FAMILY THERAPY & RECOVERY, PS
ROBYN BENNETTS, ARNP, PMHNP

This packet of additional information is intended to assist your Practitioner in providing you with the best service possible. We ask that you answer carefully and completely. All information on these forms is considered to be confidential and will be handled according to the PHI (Protected Health Information) HIPAA requirements.

Name:______________________________ **Date:**____________________

Referred By:______________________________ **Phone:**____________________

**** Please note some of the questions are not relevant to children, you may mark out the sections that do not apply****

Is there any additional information you would like to provide about what brings you here today?

____

____

____

Please list any medications not listed on the initial registration form:

CURRENT / RECENT MEDICATIONS:

NAME of Medication	Dose:	Frequency	Start	Stop

Adverse / Allergic Drug Reactions:______________________________

____

Alternative Supplements/Vitamins:______________________________

____

Highest Weight: ____________ **Current Weight:**____________ **Height:**____________

Women: Are you currently pregnant? ☐ **Yes** ☐ **No**

Number of Pregnancies: ____________ Regular menstrual periods? ☐ **Yes** ☐ **No**

Are you currently taking birth control? ☐ **Yes** ☐ **No**

Have you ever been diagnosed or treated for any of the following? Regardless of whether they are current or past problems.

Current	Past	
		Abdominal pain
		Alcohol Abuse
		Anemia
		Arthritis
		Asthma
		Bleeding mole
		Cancer (within last 5 years)
		Chest Pain/ Palbitation
		COPD/ Emphysema
		Convulsions/ Seizures
		Coughing up blood
		Diabetes
		Dizziness/ fainting spells
		Drug Abuse
		Eating Disorder(s)
		Epilepsy
		Frequent lingering cough
		Frequent severe headaches
		Heart Disease
		Hemophilia
		High Blood Pressure
		Hormone Replacement Therapy
		Hyper/ Hypoglycemia

Current	Past	
		Increased thirst/ urination
		Infection(s)
		Jaundice/ Hepatitis
		Joint/ Back problems
		Kidney Disease/ stones
		Liver disease
		Motor coordination/ paralysis
		Night sweats/ fevers
		Nutrition problems
		Pain in back or extremities
		Sexually transmitted disease
		Shortness of Breath
		Skin problems
		Smoking
		Stroke
		Sudden Loss of Smell, Taste, Vision,
		Sudden Loss of Hearing, Sensation
		Swelling of the Feet/Ankles/Hands
		Thyroid/ Gland Problems
		Tuberculosis/ TB Exposure
		Ulcers
		Unintentional weight loss/ gain
		Other:
		Surgeries/ injuries:

Have you ever received any prior Psychiatric, Psychological or Substance Use Disorder Services?

Name of treatment facility: i.e. outpatient/inpatient	Practitioners Seen:	Dates of Service	Were services helpful?

SUBSTANCE USE HISTORY: (if applicable)

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? ____________________

Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover? ____________________

FAMILY MEDICAL, PSYCHIATRIC AND SUBSTANCE USE HISTORY

Please note with a "X" in the appropriate box if these conditions are current or have occurred in relatives

	Children	Siblings	Mother	Father	Uncles/ Aunts	Grandparents	Others
Nervous Problems (anxiety)							
Depression							
Substance Abuse							
Other							

Family Data:

Place of Birth:____

Father: Living or deceased?________________ Age if living:____________

Occupation:____

Health Status:____

If deceased, cause of death:__________________________________

Frequency and nature of contact:________________________________

Mother: Living or deceased?________________ Age if living:____________

Occupation:____

Health Status:____

If deceased, cause of death:__________________________________

Frequency and nature of contact:________________________________

Brothers/ Sisters:

Name				Sex	Age	Resides where?

Did you live with anyone other than your natural parents for any significant time during your childhood years?

____

____

RELATIONSHIP HISTORY

Marital Status: Single:_____ Married:_____ Divorced:_____ Widowed:_____ Partnered:_____

If married, remarried or partnered, for how long?_______________________________

If divorced, separated, or widowed, for how long?_______________________________

If previously married or in a long-term relationship, when?__________________ how long?____________

Spouse/ Partner's age:_______________ Spouse/ Partner's occupation:_______________________

Spouse/ Partner's prior marriages:_____________ When?_____________________ How long?________

Children/ Step-children: *(if additional space needed write on the back)*

Name				Sex	Age	Resides where?

LIVING ARRANGEMENTS / HOME ENVIRONMENT

With whom do you currently live?____

Are there any concerns about living arrangements?________________________________

EDUCATIONAL HISTORY

Highest level of education completed?____

Did you receive any special educational services?_________________________________

OCCUPATIONAL HISTORY

Occupation:_____________________________ Current position:___________________________

If not currently working, date you last worked:_________________________________

List names of employers in past 10 years: ____

____

Confidentiality

Mental Health: We respect your right to confidentiality. With the exception of the specific special circumstances noted below, most issues that are discussed in the course of psychiatric or mental health evaluations and treatments are confidential. However, under the HIPAA Policies and Patients' Rights Agreement, which is made available to you, there are exceptions to this rule, which you may read about in that document. Under the Health Care Information Access and Disclosure Law of Washington State, I am allowed to confer with any current, prior, or future health care providers for purposes of continuity of care, without written Authorization, unless you instructed me otherwise. Substance Abuse (Chemical Dependency) and Domestic Violence information cannot be disclosure except as noted below.

Furthermore, there are specific exceptions to confidentiality that are mandated by law. These include:

1. If you are a specific danger to yourself or others
2. Information regarding the abuse or neglect of a child, a developmentally disabled person, or a dependent adult.
3. Information required by court proceeding.
4. If you are gravely disabled.

Alcohol/Substance Use: Alcohol and/or Substance Use treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR, Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164.

Domestic Violence: Domestic Violence records are protected under the Federal and State Confidentiality Regulations and cannot be disclosed without written consent unless otherwise provided for in the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR, Parts 160 and 164 and State (RCW 71.05.390 - WAC 275-56-240).

Generally for Drug and Alcohol Abuse or Domestic Violence, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as a client unless:

1. The patient consents in writing; OR
2. The disclosure is allowed by a court order; OR
3. The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit or program evaluation; OR
4. The patient commits or threatens to commit a crime either at the program or against any person who works for the program.

Please ask your health care provider if you have any questions about the information found within this consent.

FAMILY THERAPY & RECOVERY, PS
ROBYN BENNETTS, ARNP, PMHNP
INFORMED CONSENT FOR TREATMENT, APPOINTMENTS, FEES AND MEDICATION REFILLS

Your Right and Responsibilites

As a patient, you have the right to ask questions about any aspect of your treatment, and deserve information regarding any risks, benefits, or side effects of any proposed treatments as well as treatment alternatives. You have the right to refuse or end treatment at any time without any legal or financial obligations except to pay for evaluation and treatment already received. Similarly, we reserve the right to decline or terminate treatment at our discretion if we feel that a positive or effective treatment relationship is not possible, and in that case, we would assist you in finding an alternate provider if that became necessary.

Coverage: We believe the decision to start and maintain medications for psychiatric and substance use disorders is a shared responsibility. You and your family are expected to manage more routine and less urgent issues with your medications primarily during your appointments, or at least during weekday business hours. Currently we do not have after-hour or weekend coverage. If a truly urgent issue arises, **PLEASE CALL 911 or go to the nearest Emergency Room or Call the Crisis Line @ 866.427.4747 or 211 on your cell phone.** For non-emergent issues, you may call 253.220.9452 and leave a message that will be forward to your practitioner the next business day.

Regarding prescription refills: At each appointment we will provide enough medication to last until your next appointment. Please schedule that appointment accordingly so that you do not run out of medication. Generally, **we will not refill medications if you do not have a return appointment scheduled**. If you have that appointment, then contact your pharmacy for a refill request. Please see controlled drug expectations below. Please allow 3 business days for us to process refill requests – this means notifying us before you run out of your medications. **Any refill request made outside of this policy will be charged a $25.00 prescription request fee.**

Patient Initials:______________

Scheduled Appointment Policy

Entering into psychiatric-mental health services is effectively a contract. We agree to be available to you as scheduled to treat you ethically and to the best of our ability. We are able to provide these services because you are agreeing to make your appointments and pay for your services (usually, in part, through your insurance). If you miss an appointment or cancel with little notice, this prevents us from providing service to other patients as well as it affects the viability of our practice. We expect you to show us the courtesy of cancelling appointments with sufficient notice to be able to use that time productively.

Missed Appointment or Late Cancellation Fees: It is your responsibility to attend regularly scheduled appointments. Our usual practice is to contact you by either phone, email or send a letter if an appointment is missed either due to late cancellation or not coming. **Late cancellations and missed appointments will be charged $100 per occurrence.** These charges must be paid by you and cannot be billed to your insurance.

Any cancellation or reschedule request must be done **48 hours prior** to your appointment to avoid late cancellation fees. Cancellations are accepted via email **(admin@familytherapyrecovery)** or by phone **(253.220.9452)**, they are to be done Mon - Sat during business hours. Any cancellations or reschedule requests done after or before business hours will be processed the following business day.

If there have been **3 no shows or late cancellations** for appointments, we will need to close your mental health services with Family Therapy & Recovery, PS. At that time, you would have 30 days to request refills or referrals to other health care providers prior to final closure of your care. Clearly, we want to avoid this if at all possible, but are unable to accommodate multiple missed appointments.

Patient Initials:______________

CONSENT FOR TREATMENT, ACKNOWLEDGEMENT AND SIGNATURE FORM

Please sign and return this page as a permanent inclusion in your client file after you have read the policies on Informed Consent for Treatment, Appointments, Cancellations / Rescheduling and Medication Refills

- My signature below indicates that I have read, understand, and agree to the policies as stated on the form, "Informed Consent for Treatment, Appointments, Fees and Medication Refills.

- I understand and accept responsibility for payment of fees in accordance with these terms and conditions, including the late cancellation and missed appointment fees.

- I understand my rights and responsibilities as a client, and the responsibility of the medical staff member to me. I authorize FT&R and Staff to provide behavioral health services to me. I consent to the use of a diagnosis in billing and to release of that information and other information necessary to complete the billing process.

- I understand that under the Health Care Information Access and Disclosure Law of Washington State, your provider is allowed to confer with my current, prior, or future health care providers for purposes of continuing care, without my written Authorization, unless I have instructed my provider otherwise.

- I know I can end treatment at any time that I wish and that I can refuse any treatment recommendations made by my provider.

This authorization constitutes informed consent to treatment without any exception.

Patient Signature: ______________________ Date: __________

Parent/ Guardian Signature: ______________________ Date: __________

Name:____________________________ Date:_____________ **ANXIETY SCALE**

INSTRUCTIONS: This scale includes questions about the symptoms of anxiety. For each item please indicate how well it describes you during the PAST WEEK, INCLUDING TODAY. Circle the number in the columns next to the item that best describes you.

0=not at all true 1=rarely true 2=sometimes true 3=often true 4=almost always true

During the PAST WEEK, INCLUDING TODAY....

1.	I felt nervous or anxious	0	1	2	3	4
2.	I worried a lot that something bad might happen	0	1	2	3	4
3.	I worried too much about things	0	1	2	3	4
4.	I was jumpy and easily startled by noises	0	1	2	3	4
5.	I felt "keyed up" or "on edge"	0	1	2	3	4
6.	I felt scared	0	1	2	3	4
7.	I had muscle tension or muscle aches	0	1	2	3	4
8.	I felt jittery	0	1	2	3	4
9.	I was short of breath	0	1	2	3	4
10.	My heart was pounding or racing	0	1	2	3	4
11.	I had cold, clammy hands	0	1	2	3	4
12.	I had a dry mouth	0	1	2	3	4
13.	I was dizzy or lightheaded	0	1	2	3	4
14.	I felt sick to my stomach (nauseated)	0	1	2	3	4
15.	I had diarrhea	0	1	2	3	4
16.	I had hot flashes or chills	0	1	2	3	4
17.	I urinated frequently	0	1	2	3	4
18.	I felt a lump in my throat	0	1	2	3	4
19.	I was sweating	0	1	2	3	4
20.	I had tingling feelings in my fingers or feet	0	1	2	3	4

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME: ______________________ DATE: ______________

Over the last 2 *weeks*, how often have you been bothered by any of the following problems? *(use "✓" to indicate your answer)*	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 figety 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	0	1	2	3
add columns		+	+	
TOTAL:				

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card).

10. If you checked off *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	______

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The Mood Disorder Questionnaire (MDQ)

INSTRUCTIONS: Please answer each question as best you can.	YES	NO
1. Has there ever been a period of time when you were not your usual self and...		
... you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
... you were so irritable that you shouted at people or started fights or arguments?	○	○
... you felt much more self-confident than usual?	○	○
... you got much less sleep than usual and found that you didn't really miss it?	○	○
... you were more talkative or spoke much faster than usual?	○	○
... thoughts raced through your head or you couldn't slow your mind down?	○	○
... you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
... you had much more energy than usual?	○	○
... you were much more active or did many more things than usual?	○	○
... you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
... you were much more interested in sex than usual?	○	○
... you did things that were unusual for you or that other people might have thought were excessive, foolish or risky?	○	○
... spending money got you or your family in trouble?	○	○
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	○	○
3. How much of a problem did any of these cause you - like being able to work; having family, money or legal troubles; getting into arguments or fights? ○ No problem ○ Minor problem ○ Moderate problem ○ Serious problem		
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

FTR
FAMILY THERAPY & RECOVERY P.S.

Admin Only: Called in for Appt. on ________________
Todays Date:________Referred By: ________________

Patient Registration/Intake Packet

(Please Print & Circle Yes or No)

Name ____ Date of Birth ________/________
First Middle Initial Last Gender

Responsible Party:______________________________________Date of Birth________________
First Last

Address ____
Street City State Zip

Primary Phone #________________________ Secondary Phone/Work #________________________

Employed? **Yes / No** Current Employer____________________________ Position______________

Email______________________________________ Driver's Lic #____________________________

Marital Status: ___ Single ___Married ___Divorced ___Widowed Student Status: **Yes / No**

School & Contact:____ Phone______________________

Name of Person(s) with custodial rights____

If required is there a parenting plan on file? **Yes / No**

Physician__________________________ Phone____________________ Referral Needed: **Yes / No**

Emergency Contact: ____
Name Relationship Phone

Insurance / Payment Information

☐ PRIVATE PAY ☐ INSURANCE ☐ EAP ~ Name of EAP:__________ Reference #______________

Primary Insurance Company: ________________________________ Phone:________________________

Subscriber SSN:____________________ Ins ID:______________________ Group #:______________

Subscriber Employer (if not patient): __________________________ Phone:______________________

~ ~

Secondary Insurance Company: ______________________________ Phone:______________________

Subscriber ____
Subscriber Name Date of Birth

Subscriber SSN:____________________ Ins ID:______________________ Group #:______________

Subscriber Employer (if not patient): __________________________ Phone:______________________

*This packet is just one part of other diagnostic tools used.

Payment Policies and Disclosure Statement

1) **Payment for services:** Billing for services is based on the department of service, whether there is insurance, the type of insurance company, and whether the services are covered under insurance. For services not covered under insurance, we provide private payment options as noted below.
2) **Insurance Billing:** All **contracted** & **non-contracted** insurance companies are billed **directly as a courtesy** for all services covered by insurance. If your insurance company is **not contracted** with **Family Therapy & Recovery, PS** all charges are considered **patient responsibility** at the start of service. Any remaining balance for non-covered benefits, co-insurance and deductibles are **your responsibility.** Payment for this is expected within 30 days from receipt of your statement unless you are on a monthly contractual agreement for services not covered by insurance or placed to your responsibility by your insurance plan. All Third Party Payers (motor vehicle accident insurance) are considered non-contracted. (See assignment of Benefits below for billing)
3) **CO-PAYS:** All co-pays are expected at the time the service is rendered.
4) **Payment Arrangements:** Under special circumstances temporary payment arrangement may be made if approved in advance. Accounts on a temporary payment plan are required to make payment each and every month. Missed payments will result in late fees &/or being sent to an outside collection agency.
5) **RETURNED CHECKS:** There will be a $30.00 charge for all returned checks.
6) **SERVICE FEE:** There is an interest fee or late fee assessed on ALL accounts with balances 60 days past due, unless you have made payment arrangements in advance with regards of incurring a debt to us.
7) **Late Cancel & No Show Policy:** There is a fee for no-show and late cancellation of appointments without **24-hour notice**. (this does not apply to group sessions)
8) **Method of Payment:** We accept cash, checks, and money orders, American Express, Discover, VISA or Master Card

Assignment of Insurance Benefits & Authorization to Release Information

I hereby authorize payment directly to **Family Therapy & Recovery, PS** for **All Behavioral Service** benefits otherwise payable to me not to exceed this Practice's regular charges for this service and period. Although eligibility and benefit information will be corroborated to the best of this Practice's ability, certification for medical necessity does not guarantee financial reimbursement related to these matters. ***I understand that it is my responsibility to resolve any dispute with my insurance carrier(s) or third party payer*** and that ***I am obligated to pay all charges in the interim***. In the event of default payment, I will be held liable for the unpaid balance, including any attorney or collections charges as permitted by law.

In order to process my claim for benefits, I authorize this **Family Therapy & Recovery, PS** to release my insurance carrier or third party payer I may have, as well as to an administrator, utilization review organization or fourth party payer appointment by them, any information regarding my treatment program that may be required. I also authorize this agency to contact the Washington State Insurance Commissioner on behalf of my insurance claim, if my insurance carrier sees fit to deny charges for treatment.

Informed Consent for Billing

- My signature below indicates that I have read, understand, and agree to the Financial/Billing policies as stated above.
- I understand and accept responsibility for payment of fees in accordance with these terms and conditions, **including the late cancellation and missed appointment fees**.
- I authorize **Family Therapy & Recovery, PS** and Staff to provide behavioral health services to me. I consent to the use of a diagnosis in billing and to release that information and other information necessary to complete the billing process.
- I know I can end treatment at any time that I wish and that I can refuse any treatment recommendations made by my provider. I accept responsibility for any repercussions due to refusal of treatment changes or recommendations.
- If you have any questions about the above information or any uncertainty regarding insurance coverage, **PLEASE** don't hesitate to ask us. We are here to help you.

I have read and understand all the above information. I accept all financial responsibilities associated with the services I receive from Family Therapy & Recovery, PS.

Client Signature: ______________________________ **Date:** ____________

Patient Rights

WAC 388-877-0600

Family Therapy & Recovery P.S. shall take reasonable efforts to assure that all patients:

-Receive services without regard to race, creed, national origin, religion, gender, sexual orientation, age or disability;

-Practice the religion of choice as long as the practice does not infringe on the rights and treatment of others or the treatment service. Individual participants have the right to refuse participation in any religious practice;

-Be reasonably accommodated in case of sensory or physical disability, limited ability to communicate, limited English proficiency, and cultural differences;

-Be treated with respect, dignity and privacy, except that staff may conduct reasonable searches to detect and prevent possession or use of contraband on the premises;

-Be free of any sexual harassment;

-Be free of exploitation, including physical and financial exploitation;

-Have all clinical and personal information treated in accord with state and federal confidentiality regulations;

-Review your clinical record in the presence of the administrator or designee and be given an opportunity to request amendments or corrections;

-Receive a copy of agency complaint and grievance procedures upon request and to lodge a complaint or grievance with the agency, or regional support network (RSN), if applicable, if you believe your rights have been violated; and

-File a complaint with the department when you feel the agency has violated a WAC requirement regulating behavior health agencies.

____________________________ ____________________________

Patient Signature Date