## PATIENT INFORMATION

DATE:_____ DOB:_____ EMAIL: _____

Patient Name_____

Last First Middle

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

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

Relationship to Responsible Party: Self_____ Spouse_____ Child_____ Legal Guardian_____ SSN:_____

Biologic 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 minor patient) Father's Name:_____ DOB_____

Mother's Name:_____ DOB_____

Referring or Primary Physician:_____

## RESPONSIBLE PARTY INFORMATION

COMPLETE IF OTHER THAN THE PATIENT

Responsible Party Name:_____SSN#_____

Address:_____ City:_____ St:_____ Zip_____

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

DOB: _____ Sex: Male_____ Female_____ Marital Status: Married_____ Single_____ Divorced_____ Separated_____ Widowed_____

## INSURANCE INFORMATION

**PRIMARY INSURANCE**

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:_____

**SECONDARY INSURANCE**

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.

320 Central Ave. Ste. 321, Coos Bay, OR 97420 • 541-808-3161 • Fax: 541-808-3813 • www.compassrosepsych.com

# Financial Agreement.

1. Due to the variations within insurance plans, it is necessary to inform you that some visits may not be covered.
2. If your insurance denies any claims, it will be the patient's responsibility to pay for that service.
3. Additionally, it is your responsibility to contact your insurance provider to determine eligibility for mental health coverage.
4. If a scheduled appointment must be cancelled or rescheduled you must call the office or appointment line 24 hours prior to the appointment time to avoid charges.
5. Missed appointments will incur a charge of $50.00 for the first missed appointment, $100.00 for the second missed appointment, and $150.00 for each subsequent missed appointment. These charges apply to appointment cancellations of less than 24 hours as well.

**Please read and sign the following statement:**

I have read and agree to the above terms of this financial agreement. If my insurance denies payment, I agree to be personally responsible for payment. I have or will contact my insurance provider to confirm coverage. I agree to give 24 hours' notice of any need to cancel or reschedule an appointment. If I do not do so, the above stated charges will be incurred.

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, or we may carry the balance as a credit toward future copayments. 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 Compass Rose Psychiatry, or to Robin Finney, PMHNP for any services provided to me through their office. I understand that I am financially responsible 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 Compass Rose Psychiatry 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 Compass Rose Psychiatry for all services rendered.

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

Signature:_____ Date_____

Compass Rose Psychiatry
Robin Finney, PMHNP
320 Central Ave. Ste. 321
Coos Bay, OR 97420
Phone: 541-808-3161  Fax: 541-808-3813

## MEDICATION REFILL POLICY:

- Prescription refills are **never** available on weekends or holidays.
- We require a **minimum 48-hour notice** for all prescription refills.
- To obtain a refill of your medication, call your pharmacy and request a refill.

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 or electronic form only.

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

_____ _____

Patient or Guardian Signature  Date

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) 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 Compass Rose Psychiatry its usual charges for all services received, including any balances not covered by my insurance carrier(s). I understand that it is the patient's 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 Compass Rose Psychiatry, and direct that payment of proceeds be made directly to Compass Rose Psychiatry. 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

**Acknowledgment of Notice of Privacy Practices.**

I have received a copy if the Compass Rose Psychiatry Notice of Privacy Practices. I understand that I may ask questions to Compass Rose Psychiatry 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 Compass Rose Psychiatry to disclose current healthcare information with the family/others listed below.

_____ _____
Family Therapist

_____ _____
Other Other

Patient 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 Compass Rose Psychiatry 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 541-808-3161. 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

**ANSWERS REFLECT MOOD FOR THE LAST TWO WEEKS (Check One)**

**0 = NOT AT ALL 4 = EXTREMELY TRUE**

| **ELEVATED MOOD** | **0** | **1** | **2** | **3** | **4** |
|---|---|---|---|---|---|
| I have much more energy than usual | ☐ | ☐ | ☐ | ☐ | ☐ |
| I feel extremely happy or confident | ☐ | ☐ | ☐ | ☐ | ☐ |
| I am irritable and short-tempered | ☐ | ☐ | ☐ | ☐ | ☐ |
| I have heightened interest in sex | ☐ | ☐ | ☐ | ☐ | ☐ |
| My thoughts are racing | ☐ | ☐ | ☐ | ☐ | ☐ |

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| **DEPRESSED MOOD** | | | | | |
|---|---|---|---|---|---|
| I feel down, depressed, or sad | ☐ | ☐ | ☐ | ☐ | ☐ |
| I have feelings of helplessness | ☐ | ☐ | ☐ | ☐ | ☐ |
| I have crying spells (or feel like it) | ☐ | ☐ | ☐ | ☐ | ☐ |
| I feel hopeless about the future | ☐ | ☐ | ☐ | ☐ | ☐ |
| I've lost interest or pleasure in things | ☐ | ☐ | ☐ | ☐ | ☐ |
| I'm tired or have low energy | ☐ | ☐ | ☐ | ☐ | ☐ |
| I feel guilty or worthless | ☐ | ☐ | ☐ | ☐ | ☐ |
| I have a poor appetite, or I overeat | ☐ | ☐ | ☐ | ☐ | ☐ |
| My memory has gotten bad | ☐ | ☐ | ☐ | ☐ | ☐ |
| It's hard to concentrate | ☐ | ☐ | ☐ | ☐ | ☐ |

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| **OBSESSIVE FEATURES** | | | | | |
|---|---|---|---|---|---|
| I tend to worry excessively | ☐ | ☐ | ☐ | ☐ | ☐ |
| I tend to be a perfectionist | ☐ | ☐ | ☐ | ☐ | ☐ |
| I do tasks slowly to ensure accuracy | ☐ | ☐ | ☐ | ☐ | ☐ |
| I worry about germs or contamination | ☐ | ☐ | ☐ | ☐ | ☐ |
| It is often hard to make decisions | ☐ | ☐ | ☐ | ☐ | ☐ |

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| **COMPULSIVE FEATURES** | | | | | |
|---|---|---|---|---|---|
| I tend to check and recheck things | ☐ | ☐ | ☐ | ☐ | ☐ |
| I bite my nails or pull at my hair | ☐ | ☐ | ☐ | ☐ | ☐ |
| I wash my hands or bathe excessively | ☐ | ☐ | ☐ | ☐ | ☐ |
| I need to count things repeatedly | ☐ | ☐ | ☐ | ☐ | ☐ |
| I must keep things neat and clean | ☐ | ☐ | ☐ | ☐ | ☐ |

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| **AGITATED FEATURES** | | | | | |
|---|---|---|---|---|---|
| I pace, fidget, or am unable to sit still | ☐ | ☐ | ☐ | ☐ | ☐ |
| I feel more impatient when driving | ☐ | ☐ | ☐ | ☐ | ☐ |
| I yell at or argue with family/friends | ☐ | ☐ | ☐ | ☐ | ☐ |
| I am having outbursts of anger | ☐ | ☐ | ☐ | ☐ | ☐ |
| I have thoughts of harming others | ☐ | ☐ | ☐ | ☐ | ☐ |

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| **ATYPICAL THOUGHTS** | | | | | |
|---|---|---|---|---|---|
| People are watching/talking about me | ☐ | ☐ | ☐ | ☐ | ☐ |
| Others can read my private thoughts | ☐ | ☐ | ☐ | ☐ | ☐ |
| I hear voices that others do not hear | ☐ | ☐ | ☐ | ☐ | ☐ |
| I see things that aren't really there | ☐ | ☐ | ☐ | ☐ | ☐ |
| Someone can control my thoughts | ☐ | ☐ | ☐ | ☐ | ☐ |

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| **VEGETATIVE FEATURES** | | | | | |
|---|---|---|---|---|---|
| I sleep too much | ☐ | ☐ | ☐ | ☐ | ☐ |
| I am often in bed or on the couch | ☐ | ☐ | ☐ | ☐ | ☐ |
| My housekeeping has deteriorated | ☐ | ☐ | ☐ | ☐ | ☐ |
| I spend most of my time alone | ☐ | ☐ | ☐ | ☐ | ☐ |
| My personal hygiene has fallen off | ☐ | ☐ | ☐ | ☐ | ☐ |

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| **SOCIAL ANXIETY** | | | | | |
|---|---|---|---|---|---|
| I'm uncomfortable in social situations | ☐ | ☐ | ☐ | ☐ | ☐ |
| I'm intimidated by people in authority | ☐ | ☐ | ☐ | ☐ | ☐ |
| I fear embarrassing myself in public | ☐ | ☐ | ☐ | ☐ | ☐ |
| I get panicky in social situations | ☐ | ☐ | ☐ | ☐ | ☐ |
| I avoid going to parties | ☐ | ☐ | ☐ | ☐ | ☐ |
| I avoid being the center of attention | ☐ | ☐ | ☐ | ☐ | ☐ |
| Being criticized scares or angers me | ☐ | ☐ | ☐ | ☐ | ☐ |
| I avoid having to give speeches | ☐ | ☐ | ☐ | ☐ | ☐ |
| I'd do anything to avoid criticism | ☐ | ☐ | ☐ | ☐ | ☐ |
| Talking to strangers scares me | ☐ | ☐ | ☐ | ☐ | ☐ |

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| **PANIC ANXIETY** | | | | | |
|---|---|---|---|---|---|
| I have episodes of intense fear | ☐ | ☐ | ☐ | ☐ | ☐ |
| During these episodes, I have the following: | | | | | |
| Palpitations, pounding/fast heart rate | ☐ | ☐ | ☐ | ☐ | ☐ |
| Sweating trembling or shaking | ☐ | ☐ | ☐ | ☐ | ☐ |
| Shortness of breath/smothered feeling | ☐ | ☐ | ☐ | ☐ | ☐ |
| Chest pain or discomfort | ☐ | ☐ | ☐ | ☐ | ☐ |
| Feeling dizzy, lightheaded, or faint | ☐ | ☐ | ☐ | ☐ | ☐ |
| Losing control or feelings of dying | ☐ | ☐ | ☐ | ☐ | ☐ |
| Numbness/tingling/feeling of unreality | ☐ | ☐ | ☐ | ☐ | ☐ |
| Chills, hot flashes, or nausea | ☐ | ☐ | ☐ | ☐ | ☐ |
| Persistent concern about more attacks | ☐ | ☐ | ☐ | ☐ | ☐ |

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| **THOUGHTS OF SUICIDE** | | | | | |
|---|---|---|---|---|---|
| I often wish I were dead | ☐ | ☐ | ☐ | ☐ | ☐ |
| Others would be better off without me | ☐ | ☐ | ☐ | ☐ | ☐ |
| I think about ways to end my life | ☐ | ☐ | ☐ | ☐ | ☐ |
| I have a specific plan for suicide | ☐ | ☐ | ☐ | ☐ | ☐ |
| I have decided to commit suicide | ☐ | ☐ | ☐ | ☐ | ☐ |

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| **DIFFICULTY SLEEPING** | | | | | |
|---|---|---|---|---|---|
| I have trouble getting to sleep | ☐ | ☐ | ☐ | ☐ | ☐ |
| I wake repeatedly during the night | ☐ | ☐ | ☐ | ☐ | ☐ |
| I awaken too early in the morning | ☐ | ☐ | ☐ | ☐ | ☐ |
| I've gone for days with nearly no sleep | ☐ | ☐ | ☐ | ☐ | ☐ |
| I sleep more than 8 hours each night | ☐ | ☐ | ☐ | ☐ | ☐ |

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