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:_____

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: _____

2150 N. 107th St. Ste. 400, Seattle, WA 98133
P: (206) 402-3375 | F: (206) 492-2020 | www.psychiatrynorthwest.com

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 48 hours of your scheduled appointment.**

- In the event of a late cancelation (within 48 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 psychotherapists 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 48-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 insurance policies. 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

New Patient Evaluation: $350

Follow-Up Appointments: $150

PA-C and ARNP Appointments

New Patient Evaluation: $250

Follow-Up Appointments: $ 100

Psychotherapist and Mental Health Counselor

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

☐ 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

☐ Difficulty catching your breath

☐ Increase muscle tension

☐ Unusual sweating

☐ Easily startled, feeling "jumpy"

☐ 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

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

PSYCHIATRY NORTHWEST

Name: _____ DOB: _____ Date: _____

☐ 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…

1. Fail to give attention to details or make carless mistakes in tasks?	0	1	2	3
2. Have difficulty sustaining attention to tasks or activities	0	1	2	3
3. Seem to not listen when spoken to directly?	0	1	2	3
4. Have difficulty organizing tasks and activities (or have trouble keeping belongings in order)?	0	1	2	3
5. Avoid, dislike, or hesitate to engage in tasks that require sustained mental effort?	0	1	2	3
6. Lose things necessary for tasks or activities (ex. keys, wallet, glasses)?	0	1	2	3
7. Find yourself distracted by extraneous stimuli?	0	1	2	3
8. Have forgetfulness in daily activities (ex. scheduling, chores, etc.)?	0	1	2	3
9. Fidget with hands or feet or squirm in your seat?	0	1	2	3
10. Leave your seat at work or in other situations in which remaining seated is expected?	0	1	2	3
11. Have feelings of restlessness in situations in which remaining seated is expected?	0	1	2	3
12. Have difficulty playing or engaging in leisure activities quietly?	0	1	2	3
13. Find yourself "on the go" or unable to be still for an extended time?	0	1	2	3
14. Often talk excessively?	0	1	2	3
15. Blurt out answers before questions have been completed?	0	1	2	3
16. Have difficulty waiting your turn?	0	1	2	3
17. 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

PSYCHIATRY NORTHWEST

Name: _____ DOB: _____ Date: _____

(Office Use Only)

Height: _____

Weight: _____

Sys/Dia: _____

BPM: _____

Temp: _____

Resp: _____

☐ Payment collected

☐ Insurance/ID

☐ ROI on file

Collected by: _____ Machine: _____

☐ Dx: _____

☐ Tx plan: _____

☐ Printed Rx Given

☐ Obtain previous records from Dr. _____

☐ Refer for therapy

☐ Invite to pt portal

Special notes: _____

_____