# PATIENT NOTICE OF PRIVACY PRACTICES

As Required by the Privacy Regulations Created as a Result of the Health Insurance Portability and Accountability Act of 1996-(HIPM), Health Information Technology for Economic and Clinical Health Act (HITECH Act), and associated regulations and amendments

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

## ABOUT THIS NOTICE

We understand that health information about you is personal and we are committed to protecting your information. We create a record of the care and services you receive at Psychiatry Northwest, LLC. We need this record to provide care (treatment), for payment of care provided, for health care operations, and to comply with certain legal requirements. This Notice will tell you about the ways in which we *may* use and disclose health information about you. It also describes your rights and certain obligations we have regarding the use and disclosure of health information. We are required by law to follow the terms of this Notice that is currently in effect.

## WHAT IS PROTECTED HEALTH INFORMATION (PHI)

PHI is information that individually identifies you. We create a record or get from you or from another health care provider. health plan. your employer, or a health care clearinghouse that relates to:

- Your past, present. or future physical or mental health or conditions,
- The provision of health care to you, or
- The past, present, or future payment for your health care.

## HOW WE MAY USE AND DISCLOSE YOUR PHI

We may use and disclose your PHI in the following circumstances:

- **Treatment.** We may use or disclose your PHI to give you medical treatment or services and to manage and coordinate your medical care. For example, your PHI may be provided to a physician or other health care provider (e.g., a specialist or laboratory) to whom you have been referred to ensure that the physician or other health care provider has the necessary information to diagnose or treat you or provide you with a service.
- **Payment.** We may use and disclose your PHI so that we can bill for the treatment and services you receive from us and can collect payment from you, a health plan, or a third party. This use and disclosure may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services, we recommend for you, such as making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, we may need to give your health plan information about your treatment for your health plan to agree to pay for that treatment.
- **Health Care Operations**. We may use and disclose PHI for our health care operations. For example, we may use your PHI to internally review the quality of the treatment and services you receive and to evaluate the performance of our team members in caring for you. We also may disclose Information to physicians, nurses, medical technicians, medical students, and other authorized personnel for educational and learning purposes.
- **Appointment Reminders/Treatment Alternatives/Health-Related Benefits and Services**. We may use and disclose PHI to contact you to remind you that you have an appointment for medical care, or to contact you to tell you about possible treatment options or alternatives or health related benefits and services that may be of interest to you.
- **Minors**. We may disclose the PHI of minor children to their parents or guardians unless such disclosure is otherwise prohibited by law.
- **Research**. We may use and disclose your PHI for research purposes, but we will only do that if the research has been specially approved by an authorized institutional review board or a privacy board that has reviewed the research proposal and has set up protocols to ensure the privacy of your PHI. Even without that special approval, we may permit researchers to look at PHI to help them prepare for research, for example, to allow them to identify patients who may be included in their research project, if they do not remove, or take a copy of, any PHI. We may disclose PHI to be used in collaborative research initiatives amongst Psychiatry Northwest providers. We may use and disclose a limited data set that does not contain specific readily Identifiable information about you for research. However, we will only disclose the limited data set If we enter into a data use agreement with the recipient who must agree to (1) use the data set only for the purposes for which It was provided, (2) ensure the confidentiality and security of the data, and (3) not identify the information or use it to contact any individual.
- **As Required by Law**. We will disclose PHI about you when required to do so by international, federal. state. or local law.
- **To Avert a Serious Threat to Health or Safety.** We may use and disclose PHI when necessary to prevent a serious threat to your health or safety or to the health or safety of others. But we will only disclose the information to someone who may be able to help prevent the threat.
- **Business Associates**. We may disclose PHI to our business associates who perform functions on our behalf or providers with services if the PHI is necessary for those functions or services. For example. we may use another company to do our billing, or to

provide transcription or consulting services for us. All our business associates are obligated, under contract with us, to protect the privacy and ensure the security of your PHI.

- **Organ and Tissue Donation**. If you are an organ or tissue donor, we may use or disclose your PHI to organizations that handle organ procurement or transplantation - such as an organ donation bank- as necessary to facilitate organ or tissue donation and transplantation.
- **Military and Veterans**. If you are a member of the armed forces, we may disclose PHI as required by military command authorities. We also may disclose PHI to the appropriate foreign military authority if you are a member of a foreign military.
- **Workers' Compensation**. We may use or disclose PHI for workers' compensation or similar programs that provide benefits for work-related injuries or illness.
- **Public Health Risks.** We may disclose PHI for public health activities. This includes disclosures to: (1) a person subject to the jurisdiction of the Food and Drug Administration (FDA) for purposes related to the quality, safety or effectiveness of an FDA-regulated product or activity; (2) prevent or control disease, injury or disability; (3) report births and deaths; (4) report child abuse or neglect; (5) report reactions to medications or problems with products; (6) notify people of recalls of products they may be using; and (7) a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- **Abuse, Neglect, or Domestic Violence.** We may disclose PHI to the appropriate government authority if we believe a patient has been the victim of abuse, neglect, or domestic violence and the patient agrees or we are required or authorized by law to make that disclosure.
- **Health Oversight Activities.** We may disclose PHI to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, licensure, and similar activities that are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.
- **Data Breach Notification Purposes**. We may use or disclose your PHI to provide legally required notices of unauthorized access to or disclosure of your health information.
- **Lawsuits and Disputes**. If you are involved in a lawsuit or a dispute, we may disclose PHI in response to a court or administrative order. We also may disclose PHI in response to a subpoena, discovery request, or other legal process from someone else involved in the dispute, but only if efforts have been made to tell you about the request or to get an order protecting the information requested. We may also use or disclose your PHI to defend ourselves in the event of a lawsuit
- **Law Enforcement**. We may disclose PHI, so long as applicable legal requirements are met, for law enforcement purposes.
- **Military Activity and National Security**. If you are involved with military, national security or intelligence activities or if you are in law enforcement custody, we may disclose your PHI to authorized officials so they may carry out their legal duties under the law.
- **Coroners, Medical Examiners, and Funeral Directors**. We may disclose PHI to a coroner. medical examiner, or funeral director so that they can carry out their duties.
- **Inmates**. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may disclose PHI to the correctional institution or law enforcement official if the disclosure is necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) the safety and security of the correctional institution.
- **Uses and Disclosures That Require Us to Give You an Opportunity to Object and Opt. Out.**
- **Individuals Involved in Your Care.** Unless you object in writing, we may disclose to a member of your family, a relative, a close friend or any other person you identify, your PHI that directly relates to that person's involvement in your health care. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment.
- **Payment for Your Care**. Unless you object in writing, you can exercise your rights under HIPAA that your healthcare provider not disclose information about services received when you pay in full out of pocket for the service and refuse to file a claim with your health plan.
- **Disaster Relief**. We may disclose your PHI to disaster relief organizations that seek your PHI to coordinate your care or notify family and friends of your location or condition in a disaster. We will provide you with an opportunity to agree or object to such a disclosure whenever we practicably can do so.
- **Fundraising Activities**. We may use or disclose your PHI, as necessary, in order to contact you for fundraising activities. You have the right to opt out of receiving fundraising communications.

YOUR WRITTEN AUTHORIZATION IF REQUIRED FOR OTHER USES AND DISCLOSURES

The following uses and disclosures of your PHI will be made only with your written authorization:

- Most uses and disclosures of psychotherapy notes;
- Uses and disclosures of PHI for marketing purposes; and
- Disclosures that constitute a sale of your PHI.

Other uses and disclosures of PHI not covered by this Notice or the laws that apply to us will be made only with your written authorization. If you do give us an authorization, you may revoke it at any time by submitting a written revocation to our Privacy Officer and we will no longer disclose PHI under the authorization. But disclosure that we made in reliance on your authorization before you revoked will not be affected by the revocation.

YOUR RIGHTS REGARDING YOUR PHI:
You have the following rights, subject to certain limitations, regarding your PHI:

- **Inspect and Copy**. You have the right to inspect, receive, and copy PHI that may be used to make decisions about your care or payment for your care. We have up to 30 days to make your PHI available to you and we may charge you a reasonable fee for the costs of copying, mailing, or other supplies associated with your request. You can only direct us in writing to submit your PHI to a third party not covered in this notice. We may not charge you a fee if you need the information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. We may deny your request in certain limited circumstances. If we do deny your request, you have the right to have the denial reviewed by a licensed healthcare professional who was not directly involved in the denial of your request, and we will comply with the outcome of the review.
- **Summary or Explanation**. We can also provide you with a summary of your PHI, rather than the entire record, or we can provide you with an explanation of the PHI which has been provided to you, so long as you agree to this alternative form and pay the associated fees.
- **Electronic Copy of Electronic Medical Records**. If your PHI is maintained in an electronic format (known as an electronic medical record or an electronic health record), you have the right to request that an electronic copy of your record be given to you or transmitted to another individual or entity. If the PHI is not readily producible in the form or format you request, your record will be provided in a readable hard copy form.
- **Receive Notice of a Breach**. You have the right to be notified upon a breach of any of your unsecured PHI.
- **Request Amendments.** If you feel that the PHI we have is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as the information is kept by or for us. A request for amendment must be made in writing to the Privacy Officer at the address provided at the beginning of this Notice and it must tell us the reason for your request. In certain cases, we may deny your request for an amendment. If we deny your request for an amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.
- **Accounting of Disclosures**. You have the right to ask for an "accounting of disclosures," which is a list of the disclosures we made of your PHI. To request this list r accounting of disclosures, you may submit your request in writing to the Privacy Officer. The first accounting of disclosures you request within any 12-month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the list. We will tell you what the costs are, and you may choose to withdraw or modify your request before the costs are incurred.
- **Request Restrictions**. You have the right to request a restriction or limitation on the PHI we use or disclose about you for treatment, payment, or healthcare operations. We are not required by federal regulation to agree to your request. If we do agree with your request, we will comply unless the information is needed to provide emergency treatment. To request restrictions, you must make your request in writing to the Privacy Officer. Your request must state the specific restriction requested, whether you want to limit our use and/or disclosure, and to whom you want the restriction to apply.
- **Request Confidential Communications**. You have the right to request that we communicate with you only in certain ways to preserve your privacy. For example, you may request that we contact you by mail at a specific address or call you only at your work number. You must make any such request in writing and you must specify how or where we are to contact you.
- **Paper Copy of This Notice**. You have the right to a paper copy of this Notice, even if you have agreed to receive this Notice electronically. You may obtain a copy of this Notice by visiting our website: www.psychiatrynorthwest.com or contact the Psychiatry Northwest clinic.
- **Changes to this Notice**. We reserve the right to change this Notice. We reserve the right to make the changed Notice effective for PHI we already have as well as for any PHI we create or receive in the future. A copy of our current Notice is posted in our office and on our website.
- **Complaints**. If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the U.S. Department of Health and Human Services. To file a complaint with the Secretary, mail it to: The Secretary of the U.S. Department of Health and Human Services, 200 Independence Ave. S.W., Washington, D.C. 20201. Call (202) 619-0257 (or toll free (877) 696-6775 or go to the website of the Office for Civil Rights, www.hhs.gov/ocr/hipaa/ for more information. You will not be penalized for filing a complaint.

ACKNOWLEDGEMENT OF RECEIPT OF PATIENT NOTICE OF PRIVACY PRACTICES FOR PSYCHIATRY NORTHWEST, LLC

_____ I acknowledge that I read and/or received a copy of the Psychiatry Northwest, LLC Patient Notice of Privacy Practices effective March 28th 2018.

Signature: _____ Date: _____

PSYCHIATRY NORTHWEST

# New Patient Information

First Name: _____ Last: _____ M.I. _____

Address: _____City: _____State: _____ Zip: _____

Marital Status: S M D W Sex: M F Date of Birth: _____/_____/_____ Age: _____

Primary Phone: _____ Email Address: _____

Employer: _____

Employer Address: _____

Height: _____ Weight: _____

## Emergency Contact

Name: _____ Relationship: _____

Phone: _____ Email Address: _____

Address: _____City: _____State: _____ Zip: _____

## Insured or Responsible Party (Policy Holder) Insurance Information

Policy Holder Name: _____ Relationship: _____

Soc. Sec. #: _____ Date of Birth: _____/_____/_____

Name of Insurance Company: _____ Effective Date: _____

Member ID: _____ Group Number: _____

Employer: _____ Work Phone: _____

_____ I hereby assign medical benefits to which I am entitled to this office, unless revoked by me in writing. I authorize any information needed to be released to my insurance company for the purpose of authorizing and processing my claims. I understand that I am fully responsible for and will assume all my charges not paid by my insurance.

_____ **I UNDERSTAND THAT I WILL BE CHARGED IN FULL FOR ANY APPOINTMENTS NOT KEPT UNLESS 24 HOURS NOTICE IS GIVEN TO THE OFFICE.**

Signature: _____ Date: _____

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P: (206) 402-3375 | F: (206) 492-2020 | www.psychiatrynorthwest.com

PSYCHIATRY NORTHWEST

# Clinician-Patient Agreement

***Rights and Risks:***

- You may ask questions about any aspect of the counseling process.
- If you have been referred by a court of state agency, you have the right to divulge only what you want to be included in a report.
- Therapy is most effective when you are open and can speak honestly about your emotions and experiences.
- Therapy may include talking about emotionally provoking subjects and scenarios.

***Confidentiality:***

- Information shared by you in session will be kept confidential.
- Information will not be released without your written consent, except for professional consultation if needed and unless required by law.
- I am required by law to disclose information pertaining to suspected child abuse, the inability to care for one's basic need for food, clothing, or shelter, and threatened harm to oneself or others.
- The court may subpoena counseling records.
- It is understood that information regarding treatment and diagnosis may be provided to an insurance company.
- You may want to discuss further limits or exceptions of confidentiality.

***Appointments and Prescriptions:***

- All office visits are by appointment and may be scheduled through the front desk or counselor directly.
- **Please arrive 5-10 minutes early for your appointments for parking, billing questions, and to fill out paperwork as needed**. You use up your own time when you arrive late for an appointment. The usual length of an appointment is 50 minutes for a New Patient and 20 minutes for a Follow Up.
- **Street Parking is the only option for parking, the parking garage is only available for building tenants. You will be towed at your own expense if you park in the parking garage.**
- Late Cancellation (less than 24 hours before your appointment) and/or No-Show appointments are billed to the client at the full cost of the appointment. In the case of illness, please notify us no later than 9:00 am the day of the appointment. Please leave a message if you get our voicemail. If your appointment is cancelled or missed, contact the office for a new appointment time. Insurance companies **DO NOT** pay for No-Show charges or late cancellation charges.
- We will not refill a prescription if you have not been seen by a provider within 3 months.
- **Prescription requests may take up to 5 business days to be filled, it is your responsibility to contact us and plan to have enough medication while your request is being processed.**
- In order to improve medication management, we will only send prescriptions to one pharmacy of your choosing, designated in this packet.

Signature: _____ Date: _____

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PSYCHIATRY NORTHWEST

## Emergencies

The best phone number for Psychiatry Northwest is **(206) 402-3375**. If you receive the voicemail, please leave a message. Our office will return your call as soon as possible. If it is after normal business hours and you are experiencing a crisis, you may call the **24-hour Mental Health Crisis Line: (866) 427-4747 or go immediately to your local hospital emergency room.**

## Primary Care Provider

In order to offer the best care possible, we need to be able to coordinate with your primary care provider and other providers that you see on a regular basis. Please provide us with the contact information for your primary provider.

Provider Name _____ Phone _____

Clinic _____

## Weapons Policy

Under no circumstances are firearms or weapons of any kind permitted into this clinic. Regardless of personal carry license status, Psychiatry Northwest does not permit possession of weapons inside its facilities or on its premises.

## Single Pharmacy Policy

Many of our patients require medications as part of their ongoing treatment plan; it is important for us to be able to establish a primary pharmacy to assist in your coordinated care. For our patients' convenience, our providers offer e-scripts in order to expedite medication refills and insurance prior authorizations. We request that our patients use a single pharmacy for their prescriptions while they are being seen in our clinic. If there are extenuating circumstances that require you to fill your script at another pharmacy, your provider will evaluate these requests on a case by case basis.

Pharmacy Name _____ Phone _____

Address _____

_____ I have read, understand, and agree to the above policies. I have been offered a copy of these policies to take with me if desired.

Signature: _____ Date: _____

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PSYCHIATRY NORTHWEST

# HIPAA Email Consent

**VERY IMPORTANT! PLEASE READ!**

- HIPAA stands for Health Insurance Portability and Accountability Act
- HIPAA was passed by the U.S. government in 1996 in order to establish privacy and security protections for health information
- Information stored on our computers is encrypted
- Most popular email services (ex. Hotmail, Gmail, Yahoo) do not utilize encrypted email
- **When we send you an email, or you send us an email, the information that is sent is not encrypted. This means that a third party may be able to access the information and read it since it is transmitted over the Internet. In addition, once the email is received by you, someone may be able to access your email account and read it.**
- Email is a very popular and convenient way to communicate for a lot of people, so in their latest modification to the HIPAA act, the federal government provided guidance on email and HIPAA
- The information is available in a pdf (page 5634) on the U.S. Department of Health and Human Services website – http://www.gpo.gov/fdsys/pkg/FR-2013-01-25/pdf/2013/01073.pdf
- The guidelines state that if a patient has been made aware of the risks of unencrypted email, and that same patient provides consent to receive health information via email, then a health entity may send the patient personal medication information via unencrypted email.

OPTION 1 – **ALLOW** UNENCRYPTED EMAIL

I understand the risks of unencrypted email and do hereby give permission to Psychiatry Northwest, LLC to send me personal health information via unencrypted email.

Patient Name: _____ Date: _____

Signature: _____ Relationship to Patient:_____

OPTION 2 – **DO NOT ALLOW** UNENCRYPTED EMAIL

I do not wish to receive personal health information via email.

Patient Name: _____ Date: _____

Signature: _____ Relationship to Patient:_____

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PSYCHIATRY NORTHWEST

# Consent to Care and Treatment at Psychiatry Northwest

I, _____, understand and agree to receive treatment for psychiatric care. I understand the following:

- I voluntarily consent to participate in behavioral health treatment (e.g. psychological or psychiatric) by staff from Psychiatry Northwest, LLC.
- That I/We have been fully informed that services may include interviews, assessment or testing, psychotherapy, counseling, and/or medication management.
- That treatment may be provided by a licensed counselor, psychologist, psychiatric nurse practitioner, physician assistant, or psychiatrist.
- That this consent is given voluntarily.
- That I am legally competent and have the authority to provide consent for treatment.
- That I agree to participate in my treatment planning process to the best of my ability.
- That I have the right to withdraw my consent for this treatment at any time.
- That withdrawing consent for this treatment will not prejudice my continued treatment relationship.

Signature: _____ Date: _____

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PSYCHIATRY NORTHWEST

# Appointment No-Show and Cancellation Policy

Thank you for entrusting your medical care to Psychiatry Northwest, LLC/TMS Washington. We strive to provide excellent care to all our patients. In order to be consistent, we use an appointment system to set a designated time for a patient to meet with our medical staff and discuss their treatment.

Missed appointments or no-shows are lost time for our physicians and providers. **A Cancelation Policy has been instituted to ensure you notify our office of a cancellation within 24 hours of your scheduled appointment.**

- In the event of a late cancelation (within 24 hours of your appointment) or missed (no-show) appointment, a $50.00 fee for Psychiatric Services will be charged to the patient account without insurance coverage.

- If you arrive halfway through your scheduled appointment and the provider is unable to accommodate a full appointment for you, your appointment may be marked as a no-show and you will have to reschedule your appointment.

- If there are three consecutive late cancellations or no-show appointments, it may result in the termination of care with our practice.

- For new patient appointments, a no-show or missed appointment will result in the patient's account being charged for the full cost of the Psychotherapy Session without insurance coverage.

Out of respect to all our patients and providers, we request that you please give our office 24-hour notice if you are unable to keep your appointment. As a courtesy, you will receive reminder calls, texts, or emails prior to your appointment. If you do not receive the reminder, the Cancelation Policy will remain in effect.

____ I have read and understand the cancellation policy and agree to be bound by its terms.

Signature: _____ Date: _____

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PSYCHIATRY NORTHWEST

# Financial Policy and Agreement

Thank you for choosing us as your healthcare provider. We are committed to providing you with the best possible medical care. Please understand that payment of your bill is considered a part of your treatment. The following is provided to avoid any misunderstanding or disagreement concerning payment for services tests, and supplies provided by our office.

**Insurance:**

Our office participates with most Aetna, First Choice, Premera, and Regence policies. We are not contracted with any Medicaid, Medicare, United HealthCare, Tricare/TriWest, or Cigna plans. It is your responsibility to:

- Bring your current insurance card to every visit and notify us of any changes in your insurance coverage.
- We will attempt to confirm your insurance coverage prior to treatment. It is your responsibility to know whether we are a contracted provider with your insurance plan.
- Be prepared to pay your co-pay, coinsurance, and/or deductible at the time of service. Payment may be made by cash, check, or debit/credit card.
- All co-pays and deductible amounts owed are due at time of service. If your insurance applies any of your charge to your annual deductible or coinsurance, that portion is due and payable by you at the time of service.
- **If we are not contracted with your insurance plan, you will be considered a private self-pay patient. This means that at the time of check-in you will have to pay self-pay rates.**
- **If you have elected to use our practice and our physicians are out of your network of coverage, please check with your insurance regarding benefit levels and how you can submit for reimbursement.**
- If you have questions regarding your coverage, please contact your insurance company or use the payer web address listed on your card. It is your responsibility to understand your benefit coverage.
- As a courtesy we will submit a claim to your insurance company for you. Balances not paid per contract with your primary insurance company may be billed to your secondary insurance.
- You understand that your insurance carrier can choose to assign payments to Psychiatry Northwest, or your insurance may make payment directly to you. You understand and agree that you are financially responsible for all healthcare service chares that are paid to you directly by your insurance carrier.

**Payment Details:**

- We have the capability to accept payments over the phone with your debit/credit card information. We reserve the right to process your payment electronically based on the information you provide us.
- **Clients paying on a cash basis, and not billing any insurance company, are expected to pay in full at the time of service. Payment plans are only for past-due balances.**
- Accounts become delinquent after thirty (30) days. **Accounts 90 days in arrears will be terminated unless a payment plan is in place.**
- Any change in financial situation should be discussed with the provider. In the event you find it necessary to change mental health providers and require records to be sent from Psychiatry Northwest, LLC, your account must be paid in full.

_____ I have read the financial policies contained above and my signature below serves as acknowledgement of a clear understanding of my financial responsibility. I understand that if my insurance company denies coverage and/or payment for services provided to me, I assume financial responsibility and will pay all such charges in full.

Signature: _____ Date: _____

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PSYCHIATRY NORTHWEST

# Self-Pay Patient Payment Agreement

You have registered as a private pay patient. This means that at the time of service you will be paying by cash, check, or debit/credit card. Due to this cash payment, you are receiving a discount. **We will not bill insurance** for services provided under this arrangement. No forms will be produced now, or in the future, for you or us to submit for insurance billing.

____ I understand that I will be responsible for all charges related to the services provided to me by Psychiatry Northwest LLC/TMS Washington

____ I understand that the charges presented to me are due **in full** on the day of service, unless arrangements have been made with the physician in advance.

Self-Pay Rates:

**Physician Appointments (Drs. McClelland/Brooks)**

New Patient Evaluation: $350

Follow-Up Appointments: $150

Phone Follow-Up Appointments: $125

**PA-C and ARNP Appointments (David Applbaum/Helen Wetter)**

New Patient Evaluation: $250

Follow-Up Appointments: $ 100

**Psychotherapist and Mental Health Councilors (Abby/Ian/Emily)**

New Patient Evaluation: $175

Follow-Up Appointments: $150

**QB Test (ADHD Diagnostic Exam):** $150

I have read and fully understand the above self-pay rates and I agree to waive insurance billing and pay my balance owed at the time of check-in. I also understand by signing this acknowledgement that I will be responsible to pay for the services rendered to me and/or my child.

Responsible Party Name: _____ Relationship to Patient:_____

Signature: _____ Date: _____

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PSYCHIATRY NORTHWEST

Name: _____ DOB: _____ Date: _____

# Intake Questionnaire For New Patients (Adult)

This questionnaire is for the purpose of getting to know you better in order to provide the best possible mental health services. Please complete this form as honestly and completely as possible. All information that you provide to us will be kept confidential as required by state and federal law.

In your own words, describe the current problems as you see them:

_____

_____

_____

_____

How long has this been going on?

_____

_____

What made you come in at this time?

_____

_____

What do you hope to gain from this evaluation and/or counseling?

_____

_____

If you had difficulties in the past, what have you done to cope? Was it helpful?

_____

_____

_____

_____

_____

PSYCHIATRY NORTHWEST

Name: _____ DOB: _____ Date: _____

**SYMPTOMS**

Please check any symptoms or experiences that you have had in the last month.

Average hours of sleep per night: _____

☐ Difficulty staying asleep

☐ Difficulty falling asleep

☐ Not feeling rested in the morning

☐ Difficulty getting out of bed

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☐ Persistent loss of interest in previously enjoyed activities

☐ Withdrawing from other people

☐ Spending increased time alone

☐ Depressed mood

☐ Feeling numb

☐ Rapid mood changes

☐ Irritability

☐ Anxiety

☐ Panic attacks

☐ Frequent feelings of guilt

☐ Avoiding people, places, activities, or specific things

☐ Difficulty leaving your home

☐ Fear of certain objects or situations (ex. Flying, heights, bugs) Describe: _____

☐ Repetitive behaviors or mental acts (ex. Counting, checking doors, washing hands)

☐ Outbursts of anger

---

☐ Worthlessness

☐ Hopelessness

☐ Sadness

☐ Helplessness

☐ Fear

☐ Feeling or acting like a different person

---

☐ Changes in eating/appetite

☐ Are you trying to lose weight? _____

☐ Eating more

☐ Eating less

☐ Voluntary vomiting

☐ Use of laxatives

☐ Excessive exercise to avoid weight gain

☐ Binge eating

☐ Weight gain: _____ lbs

☐ Weight loss: _____ lbs

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☐ Difficulty catching your breath

☐ Increase muscle tension

☐ Unusual sweating

☐ Easily startled, feeling "jumpy"

☐ Increased energy

☐ Decreased energy

☐ Increased energy

☐ Decreased energy

☐ Tremor

☐ Dizziness

☐ Frequent worry

☐ Physical sensations that others don't feel

☐ Racing thoughts

☐ Intrusive memories

---

☐ Difficulty concentrating or thinking

☐ Large gaps in memory

☐ Flashbacks

☐ Nightmares

☐ Thoughts of harming or killing yourself

☐ Thoughts about harming or killing someone else

---

☐ Feeling as if you were outside yourself, detached, observing what you are doing

☐ Feeling puzzled as to what is real and unreal

PSYCHIATRY NORTHWEST

Name: _____ DOB: _____ Date: _____

☐ Persistent, repetitive, intrusive thoughts, impulses, or images

☐ Unusual visual experiences such as flashes of light or shadows

☐ Hearing voices when no one else is present

☐ Feeling that your thoughts are controlled or placed in your mind

☐ Feeling that the television or radio is communicating with you

---

☐ Difficulty problem solving

☐ Dependency on others

☐ Inappropriate expression of anger

☐ Difficulty or inability to say "no" to others

☐ Sense of lack of control

☐ Abusive relationship

☐ Concerns about your sexuality

☐ Difficulty meeting role expectations

☐ Manipulation of others to fulfill your own desires

☐ Self-mutilation/cutting

☐ Ineffective communication

☐ Decreased ability to handle stress

☐ Difficulty expressing emotions

---

For each item below, circle the answer that best describes your behavior in the last six months.

0 – Not at All 1 – Just a Little 2 – Often 3 Very Often

Do you…

| | | | | |
|---|---|---|---|---|
| Fail to give attention to details or make carless mistakes in tasks? | 0 | 1 | 2 | 3 |
| Have difficulty sustaining attention to tasks or activities | 0 | 1 | 2 | 3 |
| Seem to not listen when spoken to directly? | 0 | 1 | 2 | 3 |
| Have difficulty organizing tasks and activities (or have trouble keeping belongings in order)? | 0 | 1 | 2 | 3 |
| Avoid, dislike, or hesitate to engage in tasks that require sustained mental effort? | 0 | 1 | 2 | 3 |
| Lose things necessary for tasks or activities (ex. keys, wallet, glasses)? | 0 | 1 | 2 | 3 |
| Find yourself distracted by extraneous stimuli? | 0 | 1 | 2 | 3 |
| Have forgetfulness in daily activities (ex. scheduling, chores, etc.)? | 0 | 1 | 2 | 3 |
| Fidget with hands or feet or squirm in your seat? | 0 | 1 | 2 | 3 |
| Leave your seat at work or in other situations in which remaining seated is expected? | 0 | 1 | 2 | 3 |
| Have feelings of restlessness in situations in which remaining seated is expected? | 0 | 1 | 2 | 3 |
| Have difficulty playing or engaging in leisure activities quietly? | 0 | 1 | 2 | 3 |
| Find yourself "on the go" or unable to be still for an extended time? | 0 | 1 | 2 | 3 |
| Often talk excessively? | 0 | 1 | 2 | 3 |
| Blurt out answers before questions have been completed? | 0 | 1 | 2 | 3 |
| Have difficulty waiting your turn? | 0 | 1 | 2 | 3 |
| Interrupt or intrude on others (ex. butt into conversations)? | 0 | 1 | 2 | 3 |

Approximately when do you notice these behaviors occurring often or very often? _____

Do these symptoms impair your functioning in two or more settings? ☐ Yes ☐ No

Where is there impairment? (Check all that apply) ☐ Family ☐ Social ☐ School ☐ Work

PSYCHIATRY NORTHWEST

Name: _____ DOB: _____ Date: _____

Please describe any other symptoms or experiences you have had problems with (if not listed previously):

_____

_____

_____

Have you seen a counselor, psychologist, psychiatrist, or other mental health professional before?

☐ Yes ☐ No If yes, please list:

Name of therapist:_____ Dates of Treatment:
Reason for seeking help: _____ _____

Name of therapist:_____ Dates of Treatment:
Reason for seeking help: _____ _____

Name of therapist:_____ Dates of Treatment:
Reason for seeking help: _____ _____

Are you CURRENTLY taking psychiatric medication? ☐ Yes ☐ No If yes, please list:

| Medication | Dosage | How long have you been taking it? | Has it been helpful? |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

Are you currently taking NON-PSYCHIATRIC medication? ☐ Yes ☐ No If yes, please list:

| Medication | Dosage | How long have you been taking it? |
|---|---|---|
| | | |
| | | |
| | | |

Have you been on Psychiatric medication in the PAST that you no longer take?

☐ Yes ☐ No If yes, please list:

| Medication | Dosage | First/Last time you took it | Effect of Medication |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

PSYCHIATRY NORTHWEST

Name: _____ DOB: _____ Date: _____

Have you been hospitalized for psychiatric reasons? ☐ Yes ☐ No If yes, describe:

| Hospital | Dates | Reason |
|---|---|---|
| | | |
| | | |
| | | |

Have you ever attempted suicide? ☐ Yes ☐ No If yes, describe:

_____

_____

_____

**MEDICAL HISTORY**

Please list any medication allergies:

_____

_____

Are you CURRENTLY under treatment for any medical conditions? ☐ Yes ☐ No If yes, describe:

_____

_____

_____

List any PRIOR illnesses, operations, and accidents:

_____

_____

**FAMILY HISTORY**

Please place a check mark in the appropriate box if these are or have been present in your relatives.

| | Children | Brother | Sister | Father | Mother | Aunt/Uncle | Grandparents |
|---|---|---|---|---|---|---|---|
| Nervous Problems | | | | | | | |
| Depression | | | | | | | |
| Hyperactivity | | | | | | | |
| Counseling | | | | | | | |
| Psychiatric Medication | | | | | | | |
| Psychiatric Hospitalization | | | | | | | |
| Suicide Attempt | | | | | | | |
| Death by Suicide | | | | | | | |
| Drinking Problem | | | | | | | |

PSYCHIATRY NORTHWEST

Name: _____ DOB: _____ Date: _____

**SOCIAL HISTORY**

How was your childhood? _____

Are you currently in a long-term relationship? _____

What kind of social activities do you participate in? _____

Who do you turn to for help with your problems? _____

Do you have a religious affiliation? ☐ Yes ☐ No

If yes, what is it? _____

*Education*

Highest level completed: _____

Degree obtained, if applicable: _____

Did you have any disciplinary problems in school? ☐ Yes ☐ No

If yes, please explain _____

Were you considered hyperactive/ADHD in school? ☐ Yes ☐ No

If yes, were you on any medication? ☐ Yes ☐ No

If so, which medication(s)? _____

What kinds of grades did you get in school? _____

Have you served in the military? ☐ Yes ☐ No

If yes, please briefly describe: _____

What type of discharge (separation) did you get? _____

*Employment*

Are you currently employed? ☐ Yes ☐ No If yes, employer's name: _____

What type of work do you do? _____

Employment History (most recent first):

| Type of Job | Dates | Reason for Leaving |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

*Legal*

Have you ever been arrested? ☐ Yes ☐ No

If yes, please describe: _____

PSYCHIATRY NORTHWEST

Name: _____ DOB: _____ Date: _____

Have you ever been abused?

☐ Verbally ☐ Emotionally ☐ Physically ☐ Neglected

Please describe: _____

_____

_____

_____

**SUBSTANCE ABUSE**

*Alcohol*

Do you drink alcohol? ☐ Yes ☐ No If yes, age of first use: _____

How much do you drink? _____ How often do you drink? _____

Have you ever passed out from drinking? ☐ Yes ☐ No How often? _____

Have you ever blacked out from drinking? ☐ Yes ☐ No How often? _____

Have you ever had the "shakes"? ☐ Yes ☐ No How often? _____

*Other Drugs:*

Please indicate for each drug listed below.

| Drug | Ever Used? | Age at 1st use | Time since last use | Approx use in last 30 days |
|---|---|---|---|---|
| Marijuana | | | | |
| Cocaine | | | | |
| Crack | | | | |
| Opioids | | | | |
| Methamphetamine | | | | |
| Ecstasy | | | | |
| Other | | | | |

Have you ever drunk/used drugs in the morning to steady your nerves or relieve a hangover? ☐ Yes ☐ No

If yes, how often? _____

Have you ever felt you should cut down on your drinking/drug use? _____

Have people annoyed you by criticizing your drinking/drug use?_____

Have you ever felt bad or guilty about your drinking/drug use?_____

Do you use tobacco? ☐ Yes ☐ No If yes, how often? _____

Is there anything else you would like us to know about you?

PSYCHIATRY NORTHWEST

Name: _____ DOB: _____ Date: _____

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

| 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 |
| 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 |

PSYCHIATRY NORTHWEST

Name: _____ DOB: _____ Date: _____

| PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9) | | | | |
|---|---|---|---|---|
| **Over the last 2 weeks (or since your last appointment), how often have you been bothered by any of the following problems?** *(Please circle the appropriate number)* | **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:*** _____

10. If you circled any problems, how difficult 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

| GENERALIZED ANXIETY QUESTIONNAIRE (GAD-7) | | | | |
|---|---|---|---|---|
| **Over the last 2 weeks (or since your last appointment), how often have you been bothered by any of the following problems?** *(Please circle the appropriate number)* | **Not at all** | **Several days** | **More than 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 |

**FOR OFFICE CODING** *0* **+** _____ **+** _____ **+** _____ ***Total:*** _____

8. If you circled any problems, how difficult 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

*(Office Use Only)*

PSYCHIATRY NORTHWEST

Name: _____ DOB: _____ Date: _____

Height: _____

Weight: _____

Sys/Dia: _____

BPM: _____

Temp: _____

Resp: _____

☐ Payment collected

☐ Insurance/ID

☐ ROI on file

---

☐ Dx: _____

☐ Tx plan: _____

☐ Printed Rx Given

☐ Obtain previous records from Dr. _____

☐ Refer for therapy

☐ Invite to pt portal

Special notes: _____

_____