 3 in questions 27–40: _____

Total number of questions scored 2 or 3 in questions 41–47: _____

Total number of questions scored 4 or 5 in questions 48–55: _____

Average Performance Score: _____

American Academy of Pediatrics

DEDICATED TO THE HEALTH OF ALL CHILDREN™

NICHQ

National Initiative for Children's Healthcare Quality

McNeil

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

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. Those 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

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