# North End Psychiatry & Associates

## Client Information

NAME: ________________________________________ PHONE: ________________
LAST FIRST MI

BIOLOGICAL SEX: M__ F__ DO YOU IDENTIFY AS MALE OR FEMALE? M__ F__

SS#: _________________ DOB: ___________ MARITAL STATUS: _____________

EMAIL: _________________________________

ADDRESS: ____________________________________________________________
STREET

____________________________________________________________
CITY STATE ZIP

EMPLOYER: ______________________________________________
OCCUPATION: ____________________________________
ADDRESS: _______________________________________

_______________________________________
CITY STATE ZIP

PHONE: _________________________

## Emergency Contact

NAME: ____________________________________ PHONE: ____________________

ADDRESS: ____________________________________________________________
CITY STATE ZIP

RELATIONSHIP TO PATIENT: ______________________________________________

## Spousal/Parent Information

NAME: ____________________________________ PHONE: ____________________

ADDRESS: ____________________________________________________________
CITY STATE ZIP

RELATIONSHIP TO PATIENT: _____________________ DOB: ____________________

EMPLOYER: _________________________________ SS#: ____________________

North End Psychiatry & Associates

# Financial Agreement

## Financial Responsibility (If other than client)

Name: ______________________________ Phone: ____________
Last First MI

Address: ________________________________________________
Street

________________________________________________
City State Zip

Employer: ________________________________
Occupation: ______________________________
Address: ________________________________

________________________________
City State Zip

Phone: ____________________

Signature: ____________________________ Date: ____________

## Insurance Information

Primary Insurance: ________________________________________
Policy Holder Name: ______________________ DOB: __________
Policy #: ____________________ Group #: ____________________
Employer: ______________________________
Secondary Insurance: ______________________________________
Policy Holder Name: ______________________ DOB: __________
Policy #: ____________________ Group #: ____________________
Employer: ______________________________

**Office Policy:**

**Payment is due at the time of service. You are responsible for all fees regardless of insurance coverage. As a courtesy, we will submit claims to the above named insurance company. Benefits quoted by your insurance company are not a guarantee of payment. If your insurance company has not paid your claim within 60 days from the date of service, the claim will be payable by you. We do not bill for the following: student insurance, retroactive Medicaid, victims and worker's compensation, or third parties listed in divorce decrees. All minors must be accompanied by their parents or legal guardian. If your insurance company requires an authorization or referral, you are responsible for obtaining this. We do charge a $25.00 fee for all returned checks. If utilizing EAP benefits through an employer you are responsible to obtain authorization for the provider you are seeing, and bring that authorization with you to the first appointment.**

**Assignment of Benefits:**

**I request that payment of authorized insurance benefits be made on my behalf of the provider marked above for any services furnished to me by that provider. I authorize the holder of medical information about me or any information needed to determine these benefits to be released to the insurance company listed above.**

Responsible Party Signature
Or Policy Holder Signature ________________________ Date: __________

# North End Psychiatry & Associates

PROVIDER NAME: ______________________________________________

## YOUR RIGHTS CONCERNING YOUR PROTECTED HEALTH INFORMATION

The health and billing records we maintain are the physical property of this office. The information in it, however, you do have the filling rights which concern your protected health information. To exercise any of these rights, you must submit a written request to your provider.

**RIGHT TO REQUEST ADDITIONAL RESTRICTIONS:** You may request additional restrictions on the use or disclosure of your protected health information for treatment, payment or health care operations. We are not required to agree to a requested restriction. If we agree to a restriction, we will comply with the restriction unless an emergency or the law prevents us from complying with the restriction, or until the restriction is terminated.

**RIGHT TO RECEIVE COMMUNICATIONS BY ALTERNATIVE MEANS:** We normally contact you by telephone or mail at your home address. You may request that we contact you by some other method or at some other location. We will not ask you to explain the reason for your request. We will accommodate reasonable requests. We may require that you explain how payment will be handled if an alternative means of communication is used.

**RIGHT TO INSPECT AND COPY RECORDS:** You may inspect and obtain a copy of protected health information that is used to make decisions about your care or payment for your care. We may charge you a reasonable cost based fee for providing the records. We may deny your request under limited circumstances, e.g., if you seek psychotherapy notes; information prepared for legal proceedings, or if disclosure may result in substantial harm to you or others. Please also note, many records may not be available immediately at the time of request, but will be provided in a timely manner.

**RIGHT TO REQUEST AMMENDMENT TO YOUR RECORD:** You may request that your protected health information be amended. You must explain the reason for your request in writing. We may deny your request if we did not create the record unless the originator is no longer available; if you do not have a right to access the record, or if we determine that the record is accurate and complete. If we deny your request, you have the right to submit a statement disagreeing with our decision and have the statement attached to the record.

**RIGHT TO AN ACCOUNTING OF DISCLOSURES:** You may receive an accounting of certain disclosures we have made of your protected health information. We are not required to account for disclosures of treatment, payment, or health care operations; to family members or others involved in your health care or payment; for notification purposes; or pursuant to our facility directory or your written authorization. We will provide at your request one accounting within a twelve-month period free of charge. We may charge a reasonable cost-based fee for all subsequent requests during that twelve-month period.

**RIGHT TO A COPY OF THIS NOTICE:** You have the right to obtain a paper copy of this notice upon request.

**CHANGES TO THIS NOTICE**: **We reserve the right** to change the terms of our Notice of Privacy Practices at any time, and to make the new Notice provisions effective for all protected health information that we maintain. If we materially change our privacy practices, we will prepare a new Notice of Privacy Practices, which shall be effective for all protected health information that we maintain. You may obtain a

copy of the current Notice from any staff member or by contacting your provider.

**COMPLAINTS**

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated. You may file a complaint with us by notifying your provider.

**PRIVACY CONTACT**

If you have any questions about this Notice, or if you want to object to or complain about any use or disclosure or exercise any right as explained above, please contact your provider.

**USES AND DISCLOSURES OF INFORMATION THAT WE MAY MAKE WITHOUT WRITTEN AUTHORIZATION**

**LAW ENFORCEMENT:** We may disclose protected health information, subject to specific limitations, for certain law enforcement purposes, including to identify, locate, or catch a suspect, fugitive, material witness or missing person; to provide information about the victim of a crime; to alert law enforcement that a person may have died as a result of a crime; or to report a crime.

**NATIONAL SECURITY:** We may disclose protected health information to authorized federal officials for national security activities.

**CORONERS AND FUNERAL DIRECTORS:** We may disclose protected health information to a coroner or medical examiner to identify deceased persons, determine cause of death, or permit the coroner or medical examiner to fulfill their legal duties. We may also disclose information to a funeral director to allow them to carry out their duties.

**RESEARCH:** We may use or disclose protected health information for research if approved by an institutional review board or privacy board and appropriate steps have been taking to protect the information.

**WORKERS' COMPENSATION:** We may disclose protected health information as authorized by workers' compensation laws and other similar legally established programs.

**BUSINESS ASSOCIATES:** We may disclose protected health information to our third party business associates who perform activities involving protected health information for us, e.g., billing or transcription services. Our contacts with the business associates require them to protect your health information.

**MILITARY:** If you are in the military, we may disclose protected health information as required by military command authorities.

**INMATES OR PERSONS IN POLICE CUSTODY:** If you are an inmate or in the custody of law enforcement, we may disclose protected health information if necessary for your health care; for the health and safety of others; or for the safety or security of the correctional institution.

***USES AND DISCLOSURES OR INFORMATION THAT WE MAY MAKE UNLESS YOU OBJECT***

We may use and disclose protected health information in the following instances without your written authorization unless you object. If you object, please notify your provider.

North End Psychiatry & Associates

**PERSONS INVOLVED IN YOUR HEALTH CARE:** Unless you object, we may disclose protected health information to a member of your family, or to the person identified by you who is involved in your health care or the payment of your health care. We will limit the disclosure to the protected health information relevant to that person's involvement in your health care or payment.

**CROSS COVERAGE FOR YOUR CARE:** Unless you object, the other providers in our office will have access to your protected health information for purposes of covering any concerns which may arise while your provider is out of the office. The information available will be utilized only in the event that it is necessary for another provider to assist you while your provider is away, and may include medication refills, consultation with you, or clarification on any questions you may have.

**NOTIFICATION:** Unless you object, we may use or disclose protected health information to notify a family member or other person responsible for your care of your location and condition. Among other things, we may disclose protected health information to a disaster relief agency to help notify family members.

## USES AND DISCLOSURES OF INFORMATION THAT WE MAY MAKE WITH YOUR WRITTEN AUTHORIZATION

We will obtain a written authorization from you before using or disclosing your protected health information and or any documentation related to psychiatric care and treatment or purposes other than those summarized above or otherwise required by law. You may revoke your authorization by submitting a written notice to your provider.

_______________________________________________ ____________________

PATIENT OR GUARDIAN SIGNATURE DATE

# North End Psychiatry & Associates

## Policies and Practices

Welcome to your providers private practice located at 1423 W Franklin Street Boise, ID 83702. Your doctor sees private practice patients at this location; however, his/her practice is a separate company from all other practitioners at this location. Your doctor would like to thank you for choosing him/her as your mental health care provider. Our office is committed to giving you excellent service and treatment. The following are your provider's policies and practices in which he/she requires that you read and sign prior to treatment.

Please note that although each provider maintains their own practice, there is often group collaboration on cases. This is done without revealing client names and other protected health information, and the content of these collaborations are kept between the providers and staff of this office. If you have any questions or concerns regarding this please discuss with your provider.

**Full payment or co-payment is due at the time of service. We accept cash, check, Visa/MasterCard or American Express.**

**Regarding Insurance:** Your insurance policy is a contract between you and your insurance company. We are not party to that contract. We do, however, bill all primary insurance as a service to our clients as long as we are contracting with them. Please check your benefits prior to your appointment and whether or not your provider does contract with your insurance company. At this time your doctor does not see private practice clients contracting with Tricare, Medicaid, Medicare, however, this list is subject to change.
If your insurance has not paid your account in full within sixty days of billing, we will require the balance to be paid in full by you. We will however, make every effort to help you resolve any problems in which your insurance company may have with paying your claim. We do not accept assignment on National Student Services. If you have applied for worker's compensation benefits, we will assist you in any way we can, but require that you keep your account current at all times. If you are receiving assistance from your church or a charity organization, please talk with a Patient Accounts Representative before scheduling your appointment.

**Office Hours:** Our office hours are Monday – Thursday, 8:30a.m. To 5:00p.m. and Friday 8:30 a.m. to 3:00 p.m. unless otherwise noted. UNATTENDED CHILDREN: Please note that we do not allow and are not responsible for unattended children (under 12 years of age) in our lobby.

**EMERGENCY SITUATIONS**: For emergencies after hours, please call 911.

**Cancelation and No Show Policy:** If you need to cancel your appointment or change your appointment, please do so as soon as possible. If cancellation does not occur at least 24 hours prior to our appointment, you may be charged for that appointment. If you no show for a scheduled appointment you may be charged. If you are more than 5 minutes late you may be considered to have missed your appointment, and assessed a missed appointment fee. Any missed appointment fees are due prior to scheduling additional appointments.

**Medication Refills:** We do ask that 1-week notice be given for all refills. Please call your pharmacy for all refill requests. When calling your pharmacy the following information will be needed: your name, phone number, date of birth, date of last refill, name of your physician, name and dosage of medication, and the date of your next appointment. Please take a moment to look at your current prescription as you may have a refill waiting at your pharmacy. You may be charged for medication refills if you miss your appointment, and charges may incur for extended phone consultations. Please note that not all medications may be filled if you have not been in compliance with treatment.

### REASONS FOR TERMINATION OF CLINICIAN-PATIENT RELATIONSHIP

**A.** If you feel you are not compatible with your physician
**B**. If you are not complying with your clinician orders, they may request to discontinue

TREATMENT.
**C.** IF YOU ARE NOT MEETING FINANCIAL OBLIGATIONS, YOUR CLINICIAN MAY DISCONTINUE TREATMENT.
**D**. IF YOU ARE DISRUPTIVE OR INAPPROPRIATE TOWARDS THE STAFF, CARE MAY BE TERMINATED.
**E.** DISHONESTY AND/OR DECEITFULNESS MAY REQUIRE TERMINATION OF TREATMENT.

**I HAVE READ MY PROVIDER'S POLICIES AND PRACTICES. I UNDERSTAND AND AGREE TO COMPLY WITH THE ABOVE.**

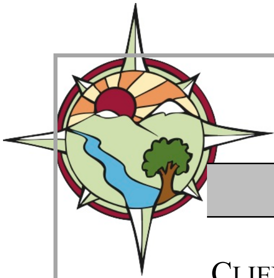
______________________________ ____________________
PATIENT OR GUARDIAN DATE

## Permission to Leave Messages

BY SIGNING BELOW, I GIVE THE STAFF OF 1423 FRANKLIN STREET, BOISE, ID, PERMISSION TO LEAVE DETAILED INFORMATION ON MY ANSWERING MACHINE AT THE PHONE NUMBER(S) THAT I HAVE PROVIDED ON THEIR OFFICE FORMS. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION AT ANY TIME.

______________________________ ____________________
PATIENT OR GUARDIAN SIGNATURE DATE

______________________________ ____________________
PRINTED NAME DATE



North End Psychiatry & Associates

# Initial Assessment

Client Name: ________________________________ Date: ______________
DOB: _____________ Gender: M__ F__
Referred by: Physician __ Friend __ Family __ Other: ____________________

*Clinician Notes:*

## Presenting Problems/ Current Events

Please Describe why you are seeking couseling or psychiatric services: ______
_______________________________________________
_______________________________________________
_______________________________________________
When did you first notice the problem? ________________________________
_______________________________________________

Has this problem affected your functioning:

| | | | | | |
|---|---|---|---|---|---|
| At Home: | ❒Severe | ❒Substantial | ❒Moderate | ❒Mild | ❒Minimal |
| At Work: | ❒Severe | ❒Substantial | ❒Moderate | ❒Mild | ❒Minimal |
| Community: | ❒Severe | ❒Substantial | ❒Moderate | ❒Mild | ❒Minimal |

Please explain: ________________________________________
_______________________________________________
_______________________________________________

## Barriers To Treatment

Can you think of anything that would prevent you from attending sessions or appointments regularly? Y__ N__
If yes, explain: ________________________________________
_______________________________________________
Do you have consistently reliable transportation? Y__ N__

Is there anything we should be aware of to best serve you? Y__ N__
If yes, explain: ________________________________________
_______________________________________________

## Resources Available

Family/Client Strengths: ________________________________
_______________________________________________
_______________________________________________

# North End Psychiatry & Associates

ECONOMIC/FINANCIAL STATUS

INCOME SOURCES

| | | |
|---|---|---|
| ❒ EMPLOYMENT WAGES/SALARY | ❒ UNEMPLOYMENT | ❒ SSI |
| ❒ WELFARE BENEFITS | ❒ FOOD STAMPS | ❒ SSD |
| ❒ HOUSING ASSISTANCE | ❒ FAMILY SUPPORT | ❒ OTHER: |

IS INCOME ADEQUATE FOR CURRENT NEEDS? Y__ N__

HOUSING ISSUES

| | | |
|---|---|---|
| ❒ SAFE/STABLE | ❒ UNSAFE/INADEQUATE: | ❒ OTHER: |
| ❒ CONFLICT WITH NEIGHBORS/ LANDLORD | ❒ TEMPORARY | ❒ NONE |

## FAMILY HISTORY

**PLEASE LIST ALL MEMBERS LIVING IN THE HOUSEHOLD:**

| NAME: | AGE: | RELATIONSHIP TO CLIENT: |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**MARRIAGE/SIGNIFICANT RELATIONSHIP(S):**

NAME: ______________________ STATUS: ______________________

NAME: ______________________ STATUS: ______________________

NAME: ______________________ STATUS: ______________________

**CHILDREN:**

| | |
|---|---|
| NAME: | AGE: |
| NAME: | AGE: |
| NAME: | AGE: |
| NAME: | AGE: |

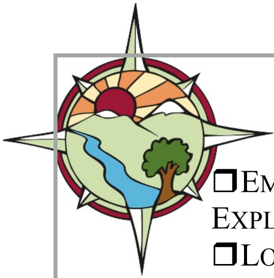
HAVE YOU AND/OR YOUR FAMILY EVER EXPERIENCED ANY OF THE FOLLOWING STRESSFUL EVENTS:

❒ DEATH OF A FAMILY MEMBER OR SIGNIFICANT PERSON
SPECIFY ______________________________________

❒ DOMESTIC VIOLENCE
EXPLAIN: ______________________________________

❒ DIVORCE OR SEPARATION
EXPLAIN: ______________________________________

❒ FREQUENT MOVES
HOW MANY TIMES? ____ LOCATION(S): ______________________



North End Psychiatry & Associates

❐Employment Problems
Explain: __________
❐Long-term physical illness of a family member
Explain: ________________________________________________________________
❐Other
Please list any additional stressful events you and/or your family have recently experienced: ______________________________________________________________
________________________________________________________________________
________________________________________________________________________

## Social and Sexual History

**Ethnicity:**

❐Caucasian ❐Asian ❐No answer
❐African American ❐Hispanic or latino
❐American Indian ❐Other: ___________

**Sexual Orientation**: __Heterosexual __Homosexual __Bisexual __Other

**Occupational Status:** __Stable __Unemployed __Job Conflict __Job Loss

Nature of usual and/or present employment/when last worked: _________________

Have you ever been fired? Y__ N__ How many times? ____
Reason(s): ______________________________________________________________

**Education:**

Highest grade completed/Degree: __________________________________________
GPA:_____

Problems with:
Truancy? Y/N Suspension? Y/N Expulsion? Y/N Special Ed? Y/N

If yes to the above, when did academic or behavioral problems in school begin?
________________________________________________________________________

**Abuse (Past and/or Present)**

Sexual Abuse? Y__ N__; Please Explain: ___________________________________
________________________________________________________________________
Physical Abuse? Y__ N__; Please Explain: __________________________________
________________________________________________________________________
List Whom, When, Reported(?), Action Taken: _______________________________
________________________________________________________________________

# North End Psychiatry & Associates

## Legal History (Past and/or Present)

Probation Officer? Y__ N__ Arrests? Y__ N__; If yes, explain: ____________

________________________________________________

Jail or prison time? Y__ N__; If yes, explain: ______________________________

________________________________________________

## Substance Use:

| Substance: | Frequency | Amount | How long since last use? |
| --- | --- | --- | --- |
| ❒ Methamphetamines | | | |
| ❒ Marijuana | | | |
| ❒ Hashish | | | |
| ❒ Cocaine | | | |
| ❒ Crack | | | |
| ❒ Heroin | | | |
| ❒ Opiates | | | |
| ❒ Prescription Drugs | | | |
| ❒ PCP | | | |
| ❒ LSD | | | |
| ❒ Mushrooms | | | |
| ❒ Mescaline | | | |
| ❒ Glue/Inhalants | | | |
| ❒ Alcohol | | | |
| ❒ Other/Specify: | | | |

Blackouts? Y__ N__ Morning Shakes? Y__ N__ Withdrawal Seizures? Y__ N__
Rehab? Y__ N__ AA/NA? Y__ N__ DUI's? Y__ N__; If yes, how many? ______
Nicotine? Y__ N__; If yes, how much/many? ____________/packs/___________
Longest period of sobriety? ______________________________________

## Medical History

Primary Care Provider: ______________________________________
Physician Name Practice Name

Other Providers: (List Name, Practice Name, and Contact #)...______________________________

________________________________________________

________________________________________________

________________________________________________

Current Health Problems: ______________________________________

________________________________________________

________________________________________________

Past major illnesses or injuries: ______________________________________

________________________________________________

# North End Psychiatry & Associates

Do you have any allergies? Y__ N__; If yes, explain: ___________________________

Have you experienced any of the following health problems in the past:

| | | |
|---|---|---|
| ❒Constipation/Diarrhea | ❒Kidney/Bladder | ❒Tics |
| ❒Diabetes | ❒Head Injury | ❒Thyroid Dysfunction |
| ❒Ear/Hearing Problems | ❒Neurological Problem | ❒Weight Loss |
| ❒Frequent Infections | ❒Lung Problem | ❒Weight Gain |
| ❒Heart Problems | ❒Seizures | ❒Other/Specify: |

Have you ever been hospitalized? Y__ N__; If yes, please explain: _______________
_______________________________________________________________________________

Have you ever had an EEG, EKG, ECHO or Head/Body Imaging (CT/MRI)? Y__ N__; If yes, explain: ___________________________________________________________________

Total Hours of sleep per night: ______ Usual sleep schedule: _______ to _______
Are the current problems related to sleep? Y__ N__; If yes, explain: ___________
_______________________________________________________________________________

Please list ALL the medications you are currently taking (Medical, Psychiatric, Over the counter): ____________________________________________________________

| Name of Medication | Dose/Frequency | Date Started |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

Please list all psychiatric medications that you have tried in the past (If greater than 4 medications, please attach a separate list): Example: Dexedrine, 5mg twice daily, 09/98-11/98, poor sleep

| Name | Dosage | Duration | Response | Reason for stopping |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## Mental Health History

Have you ever been in counseling or seen a psychiatrist? Y__ N__; If yes, please list whom, when, and type of treatment (Inpatient, Outpatient, Residential):
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

# North End Psychiatry & Associates

Have you ever had suicidal thoughts or attempted suicide? Y__N__; Explain: ____________________________________________

____________________________________________

Have you previously had any psychiatric hospitalizations? If yes, provide dates and location(s). ____________________________________________

____________________________________________

____________________________________________

Family History of mental/medical illness: (Please specify which family member)

- ❒ADHD/ADD
- ❒Anxiety/Panic Attacks
- ❒Alcohol/Drug Abuse; If checked, specify: ____________________
- ❒Autism/Asperger's/ Pervasive Developmental Disorder
- ❒Bipolar
- ❒Depression
- ❒Learning Disabilities; If checked, specify: ____________________
- ❒Obsessive Compulsive Disorder (OCD)
- ❒Panic Disorder
- ❒Post Traumatic Stress Disorder (PTSD)
- ❒Psychiatric Hospitalizations
- ❒Schizophrenia
- ❒Suicide
- ❒Cancer (Type?): ____________________
- ❒Diabetes; If checked, specify: ____________________
- ❒High Blood Pressure
- ❒Heart Problems; If checked, specify: ____________________
- ❒Lung Problems; If checked, specify: ____________________
- ❒Immune Disorders; If checked, specify: ____________________
- ❒Migraines
- ❒Seizures
- ❒Thyroid; If checked, specify: ____________________
- ❒Other/Specify: ____________________

Are you currently experiencing problems in any of the following areas:

- ❒Aggressive Actions
- ❒Aggressive Thoughts
- ❒Alcohol Use
- ❒Anger Management
- ❒Anxiety/Excessive Worry
- ❒Attention Span
- ❒Compulsions
- ❒Delusions
- ❒Depressed Mood
- ❒Divorce
- ❒Drug Use
- ❒Eating Less Than Usual
- ❒Eating More Than Usual
- ❒Family/Parenting
- ❒Fears
- ❒Hallucinations
- ❒Headaches
- ❒Hearing/Seeing Strange Things

# North End Psychiatry & Associates

- ❒ Homicidal Thoughts
- ❒ Hyperactivity
- ❒ Impulsivity
- ❒ Low Self-Esteem
- ❒ Lying
- ❒ Mania
- ❒ Nightmares
- ❒ Obsessive Thoughts
- ❒ Panic Attacks
- ❒ Paranoid Thoughts
- ❒ Phobias
- ❒ Problems at work
- ❒ Racing Thoughts
- ❒ Relationship Problems
- ❒ Sadness/Crying
- ❒ Separation
- ❒ Sexual Problems/Concerns
- ❒ Sleeping More Than Usual
- ❒ Sleeping Less Than Usual
- ❒ Social Withdrawal
- ❒ Step Parent Issues
- ❒ Stomach Aches
- ❒ Suicidal Actions
- ❒ Suicidal Plans
- ❒ Suicidal Talk
- ❒ Suicidal Thoughts