Patient Information		
Name	Date of Birth SS #	Age
Address	Cell Phone ( )	E-mail Address
City St Zip	Sex: ☐ M ☐ F ☐ Married ☐ Single ☐ Divorced ☐ Widow	
Home Phone	Referring Doctor? ( )	Who is your regular Doctor? ( )
Employer	Work Phone ( )	Cell Phone ( )
Spouse/Guardian (Relationship) Date of Birth	His/Her Employer	Work Phone ( )
Emergency Contact Person	Home Phone	Work Phone ( )

Insurance Information	
First Insurance Co.	Policy or Medicare #
Address	Insurance Phone
Name of Insured	Date of Birth
Relationship of Insured to Patient	
Second Insurance	Policy #
Address	Insurance Phone
Name of Insured	Date of Birth
Relationship of Insured to Patient	Is this a MEDIGAP policy? ☐ Yes ☐ No

Authorization For Treatment, Release of Information, Benefit Assignment & Financial Policy Agreement

I hereby authorize and direct that any **Medicare** benefits that may be payable as a result of treatment provided to me by the Behavior Health Clinic be remitted directly to the Behavior Health Clinic as they may request and direct. I authorize any holder of medical information about me to release to my insurance and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: Date:

I hereby authorize and direct that any **insurance** benefits that may be payable as a result of treatment provided to me by the Behavior Health Clinic be remitted directly to the Behavior Health Clinic as they may request and direct. I authorize any holder of medical information about me to release to my insurance and its agents any information needed to determine these benefits or the benefits payable for related services.

Signature: Date:

Behavior Health Clinic Financial Policy

PAYMENT of deductible and co-payment amount is required for all services at the time they are rendered. We accept check, cash, and credit card. We will file all Medicare claims or other primary insurance claims. Second insurances will be filed if the EOB is available to us.

FINANCE CHARGES of 18% per annum, with a minimum of $0.50 per month are added to unpaid accounts after 90 days from the date of service.

INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR INSURANCE COMPANY. We are not a party to this contract. We file insurance claims as a courtesy to our patients. We will not become involved in disputes between you and your insurance company other than supply factual information as necessary.

YOU ARE RESPONSIBLE FOR THE TIMELY PAYMENT OF YOUR ACCOUNT. Thank you for understanding our financial policy. Please let us know if you have any questions or concerns. Your signature below signifies your understanding and willingness to comply with this policy.

Signature: Date:

Portneuf MEDICAL CENTER

BEHAVIORAL HEALTH
OUTPATIENT PSYCHIATRY
500 South 11th Ave., Suite 503, Pocatello, Idaho 83201
Phone: (208) 239-1222 Fax: (208) 239-1225

OFFICE POLICY INFORMATION SHEET

I will pay all of my co-payments, co-insurance and/or deductibles at the time of service. If my insurance requires a referral, it is my responsibility to get it from my Primary Care Physician before my appointment. As a courtesy to myself, your office will file my insurance claims. However, I am responsible for all charges incurred in your office. I know the primary concern of your office is my good health. I will not allow past due balances to interfere with my course of treatment. _____________

I understand that telephone consultations with my physician are for EMERGENCY situations. There is a fee for this service that my insurance company will not pay for. I will be responsible for this charge. _____________

I will be considered a patient of this practice if I follow up with each appointment or make clear alternative arrangements if I am unable to keep this appointment. I will follow my physician's medication orders or work with him to create a treatment plan that is acceptable for both of us. _____________

I understand I am to contact the office 24 hours in advance if I will be unable to keep my appointment. Failure to notify the office 24 hours in advance of my inability to keep my appointment may result in a $35.00 charge. This charge will be due from me and will not be billed to my insurance company. I also understand that if I am more than 10 minutes late for my appointment, I may have to reschedule so that other patients may be seen on time. After three no shows I may no longer be a patient in the office, I may receive a letter stating so._______

After six months of no contact with this office, I will automatically be considered an inactive patient. Inactive status designates that my physician will reserve the right to direct emergency triage to another provider or facility if the need arises a physician had prescribed medication continuously and an inactive status starts, only a maximum of one month's medication will be prescribed while I find alternative treatment and physician.

____

I am responsible for my medications. I understand the office cannot refill lost medications, especially if the medication is a controlled substance. I also understand that it is my responsibility to call for prescription authorizations 48 hours in advance of running out of medications. Your pharmacy needs to call us your refill request. **We will call back the request during business hours Mon-Thursday office is closed on Fridays. Any samples given must be picked up before 3pm Mon-Thursday. In order to receive prescription medication I must see my physician at least once every three months. My physician will not prescribe narcotic drugs.**

____

NO EXCEPTIONS.
Additionally, I give my permission for Portneuf Behavioral Health Clinic to release treatment information to my insurance company as long as I am in treatment. _____________

I understand that these policies are subject to change without prior notification.

_________________________________ _____________________

Patient/Legal Guardian Signature Date

Patient Name: ______________________________

I herby authorize the use and disclosure of individually health information relating to me, which is called "protected health information: (PHI) under a federal health privacy law, as indicated or described below:

☐ All health information relating to me.
☐ Only the following specific information. (Describe specific information including dates of service.)

____

____

Please List the Individual(s) or Organization(s) to whom the Disclosure May be Made:

____

The protected health information will be used and/or disclosed for the following purposes:

☐ At my request for personal reasons.
☐ Other:

I understand in making this request that:

- If the individual(s) or organization(s) that receives this information is not a health plan or health care provider covered by federal privacy regulations, the released information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

- I may revoke this authorization at any time by notifying you in writing. However, if I choose to do so, I understand that my revocation will not affect any actions taken by you before receiving my revocation.

This authorization expires one year from the date signed, as indicated below, or until revoked by me in writing.

Patient Name: ______________________ Patient DOB: ______________

Patient Signature: ______________________ Date: ______________

If signed by the patient's personal representative the personal representative hereby states and represents they have been appointed, or have received authorization, to act as the patient's personal representative.

Witnessed by: ______________________ Date: ______________

PORTNEUF MEDICAL CENTER
Medical Practice Group
757 Hospital Way Building A
Pocatello, Idaho 83201

Receipt of Notice of Privacy Practices
Written Acknowledgement Form

I, ________________________________, have been informed of the Privacy Practice
Patient Name

Notice of the above organization (inclusive of all Portneuf Medical Center owned clinics).

I am aware a written copy is available to me upon request.

☐ I request a copy of the Notice of Privacy Practice. *(Please mark here if you would like to receive a copy of the Privacy Notice.)*

____ ____________________________
Signature of Patient or Legal Guardian Date

Patient MR#: ___________________________________

DOC NO MP00082 (2/23/10) MW

Date / Time: ______________________________ **Patient Name:** ____

Please describe the current problem(s) for which you are seeking treatment or have been referred for evaulation. Please include when the problem(s) first began, significant events related to the progression of your symptoms:

Clinician Comments

Please list recent stressful life events:

Past Treatment with Psychiatric Medications (current medications listed later)

Please circle the name of any medication (listed below) which has been prescribed to you for psychiatric or medical purpose:

Antidepressant		Mood Stabilizers		Tranquilizers	Sleeping Aids	Stimulants	Others	
Prozac	Serzone	Lithium	Xanax	Xanax	Ambien	Ritalin	Risperdal	Naltrexone
Zoloft	Wellbutrin	Depakote	Klonopin	Klonopin	Sonata	Dexedrine	Zyprexa	Antabuse
Paxil	Amitriptyline	Tegretol	Ativan	Ativan	Trazodone	Adderall	Seroquel	
Luvox	Nortriptyline	Lamictal	Valium	Valium		Clondine	Geodon	
Celexa	Desipramine	Neurontin	Buspar	Buspar		Concerta	Prolixin	
Effexor	Anafranil	Topamax				Provigil	Thorazine	
Remeron	Cymbalta	Gabitril					Haldol	
Lexapro		Trileptal					Abilify	

Name of Medication	Max. Dose	Doctor	Reason for use	Response Date Started	Length of use	0 = none, 1 = poor 2 = mod, 3-excellent	Side Effects

Have you ever been suicidal or attempted suicide? ❑ Yes ❑ No If yes, provide details below.

Portneuf MEDICAL CENTER

651 Memorial Dr., Pocatello, Idaho 83201

DOC NO BS00305 (02/11/09) ES

SELF-ASSESSMENT FORM: PSYCHIATRIC EVALUATION

Date / Time: ______________________________ Patient Name: ____

Past and Present Treatment with Counseling or Psychotherapy

Name of Therapist	Purpose of Treatment	Date Started	Length of Treatment	Was it helpful?	Comments

Past Hospitalizations or Residential Treatment for the Treatment of Psychiatric, Behaviorial or Substance Abuse Problems

Name of Institution/Location	Reason for Hospitalization or Type of Problem	Date	Length	Did it help?	Comments

Clinician Comments

Substance Use/Abuse

Alcohol Use/Abuse — Do you drink alcohol?
❑ Yes, now. ❑ Yes, in the past. ❑ No.
❑ I drink occasionally: ___X per month.
❑ I drink most days: ___X per week.
❑ I or significant others believe I have a drinking problem.

Drug Abuse — Have you abused "street"/illicit or prescription drugs?
❑ Yes, now. ❑ Yes, in the past. ❑ No.
If yes, what drug(s) and what ages with each drug: ____
____

Tobacco Products — Do you smoke or use other tobacco products?
❑ Yes, now. ❑ Yes, in the past. ❑ No.
If yes, how many packs per day and how many years: ____
____

Caffeine — Do you regularly drink coffee, tea or colas?
❑ Yes, now. ❑ No.
If yes, how much per day: ____

Clinician Comments

If applicable, have you recognized any major negative consequences of your substance use/abuse (i.e. legal, health, relationship difficulties, job losws, etc.)?
❑ Yes, now. ❑ Yes, in the past. ❑ No.
I yes, please list : ____

Date / Time: ______________________________ **Patient Name:** ______________________________

Medical History

Allergies — Please list all allergies, including medication allergies: ______________________________

Prenatal Medical Problems — Did your mother experience significant medical problems during her pregnancy, labor or delivery with you?

❑ Yes ❑ No. If yes, please explain:

Acute or Chronic Physical Illnesses — Please include past and present conditions.

____

____

Seizures or Head Traumas with Loss of Consciousness or Amnesia — Please list date of trauma or date of onset and type of seizures, if applicable: ______________________________

Surgeries — Please include type and date: ______________________________

____

Current Medical Symptoms — Please list any current physical symptoms including headaches or dizziness; ear, nose or throat problems; heart problems; lung or respiratory problems; stomach, liver or bowel problems; urinary tract problems; reproductive system problems; muscle, bone or joint problems; skin disease; blood, immune or hormonal problems; pain problems, etc.:

____

Current Medications — Please list all medications (prescribed or over-the-counter), herbs, or vitamins which you have used on a regular basis during the last three months:

1.

2.

3.

4.

5.

6.

7.

8.

9.

10.

(Continue if necessary)

Pharmacy: ______________________________

Family History of Psychiatric Problems

Please include psychiatric problems, in your biological relatives, such as depression, bipolar (manic-depression), anxiety disorders (i.e. panic disorder, OCD, post traumatic stress ...), schizophrenia, hyperactivity or attention deficit disorder, alcohol or drug abuse, anger or criminal problems, suicides, etc.:

Relative	Yes	No	Uncertain	Type of Problem(s)
Mother				
Mother's Parents & Siblings				
Father				
Father's Parents & Siblings				
Your Brothers and Sisters				
Your Children				

Date / Time: ______________________ **Patient Name:** ______________________

Place of Birth ______________________

Where did you live while growing up; did you move frequently?

____

What were you like as a child i.e. hyperactive, moody, happy, anxious, temperamental, etc.

____

How many siblings did you have and where did you fit in the order? How did you get along with them?

____

Please describe **family constellation** while growing up i.e. divorces, remarriages and step-parents, etc.

____

Please give a brief description of your **father's or step-father's personality** and your **relationship** to him/them.

____

Please give a brief description of your **mother's or step-mother's personality** and your **relationship** to her/them.

____

What was your **family structure** like when you were growing up i.e. too strict, harsh, difficult, affectionate, close, unstable, too loose, etc.?

____

Did you experience any traumatic events or abuse (physical, sexual, verbal, neglect) while you were growing up?

❑ Yes ❑ No If yes, please explain:

____

How did you do during **grade school** academically, socially, and behaviorally? Did you require an IEP or resource classes?

____

How did you do during your **teenage years** academically, socially, and behaviorally?

____

If you were in the **military service**, please describe:

____

Have you had any **legal charges**, past or present?

❑ Yes ❑ No If yes, please describe:

____

Are you involved in a religious group or organization?

- ❑ no involvement
- ❑ active in growing up
- ❑ would like to be more active
- ❑ feel uncomfortable with church
- ❑ attend occasionally
- ❑ attend regularly
- ❑ went on a church mission/service
- ❑ involved in church leadership/teaching
- ❑ converted to a new religion
- ❑ other ______________________

Please list your **Hobbies and Interests**:

____

What are your **strengths**?

____

What are your **weaknesses**?

____

What do you **hope to accomplish in treatment**?

____

Clinician Comments