PATIENT INFORMATION

DATE:_____ CHART#_____ SSN_____

Patient Name_____ _____ _____

Last First Middle

Address:_____ City:_____ St:_____ Zip:_____

Home Phone:( )_____ Cell:( )_____ Work:( )_____Ext:_____

DOB_____ Relationship to Responsible Party: Self___ Spouse___ Child___ Legal Guardian___

Sex: Male___ Female___ Marital Status: Married___ Single___ Divorced___ Separated___ Widowed___

Employer Name:_____ Employment Status: Full Time____ Part Time____

Employer Address:_____ City:_____ St:____ Zip_____

Occupation:_____ Student: Full Time____ Part Time_____

Parents: (If patient is a minor) Father's Name:_____ DOB_____

Mother's Name:_____ DOB_____

Referring Physician:_____

RESPONSIBLE PARTY INFORMATION

COMPLETE IF OTHER THAN THE PATIENT

Responsible Party Name:_____

Address:_____ City:_____ St:_____ Zip_____

Home Phone:( )_____ Cell:( )_____ Work:( )_____ Ext:_____ DOB:_____

Sex: Male___ Female___ Marital Status: Married___ Single___ Divorced___ Separated___ Widowed___

INSURANCE INFORMATION

INSURANCE ONE

Policy Holder's Name (As it appears on card) _____DOB:_____

Address:_____ City:_____ St:_____ Zip_____

Phone:( )_____ Insurance Co. Phone #:( )_____

Name of Plan:_____Policy Holders #:_____

Policy Group #:_____Effective Date:_____

INSURANCE TWO

Policy Holder's Name (As it appears on card) _____DOB:_____

Address:_____ City:_____ St:_____ Zip_____

Phone:( )_____ Insurance Co. Phone #:( )_____

Name of Plan:_____Policy Holders #:_____

Policy Group #:_____Effective Date:_____

EMERGENCY CONTACT INFORMATION

Name:_____

Home Phone:( )_____ Cell:( )_____Relationship_____

COMPREHENSIVE INTAKE FORM

MEDICAL HISTORY Today's Date_____

Name_____ Age_____ DOB_____

Why are you seeing us today?_____

Who else do you see for health care?_____

Please list all **MEDICATIONS** you currently take, including vitamins, herbal or homeopathic products, and over the counter medications:

MEDICATION	DOSAGE	FREQUENCY	REASON

Please list any **ALLERGIC REACTIONS** to medications in the past._____

_____

Any current medical problems? _____

_____

Any serious medical problems in the

past?_____

_____

Any history of surgery or hospitalization?_____

_____

Do you drink alcohol? ___Yes ___No How many drinks per week_____

Do you use tobacco? ___Yes ___No How much per day?_____

Do you drink coffee, tea, soda, other caffeinated products? ___Yes ___No How many daily?_____

Do you engage in formal exercise? ___Yes ___No How many hours per week___

Current drug use? ___Yes ___No

If so, what drugs do you use?_____

_____

FAMILY MEDICAL HISTORY

Please list any family members with health problems and describe what conditions they have:_____

_____

SOCIAL HISTORY

Are you married ___Yes ___No

Children? ___Yes ___No Ages of children?_____

Who lives with you in your home now?_____

_____

Are you currently employed? ___Yes ___No What type of work?_____

Pets?_____ Hobbies?_____

___My childhood was happy. ___My childhood was OK. ___My childhood was unhappy

because:_____

___I was not abused. ___I was abused. Type of abuse: ___physical ___sexual___emotional

Did you experience difficulties in school? ___Yes ___No ___academic ___social___behavioral

Please check which best describes your social experience:

___I have many close friends and we interact regularly.

___I have many close friends, but haven't spent much time with them recently.

___I have few close friends. ___I don't have any close friends.

___I have some acquaintances. ___I prefer to be alone.

Please check all that apply for your legal history:

___I have never been arrested.

___I have been arrested ___ times in my life. Last time (mo/yr)_____

___I have been to drug court.

___I have served ___ months in jail/prison.

___I have spent ___ months in juvenile detention.

___I have a history of violence. ___I have a history of domestic violence.

___I am on probation/parole until (mo/yr)_____

PSYCHIATRIC HISTORY

Have you ever been diagnosed with a mental health disorder? ___Yes ___No

If so, what were the diagnoses?_____

_____

What medications are you currently taking for these

disorders?_____

_____

What other medications have you taken for them in the

past?_____

_____

Are you seeing a counselor? ___Yes ___No

If so, who are you seeing?_____

Do you have, or ever had, a problem with drugs or alcohol? ___Yes ___No

If yes, please describe:_____

_____

Have you ever been in a treatment facility for substance abuse? ___Yes ___No

Thank you for taking the time to fill this questionnaire in carefully and accurately. We look forward to working together with you to build a happy and healthy future.

Mill Street Psychiatric

Jan Maybee FNP, PMHNP

Mill Street Psychiatric 1404 SE Mill Street, Roseburg, OR 97470
Phone: 541-492-1340 FAX: 541-492-1339

Janus Maybee, FNP, PMHNP

Financial Agreement.

Due to the enormous variations with different insurance plans, it is necessary to inform you that some visits may not be covered. If your insurance denies any claims, it will be the patient's responsibility to pay for that service.

*IN ADDITION IT IS YOUR RESPONSIBILITY TO CONTACT YOUR INSURANCE TO DETERMINE IF YOU HAVE MENTAL HEALTH COVERAGE.

*In addition, if a scheduled appointment must be cancelled or rescheduled, you must call 24 hours prior to that appointment to avoid charges. IF YOU DO NOT APPEAR FOR A SCHEDULED APPOINTMENT YOU WILL BE CHARGED $50.00 THE FIRST TIME, $100 THE SECOND TIME, AND $150 FOR ALL SUBSEQUENT FAILURES TO APPEAR OR ADEQUATELY NOTIFY US OF THE NEED TO CANCEL.

Please read and sign the following statement:

If my insurance denies payment, I agree to be personally responsible for payment.

Print Name_____ Date of Birth_____

Patient's Signature_____ Today's Date_____

INSURANCE INFORMATION AND FINANCIAL AGREEMENT

Office Financial and Insurance Policies

In many cases we will be able to call to verify your coverage before your first visit. If benefits cannot be determined before your visit and/or there is any doubt about your coverage, payment in full is expected at the beginning of your scheduled appointment. If your insurance company remits payment you will then be reimbursed. It is important to understand that a verbal confirmation of coverage over the phone from the insurance company does **not** guarantee payment. As it is not uncommon for an insurance company to misquote a policy we recommend that you review your policy to confirm that the information we receive is correct.

I hereby authorize payment of insurance benefits made on my behalf to Mill Street Psychiatric, or to Jan Maybee FNP, PMHNP for any services provided to me through their office. I understand that I am financially responsible to Mill Street Psychiatric for charges not paid by my insurance carrier. If an unpaid balance is sent to a collection agency, I will also be responsible for any legal fees, expenses, and/or interest associated with the collection of the debt.
Initial Here_____

I understand that it is my responsibility to pay for visits/treatment not paid by my insurance within the usual and customary time frame (30 - 90 days). If after 90 days I would like Mill Street Psychiatric to continue to pursue billing my insurance carrier, I accept that I will be charged $15 per repeated claim to defray the costs associated with the additional time spent pursuing insurance payment. **Initial Here**_____

METHODS OF PAYMENT

We currently accept cash, checks, debit, Visa, Mastercard, and American Express. We charge $25 for any returned checks or credit card charge backs to cover bank fees. We understand that on occasion financial problems may affect timely payment on your account. If such a situation arises, please contact our office promptly so that payment arrangements can be made. In the event account must be referred to a third party for collection, you agree to pay all reasonable collection and/or attorney fees, as well as court costs incurred to effect collection.

AUTHORIZATIONS

I have read the above information and agree, regardless of my insurance status, to be responsible for the balance of my account. I agree to pay the co-pay, co-insurance, any remaining balance my insurance carrier deems to be a patient responsibility, and any fee for services rendered that are not covered by my insurance. I agree to notify this office should there be any change in my insurance coverage.
I authorize the release of any medical or other information necessary to process my claims.
I authorize payment of medical or mental health benefits to Mill Street Psychiatric for all services rendered.

Name (print):_____
Patients or Authorized Person's name

Signature:_____ **Date**_____

Mill Street Psychiatric
Jan Maybee FNP, PMHNP
1404 SE Mill Street
Roseburg, OR 97470
(Phone) 541-492-1340 (FAX) 541-492-1339

MEDICATION REFILL POLICY:

- Prescription refills are never available on weekends or holidays.
- We require a 48 hour notice for all prescription refills.
- To obtain a refill of your medication, call the office at 541-492-1340. To effectively process your request we will need the following information:

1. Spell your first name and last name
2. Your date of birth
3. Spell the name of the medication(s) to be refilled
4. The name and location of your pharmacy
5. Area code and phone number where we can reach you

- Controlled substances cannot be refilled by phone and must be on paper form only.

I have read and understood the above policy regarding medication refills.

_____ _____

Patient or Guardian Signature Date

PRIVACY STATEMENT

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION MAY BE USED OR DISCLOSED, AND HOW YOU CAN ACCESS YOUR MEDICAL INFORMATION

Patient Rights, uses and Disclosure of Health Information:

During the course of your care with Mill Street Psychiatric we may use or disclose personal or health-care related information.

Examples:

- Personal Health information and clinical records may be disclosed to another health care provider or hospital.
- Health care and billing records may be disclosed to another party, such as an insurance carrier, or your employer, if they are responsible for payment of services you receive.
- Name, address, phone number, and health care records may be used to contact you regarding appointment reminders, or your care (If you are not at home to receive an appointment reminder, we may leave a message. You have the right to refuse authorization to contact you. If you do not provide us with this authorization it will not affect the health care we provide to you or the reimbursement avenues associated with your care.).

Under federal law we may also disclose your health information without consent under these circumstances:

- In providing health care services based on the orders of another health care provider.
- In an emergency.
- If we are required by law to provide care, and are unable to obtain your consent.
- If there are barriers to communicating with you, but in our professional judgement we believe you intend for us to provide care.
- If we are ordered by the courts or another appropriate agency.

Any use or disclosure of your protected health information other than as outlined above will occur only with your written authorization. You have the right to inspect and/or copy your health information. You have the right to request a correction or amendment to your health information. Requests to inspect, copy or amend your health related information should be provided in writing.

PHYSICIAN LEGAL DUTIES:

We are required by state and federal law to maintain the privacy of your patient file and protected health information. We are also required to provide you with this notice of our privacy practices. We are further required by law to abide by the terms of this notice while it is in effect. We reserve the right to alter or amend the terms of this privacy notice. If changes are made to our privacy notice, we will notify you in writing as soon as possible.

COMPLAINTS AND QUESTIONS:

If you have a question or complaint regarding our privacy notice, please contact us at 541-492-1340. This notice and any alterations or amendments will expire seven years after the date when this notice is signed. My signature acknowledges that I have received a copy of this notice.

_____

Patient Name (Please print)

_____ _____

Signature Date

If patient is a minor, or if patient is being represented by another party, your representative signs below:

_____

Personal Representative (Please Print)

_____ _____

Personal Representative Signature Date

Mill Street Psychiatric

Jan Maybee FNP, PMHNP

1404 SE Mill Street

Roseburg, OR 97470

(Phone) 541-492-1340 (FAX) 541-492-1339

AUTHORIZATION FORM

PRIMARY CARE PHYSICIAN
Insurance plans and managed care organizations encourage the exchange of information between this office and your Primary Care Physician (PCP) in order to coordinate medical and psychiatric care. A letter may be sent to your:

PCP/Referring
Physician/Pediatrician_____

located at_____

to exchange information regarding your medical and psychiatric care with no limitations placed on dates, history of illness or diagnostic and therapeutic information, including treatment for drug and/or alcohol abuse.

_____ **I do not want information sent to my PCP/Pediatrician**
Initial

INSURANCE CLAIMS PAYMENT
I authorize the release of medical record information, or excerpts thereof, to any insurance company or third party payor for utilization management, audit purposes and/or the purposes of verifying the services rendered and obtaining payment of the account. I understand that execution of this authorization waives my right of confidentiality as to the material released pursuant to this authorization.

_____ **I do not want information sent to my insurance company and agree to be personally responsible for all charges.**
Initial

FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENEFITS
I understand that I am financially responsible to pay Mill Street Psychiatric its usual charges for all services received, including any balances not covered by my insurance carrier(s). I understand that it is the patients responsibility to obtain any prior authorization or doctor's referral. I understand that failure to meet this requirement may result in a significant loss of benefits. I hereby assign all of my rights to receive any and all insurance proceeds, otherwise payable to me, for coverage(s) provided by my health insurance carrier(s) to Mill Street Psychiatric, and direct that payment of proceeds be made directly to Mill Street Psychiatric. Because we reserve your appointment time for you we charge a fee for missed appointments not cancelled at least 24 hours in advance.

My signature below represents that I have read and understood the terms and statements above.

This consent and authorization form will remain in effect for the duration of my treatment unless revoked by me in writing and may not be revoked as to services rendered prior to my notice of revocation. A photocopy of this consent and authorization form is to be considered as valid as an original.

_____ _____
Patient's Signature Date Parent/Guardian's Signature Date

I have witnessed the completion of this authorization form. _____
Employee Signature Date

Acknowledgment of Notice of Privacy Practices.
I have received a copy if the Mill Street Psychiatric Notice of Privacy Practices. I understand that I may ask questions to Mill Street Psychiatric if I do not understand any information contained in the Notice of Privacy Practices.

_____
Patient/Parent/Guardian's Signature Date

Third Party Access
I authorize Mill Street Psychiatric to disclose current healthcare information with the family/others listed below.

_____ _____
Family Therapist

_____ _____
Other Other

Patient Signature _____ Date _____

ANSWERS SHOULD REFLECT HOW YOU HAVE FELT OVER THE LAST TWO WEEKS 0 = NOT AT ALL 4= EXTREMELY

ELEVATED MOOD

I have much more energy than usual. 0___ 1___ 2___ 3___ 4___
I feel extremely happy or confident. 0___ 1___ 2___ 3___ 4___
I am irritable and short tempered. 0___ 1___ 2___ 3___ 4___
I have a heightened interest in sex. 0___ 1___ 2___ 3___ 4___
My thoughts are racing. 0___ 1___ 2___ 3___ 4___

T___/20

VEGETATIVE FEATURES

I sleep too much. 0___ 1___ 2___ 3___ 4___
I am often in bed or on the couch. 0___ 1___ 2___ 3___ 4___
My housekeeping has deteriorated. 0___ 1___ 2___ 3___ 4___
I spend most of my time alone. 0___ 1___ 2___ 3___ 4___
My personal hygiene has fallen off. 0___ 1___ 2___ 3___ 4___

T___/20

DEPRESSED MOOD

I feel down, depress ed, or sad. 0___ 1___ 2___ 3___ 4___
I have feelings of helplessness. 0___ 1___ 2___ 3___ 4___
I have crying spells (or feel like it). 0___ 1___ 2___ 3___ 4___
I feel hopeless about the future. 0___ 1___ 2___ 3___ 4___
I've lost interest or pleasure in things. 0___ 1___ 2___ 3___ 4___
I'm tired or have low energy. 0___ 1___ 2___ 3___ 4___
I feel guilty or worthless. 0___ 1___ 2___ 3___ 4___
I have a poor appetite, or I overeat. 0___ 1___ 2___ 3___ 4___
My memory has gotten bad. 0___ 1___ 2___ 3___ 4___
It's hard to concentrate. 0___ 1___ 2___ 3___ 4___

T___/40

SOCIAL ANXIETY

I am uncomfortable in social situations 0___ 1___ 2___ 3___ 4___
I am intimidated by people in authority. 0___ 1___ 2___ 3___ 4___
I fear embarrassing myself in public. 0___ 1___ 2___ 3___ 4___
I get panicky in social situations. 0___ 1___ 2___ 3___ 4___
I avoid going to parties. 0___ 1___ 2___ 3___ 4___
I avoid being the center of attention. 0___ 1___ 2___ 3___ 4___
Being criticized scares or angers me. 0___ 1___ 2___ 3___ 4___
I avoid having to give speeches. 0___ 1___ 2___ 3___ 4___
I'd do anything to avoid being criticized. 0___ 1___ 2___ 3___ 4___
Talking to strangers scares me. 0___ 1___ 2___ 3___ 4___

T___/40

OBSESSIVE FEATURES

I tend to worry excessively. 0___ 1___ 2___ 3___ 4___
I tend to be a perfectionist. 0___ 1___ 2___ 3___ 4___
I do tasks slowly to ensure accuracy. 0___ 1___ 2___ 3___ 4___
I worry about germs or contamination. 0___ 1___ 2___ 3___ 4___
It is often hard to make decisions. 0___ 1___ 2___ 3___ 4___

T___/20

COMPULSIVE FEATURES

I tend to check and recheck things. 0___ 1___ 2___ 3___ 4___
I bite my nails or pull at my hair. 0___ 1___ 2___ 3___ 4___
I wash my hands or bathe excessively. 0___ 1___ 2___ 3___ 4___
I need to count things repeatedly. 0___ 1___ 2___ 3___ 4___
I must keep things neat and clean. 0___ 1___ 2___ 3___ 4___

T___/20

PANIC ANXIETY

I have episodes of intense fear. 0___ 1___ 2___ 3___ 4___
During these episodes I have the following:
Palpitations, pounding or fast heart rate. 0___ 1___ 2___ 3___ 4___
Sweating, trembling or shaking. 0___ 1___ 2___ 3___ 4___
Shortness of breath/ smothered feeling. 0___ 1___ 2___ 3___ 4___
Chest pain or discomfort. 0___ 1___ 2___ 3___ 4___
Feeling dizzy, lightheaded or faint. 0___ 1___ 2___ 3___ 4___
Fear of losing control or of dying. 0___ 1___ 2___ 3___ 4___
Numbness, tingling or feeling of unreality. 0___ 1___ 2___ 3___ 4___
Chills or hot flashes or nausea. 0___ 1___ 2___ 3___ 4___
Persistent concern about more attacks. 0___ 1___ 2___ 3___ 4___

T___/40

AGITATED FEATURES

I pace, fidget, or am unable to sit still. 0___ 1___ 2___ 3___ 4___
I feel more impatient when driving. 0___ 1___ 2___ 3___ 4___
I yell at or argue with family or friends. 0___ 1___ 2___ 3___ 4___
I am having outbursts of anger. 0___ 1___ 2___ 3___ 4___
I am having thoughts of harming others. 0___ 1___ 2___ 3___ 4___

T___/20

THOUGHTS OF SUICIDE

I often wish I were dead. 0___ 1___ 2___ 3___ 4___
Others would be better off without me. 0___ 1___ 2___ 3___ 4___
I think about various ways to end my life. 0___ 1___ 2___ 3___ 4___
I've settled on a specific plan for suicide. 0___ 1___ 2___ 3___ 4___
I have decided to commit suicide. 0___ 1___ 2___ 3___ 4___

T___/20

ATYPICAL THOUGHTS

People are watching or talking about me. 0___ 1___ 2___ 3___ 4___
Others can read my private thoughts. 0___ 1___ 2___ 3___ 4___
I hear voices that others do not hear. 0___ 1___ 2___ 3___ 4___
I see things that aren't really there. 0___ 1___ 2___ 3___ 4___
Someone can control my thoughts. 0___ 1___ 2___ 3___ 4___

T___/20

DIFFICULTY SLEEPING

I have trouble getting to sleep. 0___ 1___ 2___ 3___ 4___
I wake repeatedly during the night. 0___ 1___ 2___ 3___ 4___
I awaken too early in the morning. 0___ 1___ 2___ 3___ 4___
I've gone for days with nearly no sleep. 0___ 1___ 2___ 3___ 4___
I sleep more than eight hours each night. 0___ 1___ 2___ 3___ 4___

T___/20

MILL STREET PSYCHIATRIC
1404 SE Mill Street
FAX: 541-492-1339 Roseburg, OR 97470 PHONE: 541-492-1340

AUTHORIZATION TO USE AND/OR DISCLOSE PROTECTED HEALTH INFORMATION

_____DOB_____
Patient name

_____ _____ _____ _____
Street Address City St ZIP

Phone_____

_____/_____
Name of clinician and/or facility to whom records are to be sent or from whom records are requested

_____
Address

Ph:_____ FAX_____

By **initialing** the spaces below, I specifically authorize the use and/or disclosure of the following medical information and/or medical records, if such information and/or records exist:

_____ Send information _____ Receive information

Date range_____ -_____ or _____**All Dates of Service**

_____ *Mental health information and/or records _____ Progress notes _____ Laboratory reports

_____ Patient Demographics _____ Pathology reports _____ Emergency and urgent care records

_____ Clinic Records _____ Billing statements _____ Transcribed hospital notes

_____ Psychotherapy notes _____ Diagnostic imaging reports _____ *Genetic testing information and/or records

_____ HIV-Positive test results and HIV diagnosis _____ *Other sexually transmitted diseases

_____ Drug/alcohol diagnosis, treatment or referral information (Federal regulations require a description of how much and what kind of information is to be disclosed.)

Describe:_____

I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure and may no longer be protected under federal law. However, I also understand that federal or state law may restrict redisclosure of HIV-Positive test results and HIV diagnosis, other sexually transmitted disease information, specially protected mental health information, genetic testing information, and drug/alcohol diagnosis treatment or referral information.

I understand that the only person or entity I am authorizing to use and/or disclose information may receive compensation for doing so.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain health care services or reimbursement for services unless authorization is required to bill my insurance company. The only circumstance when refusal to sign means I will not receive health care services is if the health care services are solely for the purpose of providing health information to someone else, and the authorization is necessary to make that disclosure. My refusal to sign this authorization will not adversely affect my enrollment in a health plan or eligibility for health benefits unless the authorized information is necessary to determine if I am eligible to enroll in the health plan.

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance upon this authorization. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this authorization.

_____ DATE_____
Signature of patient or patient's legal representative

This Authorization will expire one year from date signed unless otherwise noted here:_____

_____ _____
Print patient's name or name of patient's legal representative Relationship to patient

___ Patient's or legal representative's personal identification verified Records copied by_____