Mental Health Solutions, LLC
PATIENT REGISTRATION FORM
PATIENT INFORMATION (NAME MUST MATCH INSURANCE CARD)

DATE___/___/___

NAME _____ BIRTH DATE ___/___/___ AGE _____

MARITAL STATUS: SGL MAR DIV SEP WID SOCIAL SECURITY NUMBER _____

STREET _____ CITY _____ STATE _____ ZIP _____

MAILING ADDR (or Same) _____CITY _____ STATE ____ ZIP_____

OCCUPATION _____ EMPLOYER _____

HOME PH (____) _____ MAY WE LEAVE A DETAILED MESSAGE? Yes No

CELLULAR PHONE (____) _____ MAY WE LEAVE A DETAILED MESSAGE? Yes No

EMERGENCY CONTACT (____) _____ NAME _____ RELATIONSHIP _____

REFERRED TO CLINIC BY _____ OTHER FAMILY MEMBERS SEEN HERE _____

NAME OF PRIMARY CARE DOCTOR _____PRIMARY DOCTOR PHONE _____

RESPONSIBLE FINANCIAL PARTY (IF APPLICABLE)

NAME _____ RELATIONSHIP TO PATIENT _____

MAILING ADDR (or Same) _____ HOME PHONE (____) _____

CELL PHONE (____) _____ WORK PHONE (____) _____

-

INSURANCE INFORMATION (PLEASE PROVIDE YOUR INSURANCE CARD AT CHECK IN)

PRIMARY INSURANCE _____ SUBSCRIBER'S NAME _____

SUBSCRIBER BIRTH DATE___/___/___ YOUR RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER

Patient ID NUMBER _____ Group# _____

SECONDARY INSURANCE _____ SUBSCRIBER'S NAME
_____

SUBSCRIBER BIRTH DATE___/___/___ YOUR RELATIONSHIP TO SUBSCRIBER: SELF SPOUSE CHILD OTHER

Patient ID NUMBER _____ Group# _____

Reason for visit today?

Credit Card Type: VISA / MC Credit Card Number: _____+ Expiration Date: _____

Name on card: _____ Billing Address of card: same as STREET or MAILING or RESP PARTY

Or BILLING ADDR _____CITY _____ STATE _____ ZIP_____

The above information is true to the best of my knowledge. I authorize payment of medical benefits to Mental Health Solutions LLC. I also authorize the release of any medical information necessary to process these claims. I understand that regardless of insurance coverage, I am responsible for my account.

_____ _____

PATIENT/ GUARDIAN SIGNATURE DATE

Mental Health Solutions, LLC
FINANCIAL & ADMINISTRATIVE POLICIES
(*Please make yourself a copy*)

RECEIPT OF PRIVACY PRACTICES

I acknowledge that I have received or been allowed to view a copy of Mental Health Solutions LLC, Notice of Privacy Practices as required by HIPAA. This notice describes how Mental Health Solutions LLC, may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information. **Initial_____**

PATIENT PAYMENT POLICY

· It is the policy of Mental Health Solutions to collect all payments and co-payments due from patients at the time of service. All benefits estimated to be the patient portion will need to be paid prior to sessions.

· If your insurance claim denies payment due to incorrect personal information or incorrect insurance information that you have provided intentionally or unintentionally, you will be charged and payment in full will be due immediately. Credit cards on file will be charged immediately unless other prior arrangements have been made.

· If your account or any account that you are responsible for is sent to a collection agency or to small claims court for nonpayment, you will face possible dismissal from care and will be charged collection agency fees and any court fees.

· It is your responsibility to know the services covered by your insurance and if your insurance does not cover these services, you will be responsible for payment.

· If you do not have insurance, you will be asked to pay at the time of service.

· A photo ID will be requested from all patients.

· New patients who do not supply their insurance card and/or who do not know what their specific mental health benefits are (i.e. deductibles, copay, percentage covered, number of visits allowed/year, whether treatment plan is required) must pay in full at the time of service. Adjustments will be made later.

· If you are required to have a referral or authorization for office services, it is your responsibility to get one. **Initial_____**

FLEX SPENDING PLANS/REIMBURSEMENT PLANS

· If you have a Flex Spending Plan or other type of Reimbursement Plan, you will be required to pay the portion which is the patient's responsibility prior to any session and will be provided with a receipt to use for reimbursement from you plan. If your plan provides you with a "credit card" for payments, we will be happy to accept this form of payment. **Initial ____**

CANCELLATION POLICY

· Our office requires a *48 hour business day cancellation notice. This does not include weekends.*

· No shows and cancellations without proper notice for all appts previously made ahead or the same day of, except in cases of medical emergency where notice is impossible, will require a **$100 fee** which will be due immediately and credit card charged This is the patient's responsibility and is **not reimbursed by insurance**. In some situations, a phone visit may be allowed in lieu of personal visit to clinic. If a patient repeatedly misses or cancels an appointment, the patient may be dismissed from the practice. **Initial_____**

COURT APPEARANCES/TRAVEL TIME/CREATION OF REPORTS: $300/hr**. Initial_____**

RECORDS REQUEST CHARGE: I charge a flat administration fee of $25 for each request. Records requests are free to your other medical providers. **Initial_____**

RETURNED CHECK CHARGE

· Mental Health Solutions, LLC will charge the patient account $25.00 for any returned checks to cover the cost of the associated bank charges. **Initial ____**

I have read, understand and agree to abide by the above policies.

Patient Signature:_____ Date:_____

PRINTED NAME_____

MEDICATION MANAGEMENT POLICY
Mental Health Solutions, LLC
Satu Woodland PMHNP
(Please initial each paragraph and make yourself a copy)

As a specialist, I get many referrals from other practitioners to help people they may feel ill-equipped to help. In doing specialty work, my training and services go beyond that of a general practitioner. General practitioners prescribe medication. They may make decisions for medication based on very short blocks of time with a patient. They often do not do, or are not trained to do, extensive psychiatric evaluation or counseling/ therapy. This is where my services differ. Considering the complicated psychosocial nature of my clients' problems, I need time with my clients to provide counseling/therapy and make proper, specialized decisions about medication and treatment. I do not believe this can be done responsibly without frequent regular contact. Therefore, I have established the following policies:

1) All clients under my care who require medication management services but do not require/want weekly counseling must come in at a minimum for a check-in *every 3 months; and more often initially*. I would prefer a regular 45 minute session to optimally evaluate progress and provide some regular minimal counseling. If the full 45 minutes is a hardship because of financial or work requirements, then a 30 min session will be the bare minimum time required. There are few exceptions to this rule which I reserve the right to decide.

2) If a client cannot make the scheduled appt for whatever reason, I need to be contacted immediately to reschedule. (Also, remember without 48 hour notice, the client will be charged directly—I am unable to charge insurance for this.) All medication management services are to be given during our sessions and **not** via internet or phone. I will occasionally make exceptions but may charge you for the time.

3) Refills: To request refills, please note I take care of these only during business hours. I require a 72 hour turn-around time, not including weekends.

4) My benzodiazepine (controlled substances) policy: I consider these rescue meds and I prescribe them rarely and only if a patient is working with me to get off them which includes regular therapy with me or another counselor. For any of the controlled medications, please note, if you lose the prescription, you are out of luck till our next refill. If someone steals your prescription, please file a police report and bring to me.

5) I reserve the right to discontinue our professional contract if these policies are not respected.

I have read and understand these policies and agree to follow them.

Patient Signature _____ Date: _____

Printed Name _____

Mental Health Solutions—Initial Questionnaire
Name:

MEDICAL HISTORY

Current medical problems/medications: _____
_____
Current supplements/vitamins/herbs:_____
Past medical problems/medications: _____
_____
Other doctors/clinics seen regularly: _____
Any history of head trauma? (describe): _____
Ever any seizures or seizure-like activity? _____
Prior hospitalization (place, cause, date, outcome): _____
Prior abnormal lab tests, X-rays, EEG, etc.: _____
Allergies/drug intolerances (describe): _____
Present Height _____ *Present Weight* _____

CURRENT LIFE STRESSES (include anything that is currently stressful for you, examples include relationships, job, school, finances, children): _____
_____
_____

Prenatal and birth events: Your parents' attitude toward their pregnancy with you
Pregnancy complications (bleeding, excess vomiting, medication, infections, X-rays, smoking, alcohol, etc.
Any birth problems, trauma, forceps or complications?:

Sleep behavior: sleepwalking, nightmares, recurrent dreams, current problems (getting up, going to bed)

School history: Last grade completed _____ Last school attended _____
Average grades received _____ Specific learning disabilities _____
Learning strengths _____
Any behavior problems in school? _____
What teachers have said about you _____
Please bring school report cards and any state, national or special testing that has been performed.

Employment history (summarize jobs you've had, list most favorite and least favorite): _____
_____
_____
Any work-related problems? _____
What would your employers or supervisors say about you? _____
_____

Military history? _____

Ever any legal problems? _____

Sexual history (answer only as much as you feel comfortable):
Age at the time of first sexual experience: _____ Number of sexual partners: _____
Any history of sexually transmitted disease? _____ History of abortion? _____
History of sexual compulsions, sexual abuse, molestation or rape?

Alcohol and drug history (Please list age started and types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them. Include alcohol [hard liquor, beer, wine], marijuana or hash, prescription tranquilizers or sleeping pills, inhalants [glue, gasoline, cleaning fluids, etc.], cocaine or crack, amphetamines or crank or ice, steroids, opiates [heroin, codeine, morphine or other pain killers], barbituaries, hallucinating drugs [LSD, mescaline, mushrooms], PCP.

Ever experience withdrawal symptoms from alcohol or drugs? _____
Has anyone told you they thought you had a problem with drugs or alcohol? _____
Have you ever felt guilty about your drug or alcohol use? _____
Have you ever felt annoyed when someone talked to you about your drug or alcohol use? ___
Have you ever used drugs or alcohol first thing in the morning? _____
Caffeine use per day (coffee, tea, sodas, chocolate) _____
Nicotine use per day, past and present (cigarettes, cigars, tobacco chew) _____

FAMILY HISTORY

Family structure (who lives in your current household, please give relationship to each):

Current marital or relationship satisfaction _____

Significant developmental events (include marriages, separations, divorces, deaths, traumatic events, losses, abuses, etc.) _____

History of past marriages _____

Natural mother's history: age _____ outside work _____
School: highest grade completed _____
Learning problems _____ Behavior problems _____
Marriages _____
Medical problems _____
Childhood atmosphere (family position, abuse, illnesses, etc.) _____
Has mother ever sought psychiatric treatment? _____If yes, for what purpose? _____
Mother's alcohol/drug use _____
Have any of your mother's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations (specify) _____

Mental Health Solutions—Initial Questionnaire
Name:

Natural father's history: age _____ outside work _____
School: highest grade completed _____
Learning problems _____ Behavior problems _____
Marriages _____
Medical problems _____
Childhood atmosphere (family position, abuse, illnesses, etc.) _____
_____
Has father ever sought psychiatric treatment? _____If yes, for what purpose? _____
_____
Father's alcohol/drug use _____
Have any of your father's blood relatives ever had any learning problems or psychiatric problems including such things as alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalizations (specify) _____
_____
_____

Siblings (names, ages, problems, strengths, relationship to patient) _____
_____
_____
_____

Children (names, ages, problems, strengths) _____
_____
_____
_____

Cultural/ethnic background _____
_____

Describe your relationship with friends _____
_____

Describe yourself _____
_____

Describe your strengths _____
_____

Mental Health Solutions—Initial Questionnaire
Name:

Amen Adult General Symptom Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List other person. _____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not applicable/unknown

Other Self

_____ ___ 1. Feeling depressed or being in a sad mood
_____ ___ 2. Having a decreased interest in things that are usually fun, including sex
_____ ___ 3. Experiencing a significant change in weight or appetite, increased or decreased
_____ ___ 4. Having recurrent thoughts of death or suicide
_____ ___ 5. Experiencing sleep changes, such as a lack of sleep or a marked increase in sleep
_____ ___ 6. Feeling physically agitated or of being "slowed down"
_____ ___ 7. Having feelings of low energy or tiredness
_____ ___ 8. Having feelings of worthlessness, helplessness, hopelessness or guilt
_____ ___ 9. Experiencing decreased concentration or memory
_____ ___ 10. Having periods of an elevated, high or irritable mood
_____ ___ 11. Having periods of a very high self-esteem or grandiose thinking
_____ ___ 12. Having periods of decreased need for sleep without feeling tired
_____ ___ 13. Being more talkative than usual or feeling pressure to keep talking
_____ ___ 14. Having racing thoughts or frequently jumping from one subject to another
_____ ___ 15. Being easily distracted by irrelevant things
_____ ___ 16. Having a marked increase in activity level
_____ ___ 17. Excessive involvement in pleasurable activities that have the potential for painful consequences (e.g., spending money, sexual indiscretions, gambling, foolish business ventures)
_____ ___ 18. Experiencing panic attacks, which are periods of intense, unexpected fear or emotional discomfort (list number per month ____)
_____ ___ 19. Having periods of trouble breathing of feeling smothered
_____ ___ 20. Having periods of feeling dizzy, faint or unsteady on your feet
_____ ___ 21. Having periods of heart pounding or rapid heart rate
_____ ___ 22. Having periods of trembling or shaking
_____ ___ 23. Having periods of sweating
_____ ___ 24. Having periods of choking
_____ ___ 25. Having periods of nausea or abdominal discomfort/trouble
_____ ___ 26. Having feelings of a situation "not being real"
_____ ___ 27. Experiencing numbness or tingling sensations
_____ ___ 28. Experiencing hot or cold flashes
_____ ___ 29. Having periods of chest pain or discomfort
_____ ___ 30. Fearing death
_____ ___ 31. Fearing going crazy or doing something out-of-control
_____ ___ 32. Avoiding everyday places for 1) fear of having a panic attack or 2) needing to go with other people in order to feel comfortable
_____ ___ 33. Excessive fearing of being judged by others, which causes you to avoid or get anxious in situations

_____ ___ 34. Experiencing persistent, excessive phobia (heights, closed spaces, specific animals, etc.) please list _____
_____ ___ 35. Having recurrent bothersome thoughts, ideas, or images that you try to ignore
_____ ___ 36. Having trouble getting "stuck" on certain thoughts, or having the same thought over and over
_____ ___ 37. Experiencing excessive or senseless worrying
_____ ___ 38. Others complaining that you worry too much or get "stuck" on the same thoughts
_____ ___ 39. Having compulsive behaviors that you must do or else you feel very anxious, such as excessive hand washing, checking locks, or counting or spelling
_____ ___ 40. Needing to have things done a certain way or else you become very upset
_____ ___ 41. Others complaining that you do the same thing over and over to an excessive degree (such as cleaning or checking)
_____ ___ 42. Experiencing recurrent and upsetting thoughts of a past traumatic event (molestation, accident, fire, etc.), please list _____
_____ ___ 43. Experiencing recurrent distressing dreams of a past upsetting event
_____ ___ 44. Having a sense of reliving a past upsetting event
_____ ___ 45. Having a sense of panic or fear of events that resemble an upsetting past event
_____ ___ 46. Spending effort avoiding thoughts or feelings associated with a past trauma
_____ ___ 47. Regularly avoiding activities/situations which cause remembrance of an upsetting event
_____ ___ 48. Being unable to recall an important aspect of a past upsetting event
_____ ___ 49. Having a marked decreased interest in important activities
_____ ___ 50. Feeling detached or distant from others
_____ ___ 51. Feeling numb or restricted in your feelings
_____ ___ 52. Feeling that your future is shortened
_____ ___ 53. Being quick to startle
_____ ___ 54. Feeling like you're always watching for bad things to happen
_____ ___ 55. Experiencing a marked physical response to events that remind you of a past upsetting event (e.g., sweating, increased pulse, etc. when getting in a car if you had been in a car accident)
_____ ___ 56. Being markedly more irritable or experiencing anger outbursts
_____ ___ 57. Having unrealistic or excessive worry in at least a couple areas of your life
_____ ___ 58. Trembling, twitching, or feeling shaky
_____ ___ 59. Experiencing muscle tension, aches, or soreness
_____ ___ 60. Having feelings of restlessness
_____ ___ 61. Becoming easily fatigued
_____ ___ 62. Experiencing shortness of breath or feeling smothered
_____ ___ 63. Experiencing a pounding or racing heartbeat
_____ ___ 64. Sweating or having cold, clammy hands
_____ ___ 65. Experiencing dry mouth
_____ ___ 66. Experiencing dizziness or lightheadedness
_____ ___ 67. Having nausea, diarrhea or other abdominal distress
_____ ___ 68. Having hot or cold flashes
_____ ___ 69. Having to urinate frequently
_____ ___ 70. Having trouble swallowing or feeling a "lump in your throat"
_____ ___ 71. Feeling keyed up or on edge
_____ ___ 73. Finding it difficult to concentrate, or having your "mind go blank"
_____ ___ 74. Having trouble falling or staying asleep
_____ ___ 75. Experiencing irritability
_____ ___ 76. Having trouble sustaining attention or being easily distracted
_____ ___ 77. Experiencing difficulty completing projects

_____ ___ 78. Feeling overwhelmed by the tasks of everyday living
_____ ___ 79. Having trouble maintaining an organized work or living area
_____ ___ 80. Being inconsistent in work performance
_____ ___ 81. Lacking in attention to detail
_____ ___ 82. Making decisions impulsively
_____ ___ 83. Having difficulty delaying what you want, having to have your needs met immediately
_____ ___ 84. Feeling restless and/or fidgety
_____ ___ 85. Making comments to others without considering their impact
_____ ___ 86. Being impatient and/or easily frustrated
_____ ___ 87. Experiencing frequent traffic violations or near accidents
_____ ___ 88. Refusing to maintain body weight above a level that most people consider healthy
_____ ___ 89. Intensely fearing gaining weight or becoming fat even though underweight
_____ ___ 90. Having feelings of being fat, even though you're underweight
_____ ___ 91. Experiencing recurrent episodes of binge eating large amounts of food
_____ ___ 92. Feeling of lack of control over eating behavior
_____ ___ 93. Engaging in regular activities to purge binges, such as self-induced vomiting, laxatives, diuretics, strict dieting, or strenuous exercise
_____ ___ 94. Being over-concerned with body shape and/or weight
_____ ___ 95a. Experiencing involuntary physical movements and/or motor tics (such as eye blinking, shoulder shrugging, head jerking or picking). How long have tics been present?_____ How often?_____
Please describe _____
____ ____ 95b. Experiencing involuntary vocal sounds or verbal tics (such as coughing, puffing, blowing, whistling, or swearing). How long have tics been present?_____ How often?_____ Please describe:_____
_____ ___ 96. Having delusional or bizarre thoughts (thoughts you know others would think are false)
_____ ___ 97. Seeing objects, shadows or movements that are not real
_____ ___ 98. Hearing voices or sounds that are not real
_____ ___ 99. Experiencing periods of time where your thoughts or speech were disjointed or didn’t make sense to you or others
_____ ___ 100. Feeling socially isolated or withdrawn
_____ ___ 101. Having a severely impaired ability to function at home or at work
_____ ___ 102. Behaving peculiarly
_____ ___ 103. Lacking personal hygiene or grooming
_____ ___ 104. Being in an inappropriate mood for a given situation (e.g., laughing at sad events)
_____ ___ 105. Having a marked lack of initiative
_____ ___ 106. Having frequent feelings that someone or something is out to hurt you or discredit you
_____ ___ 107. Snoring loudly (or others complaining about your snoring)
_____ ___ 108. Others saying that you stop breathing when you sleep
_____ ___ 109. Feeling fatigued or tired during the day
_____ ___ 110. Often feeling cold when others feel fine or they are warm
_____ ___ 111. Often feeling warm when others feel fine or they are cold
_____ ___ 112. Having problems with brittle or dry hair
_____ ___ 113. Having problems with dry skin
_____ ___ 114. Having problems with sweating
_____ ___ 115. Having problems with chronic anxiety or tension

____ ___ 116. Having impairment in communication as manifested by at least one of the following (please circle all that apply):

- A delay in or total lack of the development of spoken language (not accompanied by an attempt to compensate);
- In individuals with adequate speech, having a marked impairment in the ability to initiate or sustain a conversation with others;
- The repetitive use of language, or the use of odd language;
- A lack of varied, spontaneous make-believe play or social imitative play appropriate to developmental level.

____ ___ 117. Having an impairment in social interaction, with at least two of the following (please circle all that apply):

- A marked impairment in the use of multiple nonverbal behaviors such as eye-to-eye gaze, facial expression, body postures, and gestures to regulate social interaction;
- A failure to develop peer relationships appropriate to developmental level;
- A lack of spontaneously seeking to share enjoyment, interests, or achievements with other people (e.g., by a lack of showing, bringing, or pointing out objects of interest);
- A lack of social or emotional reciprocity.

____ ___ 118. Having repetitive patterns of behavior, interests, and activities, as manifested by at least one of the following (please circle all that apply):

- A preoccupation with an area that is abnormal either in intensity or focus;
- A rigid adherence to specific, nonfunctional routines or rituals;
- Repetitive motor mannerisms (e.g., hand or finger flapping or twisting, or complex whole-body movements);
- A persistent preoccupation with parts of objects.

Mental Health Solutions—Initial Questionnaire
Name:

Amen Adult Brain System Checklist

Please rate yourself on each of the symptoms listed below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (such as a spouse, partner or parent) rate you as well. List other person. _____

0	1	2	3	4	NA
Never	Rarely	Occasionally	Frequently	Very Frequently	Not applicable/unknown

Other Self

_____ ___ 1. Failing to give close attention to details or making careless mistakes
_____ ___ 2. Having trouble sustaining attention in routine situations (e.g., homework, chores, paperwork)
_____ ___ 3. Having trouble listening
_____ ___ 4. Failing to finish things
_____ ___ 5. Having poor organization for time or space (such as a backpack, room, desk, paperwork)
_____ ___ 6. Avoiding, disliking, or being reluctant to engage in tasks that require sustained mental effort
_____ ___ 7. Losing things
_____ ___ 8. Being easily distracted
_____ ___ 9. Being forgetful
_____ ___10. Having poor planning skills
_____ ___11. Lacking clear goals or forward thinking
_____ ___12. Having difficulty expressing feelings
_____ ___13. Having difficulty expressing empathy for others
_____ ___14. Experiencing excessive daydreaming
_____ ___15. Feeling bored
_____ ___16. Feeling apathetic or unmotivated
_____ ___17. Feeling tired, sluggish or slow moving
_____ ___18. Feeling spacey or “in a fog”
_____ ___19. Feeling fidgety, restless or trouble sitting still
_____ ___20. Having difficulty remaining seated in situations where remaining seated is expected
_____ ___21. Running about or climbing excessively in situations in which it is inappropriate
_____ ___22. Having difficulty playing quietly
_____ ___23. Being always "on the go" or acting as if "driven by a motor"
_____ ___24. Talking excessively
_____ ___25. Blurting out answers before questions have been completed
_____ ___26. Having difficulty waiting for turn
_____ ___27. Interrupting or intruding on others (e.g., butting into conversations or games)
_____ ___28. Behaving impulsively (saying or doing things without thinking first)
_____ ___29. Worrying excessively or senselessly
_____ ___30. Getting upset when things do not go your way
_____ ___31. Getting upset when things are out of place
_____ ___32. Tending to be oppositional or argumentative
_____ ___33. Tending to have repetitive negative thoughts
_____ ___34. Tending toward compulsive behaviors (i.e., things you feel you *must* do)
_____ ___35. Intensely disliking change

_____ ___36. Tending to hold grudges
_____ ___37. Having trouble shifting attention from subject to subject
_____ ___38. Having trouble shifting behavior from task to task
_____ ___39. Having difficulties seeing options in situations
_____ ___40. Tending to hold on to own opinion and not listen to others
_____ ___41. Tending to get locked into a course of action, whether or not it is good
_____ ___42. Needing to have things done a certain way or else becoming very upset
_____ ___43. Others complaining that you worry too much
_____ ___44. Tending to say no without first thinking about the question
_____ ___45. Tending to predict fear
_____ ___46. Experiencing frequent feelings of sadness
_____ ___47. Having feelings of moodiness
_____ ___48. Having feelings of negativity
_____ ___49. Having low energy
_____ ___50. Being irritable
_____ ___51. Having a decreased interest in other people
_____ ___52. Having a decreased interest in things that are usually fun or pleasurable
_____ ___53. Having feelings of hopelessness about the future
_____ ___54. Having feelings of helplessness or powerlessness
_____ ___55. Feeling dissatisfied or bored
_____ ___56. Feeling excessive guilt
_____ ___57. Having suicidal feelings
_____ ___58. Having crying spells
_____ ___59. Having lowered interest in things that are usually considered fun
_____ ___60. Experiencing sleep changes (too much or too little)
_____ ___61. Experiencing appetite changes (too much or too little)
_____ ___62. Having chronic low self-esteem
_____ ___63. Having a negative sensitivity to smells/odors
_____ ___64. Frequently feeling nervous or anxious
_____ ___65. Experiencing panic attacks
_____ ___66. Symptoms of heightened muscle tension (such as headaches, sore muscles, hand tremors, etc.)
_____ ___67. Experiencing periods of a pounding heart, a rapid heart rate, or chest pain
_____ ___68. Experiencing periods of troubled breathing or feeling smothered
_____ ___69. Experiencing periods of dizziness, faintness, or feeling unsteady on your feet
_____ ___70. Feeling nausea or having an upset stomach
_____ ___71. Experiencing periods of sweating, hot flashes, or cold flashes
_____ ___72. Tending to predict the worst
_____ ___73. Having a fear of dying or doing something crazy
_____ ___74. Avoiding places for fear of having an anxiety attack
_____ ___75. Avoiding conflict
_____ ___76. Excessively fearing being judged or scrutinized by others
_____ ___77. Having persistent phobias
_____ ___78. Having low motivation
_____ ___79. Having excessive motivation
_____ ___80. Experiencing tics (either motor or vocal)
_____ ___81. Having poor handwriting
_____ ___82. Being quick to startle
_____ ___83. Having a tendency to freeze in anxiety-provoking situations
_____ ___84. Lacking confidence in own abilities
_____ ___85. Feeling shy or timid

_____ ___86. Being easily embarrassed
_____ ___87. Being sensitive to criticism
_____ ___88. Biting fingernails or picking at skin
_____ ___89. Having a short fuse or experiencing periods of extreme irritability
_____ ___90. Having periods of rage with little provocation
_____ ___91. Often misinterpreting comments as negative when they are not
_____ ___92. Finding that own irritability tends to build, then explodes, then recedes, often being tired after a rage
_____ ___93. Having periods of spaciness and/or confusion
_____ ___94. Experiencing periods of panic and/or fear for no specific reason
_____ ___95. Experiencing visual and/or auditory changes, such as seeing shadows or hearing muffled sounds
_____ ___96. Having frequent periods of *déjà vu* (that is, feelings of being somewhere you have never been)
_____ ___97. Being sensitive or mildly paranoid
_____ ___98. Experiencing headaches or abdominal pain of uncertain origin
_____ ___99. Having a history of a head injury or family history of violence or explosiveness
_____ ___100. Having dark thoughts, ones that may involve suicidal or homicidal thoughts
_____ ___101. Experiencing periods of forgetfulness or memory problems

CULTURAL ASSESSMENT

Where is your place of birth? _____
If an immigrant or a refugee, how long resided in this country? _____
What kind of health and education facilities has the family had experience with? _____

_____

_____
What is the patient's ethnic identity? _____
Who are the patient's major support people: family members, friends, any of the other pupils or families in the district? _____

_____
Who are the dominant family members? _____
What are the primary and secondary languages, speaking and reading ability of the family members? _____

_____
What is the level of proficiency in English? _____
How would you characterize nonverbal communication style?
Eye contact (what does it mean to the patient?) _____

_____
Space _____

_____
Touch practices (kissing when greeting? Shaking hands?) _____

_____
Are the family's cultural/religious practices of major importance in daily life: activity or dietary restrictions? Please explain: _____

_____

_____

_____
What are health and illness beliefs and practices of the family? _____

_____

_____
What diseases/disorders are endemic to the culture or country of origin? _____

_____
What is believed to be the cause of the mental condition? _____

_____
What has been tried in the treatment of the mental condition? _____

_____
Is there some other practitioner or healer that has been consulted or will be consulted? _____

_____
What are the beliefs about the role of men and women in the culture? _____

_____
Explain any difficulties/challenges in assimilating into the larger culture. _____

_____

_____

_____

RELIGIOUS/SPIRITUAL

Are religious or spiritual issues important in your life? _____
Do you wish to discuss them in counseling, when relevant? _____
Do you believe in God or a Supreme Being? _____
Do you believe you can experience spiritual guidance? _____
What is your current religious affiliation (if any?) _____
Are you committed to it and actively involved? _____
What was your childhood religious affiliation (if any?) _____
How important were religion or spiritual beliefs to you as a child and adolescent? Please elaborate if you wish: _____

_____

_____

Are you aware of any religious or spiritual resources in your life that could be used to help you overcome your problems? If yes, what are they? _____

_____

Do you believe that religious or spiritual influences have hurt you or contributed to some of your problems? _____ If yes, explain _____

_____

_____

Would you like your counselor to consult with your religious leader if it appears this could be helpful to you? _____ If yes, a permission and confidentiality form will be provided for you to sign.
Are you willing to consider trying religious or spiritual suggestions from your counselor if it appears that they could be helpful to you? _____

NOTICE OF PRIVACY PRACTICES
Mental Health Solutions, LLC

BOISE LOCATION: 3152 S Bown Way Suite 6 MERIDIAN LOCATION: 2596 N Stokesberry Pl. Suite 135
Phone: 208-371-8040 Fax: 866-371-6410
IF YOU HAVE ANY QUESTIONS ABOUT THIS NOTICE, PLEASE CONTACT:
Satu Woodland PMHCNS NP 208-371-8040

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. THIS NOTIFICATION IS CONSISTENT WITH THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) PRIVACY RULE. PLEASE REVIEW IT CAREFULLY.

We understand the importance of privacy and are committed to maintaining the confidentiality of your medical information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you as allowed by your health plan and to enable use to meet our professional and legal obligations to operate this medical practice properly. We are required by law to maintain the privacy of protected health information and to provide individuals with notice of our legal duties and privacy practices with respect to protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information.

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A. How this Medical Practice May Use or Disclose Your Health Information

This medical practice collects health information about you and stores it in a chart and on a computer. This is your medical record. The medical record is the property of this medical practice, but the information in the medical record belongs to you. The law permits us to use or disclose your health information for the following purposes:

1. Treatment. We use medical information about you to provide your medical care. We disclose medical information to our employees and others who are involved in providing the care you need. For example, we may share your medical information with other physicians or other health care providers who will provide services which we do not provide. Or we may share this information with a pharmacist who needs it to dispense a prescription to you, or a laboratory that performs a test. We may also disclose medical information to members of your family or others who can help you when you are sick or injured.
2. Payment. We use and disclose medical information about you to obtain payment for the services we provide. For example, we give your health plan the information it requires before it will pay us. We may also disclose information to other health care providers to assist them in obtaining payment for services they have provided to you
3. Health Care Operations. We may use and disclose medical information about you to operate this medical practice. For example, we may use and disclose this information to review and improve the quality of care we provide, or the competence and qualifications of our professional staff. Or we may use and disclose this information to get your health plan to authorize services or referrals. We may also use and disclose this information as necessary for medical reviews, legal services and audits, including fraud and abuse detection and compliance programs and business planning and management. We have a written contract with these business associates that contains terms requiring them to protect the confidentiality of your medical information. Although federal law does not protect health information, which is disclosed to someone other than another healthcare provider, health plan or healthcare clearinghouse, under Oregon law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law. We may also share your information with other health care providers, health care clearinghouses or health plans that have a relationship with you, when they request this information to help them with their quality assessment and improvement activities, their efforts to improve health or reduce health care costs, their review of competence, qualifications and performance of health care professionals, their training programs, their accreditation, certification or licensing activities, or their health care fraud and abuse detection and compliance efforts. If you belong to a Managed Health Care Plan we may also share medical information about you to all the other health care providers in said plan, who participate in the plan for any health care operations activities related to the plan.
4. Appointment Reminders (If applicable). We may use and disclose medical information to contact and remind you about appointments. If you are not home, we may leave this information on your answering machine or in a message left with the person answering the phone or send via email.
5. Waiting room. We may also call out your name when we are ready to see you.
6. Notification and communication with family. We may disclose your health information to notify or assist in notifying a family member, your personal representative or other person responsible for your care about your location, your general condition or in the event of your death. In the event of a disaster, we may disclose information to a relief organization so that they may coordinate these notification efforts. We may also disclose information to someone who is involved with your care or helps pay for your care. If you are able and available to agree or object, we will give you the opportunity to object prior to making these disclosures, although we may disclose this information in a disaster even over your objection if we believe it is necessary to respond to the emergency circumstances. If you are unable or unavailable to agree or object, our health professionals will use their best judgment in communication with family and others.
7. Marketing. We may contact you to give you information about products or services related to your treatment, case management or care coordination, or to direct or recommend other treatments or health-related benefits and services that may be of interest to you, or to provide you with small gifts. We may also encourage you to purchase a product or service when we see you. We will not use or disclose your medical information for marketing purposes without your written authorization.
8. Required by law. As required by law, we will use and disclose your health information, but we will limit our use or disclosure to the relevant requirements of the law. When the law requires us to report abuse, neglect or domestic violence, or respond to judicial or administrative proceedings, or to law enforcement officials, we will further comply with the requirement set forth below concerning those activities.
9. Public health. We may, and are sometimes required by law to disclose your health information to public health authorities for purposes related to: preventing or controlling disease, injury or disability; reporting child, elder or dependent adult abuse or neglect; reporting domestic violence; reporting to the Food and Drug Administration problems with products and reactions to medications; and reporting disease or infection exposure. When we report suspected elder or dependent adult abuse or domestic violence, we will inform you or your personal representative promptly unless in our best professional judgment, we believe the notification would place you at risk of serious harm or would require informing a personal representative we believe is responsible for the abuse or harm.
10. Health oversight activities. We may, and are sometimes required by law to disclose your health information to health oversight agencies during the course of audits, investigations, inspections, licensure and other proceedings, subject to the limitations imposed by federal and Oregon law.
11. Judicial and administrative proceedings. We may, and are sometimes required by law, to disclose your health information in the course of any administrative or judicial proceeding to the extent expressly authorized by a court or administrative order. We may also disclose information about you in response to a subpoena, discovery request or other lawful process if reasonable efforts have been made to notify you of the request and you have not objected, or if your objections have been resolved by a court or administrative order.
12. Law enforcement. We may, and are sometimes required by law, to disclose your health information to a law enforcement official for purposes such as identifying of locating a suspect, fugitive, material witness or missing person, complying with a court order, warrant, grand jury subpoena and other law enforcement purposes.

13. Coroners. We may, and are often required by law, to disclose your health information to coroners in connection with their investigations of deaths.
14. Public safety. We may, and are sometimes required by law, to disclose your health information to appropriate persons in order to prevent or lessen a serious and imminent threat to the health or safety of a particular person or the general public.
15. Specialized government functions. We may disclose your health information for military or national security purposes or to correctional institutions or law enforcement officers that have you in their lawful custody.
16. Change of Ownership. In the event that this medical practice is sold or merged with another organization, your health information/record will become the property of the new owner, although you will maintain the right to request that copies of your health information be transferred to another physician or medical group.
17. Research. We may disclose your health information to researchers conducting research with respect to which your written authorization is not required as approved by an Institutional Review Board of privacy board, in compliance with governing law.

18. Please note: Communication: Please do not communicate personal health information to me via email or text message. Either call me on the phone and/or download PingMd app on your phone which is HIPAA secure. Any other form is not HIPAA secure.

19. Workers' Compensation: Our practice may disclose your health information as necessary to comply with workers' compensation and similar programs.
20. Office Location: If you are concerned for privacy at any of our locations (e.g. you know a worker in that building, etc.) you may ask to make appointments at a particular time or at another of our locations.
BOISE LOCATION: 3152 S Bown Way Suite 6 MERIDIAN LOCATION: 2596 N. Stokesberry Pl. Suite 135

B. When This Medical Practice May Not Use or Disclose Your Health Information
Except as described in this Notice of Privacy Practices, this medical practice will not use or disclose health information which identifies you without your written authorization. If you do authorize this medical practice to use disclose your health information for another purpose, you may revoke your authorization in writing at any time.

C. Your Health Information Rights
1. Right to Request Special Privacy Protections. You have the right to request restrictions on certain uses and disclosures of your health information, by a written request specifying what information you want to limit and what limitations on our use or disclosure of that information you wish to have imposed. We reserve the right to accept or reject your request, and will notify you of our decision.
2. Right to Request Confidential Communications. You have the right to request that you receive your health information in a specific way or at a specific location. For example, you may ask that we send information to a particular e-mail account or to your work address. We will comply with all reasonable requests submitted in writing which specify how or where you wish to receive these communications.
3. Right to Inspect and Copy. You have the right to inspect and copy your health information, with limited exceptions. To access your medical information, you must submit a written request detailing what information you want access to and whether you want to inspect it or get a copy of it. We will charge a reasonable fee, as allowed by Oregon law. We may deny your request under limited circumstances. If we deny your request to access your child's records because we believe allowing access would be reasonably likely to cause substantial harm to your child, you will have a right to have them transferred to another mental health professional.
4. Right to Amend or Supplement. You have a right to request that we amend your health information that you believe is incorrect or incomplete. You must make a request to amend in writing, and include the reasons you believe the information is inaccurate or incomplete. We are not required to change your health information, and will provide you with information about this medical practice's denial and how you can disagree with the denial. We may deny your request if we do not have the information, if we did not create the information (unless the person or entity that created the information is no longer available to make the amendment), if you would not be permitted to inspect or copy the information at issue, or if the information is accurate and complete as is. You also have the right to request that we add to your record a statement of up to 250 words concerning any statement or item you believe to be incomplete or incorrect.
5. Right to an Accounting of Disclosures. You have a right to receive an accounting of disclosures of your health information made by this medical practice, except that this medical practice does not have to account for the disclosures provided to you or pursuant to your written authorization, or as described in paragraphs 1 through 16 Section A of this Notice of Privacy Practices or disclosures for purposes of research or public health which exclude direct patient identifiers, or which are incident to a use or disclosure otherwise permitted or authorized by law, or the disclosures to a health oversight agency or law enforcement official to the extent this medical practice has received notice from that agency or official that providing this accounting would be reasonably likely to impede their activities.
6. Right to Paper Copy. You have a right to a paper copy of this Notice of Privacy Practices, even if you have previously requested its receipt by e-mail.

D. Changes to this Notice of Privacy Practices
We reserve the right to amend this Notice of Privacy Practices at any time in the future. Until such amendment is made, we are required by law to comply with this Notice. After an amendment is made, the revised Notice of Privacy Protections will apply to all protected health information that we maintain, regardless of when it was created or received. We will keep a copy of the current notice posted in our office area, and will have available to you a copy at each appointment. We will also post the current notice on our website, if and when one is developed.

E. Complaints
Complaints about this Notice of Privacy Practices or how this medical practice handles your health information should be done in writing and directed to our Practice Manager.
Mailing Address:
Mental Health Solutions
3060 S Rookery Lane
Boise , ID 83706
Or Fax to 866-371-6410
If you are not satisfied with the manner in which this office handles a complaint, you may submit a formal complaint to:
Department of Health and Human Services
Office for Civil Rights
Hubert H. Humphrey Blvd.
200 Independence Avenue, S.W.
Room 509F HHH Building
Washington, DC 20201
You will not be penalized for filing a complaint.

To be completed during session

Satu H. Woodland PMHCNS

Coordination of Care between Health Care Providers and Release of Information

Communication between behavioral health (BH) care providers and your primary care physician (PCP), and other behavioral health providers and/or facilities, is important to ensure you receive comprehensive and quality health care. This form will allow your behavioral health care provider to share protected health information (PHI) with your other providers. This information will not be released without your signed authorization. This PHI may include diagnosis, treatment plan, progress and medication, if necessary.

Patient Rights

- You may end this authorization (permission to use or disclose information) any time by contacting the practitioner's office.
- If you make a request to end this authorization, it will not include information that already may have been used or disclosed based on your previous permission.
- You will not be required to sign this form as a condition of treatment, payment, enrollment or eligibility for benefits.
- You have a right to a copy of this signed authorization.
- If you choose not to agree with this request, your benefits or services will not be affected.

Patient Authorization

I hereby authorize the individual(s) or entities named below to release verbally or in writing information regarding any medical, mental health and/or alcohol/drug abuse diagnosis or treatment recommended or rendered to the following identified patient. I understand that these records are protected by federal and state laws governing the confidentiality of mental health and substance abuse records and cannot be disclosed without my consent unless otherwise provided in the regulations. I also understand that I may revoke this consent at any time and must do so in writing. A request to revoke this authorization will not affect any actions taken before the provider receives the request. This consent expires in 1 year from the date of my signature below unless otherwise stated herein.

Satu H Woodland, PMHCNS, is authorized to release protected health information related to the evaluation and

treatment of _____ _____/_____/_____ to:
(Patient name) (Date of birth – MM/DD/YYYY)

PCP name: _____ PCP phone: _____

PCP address: _____ _____
(Street) (City) (State) (ZIP code)

BH provider name: _____ BH provider phone: _____

BH provider address: _____ _____
(Street) (City) (State) (ZIP code)

Other name: _____ Other phone: _____

Other address: _____ _____
(Street) (City) (State) (Zip code)

Disclosure may include the following verbal or written information: (check all that apply)

___ Face sheet	___ History and physical	___ Laboratory/diagnostic testing results	___ School information
___ Discharge summary	___ Medication records	___ Behavioral health/psychological consult	___ Psychological evaluation/testing results
___ ER record report	___ Psychiatric evaluation	___ Psychosocial assessment	___ Other
___ Substance abuse treatment record		___ Summary of treatment records and contact dates	

___ I hereby refuse to give authorization for any release of information until specified otherwise.

_____ _____
(Signature of patient, parent, guardian or authorized representative) (Date)

If signed by a guardian or authorized representative, please provide legal documentation that proves such authority under state law (i.e., power of attorney, living will, guardianship papers, etc.)

To be completed during session

Satu H. Woodland PMHCNS

Coordination of Care between Health Care Providers and Release of Information

I want to inform you that _____ was seen by me for the treatment of:
(Member name)

DSM-5, ICD-10 and/or medical diagnosis:_____

Date of appointment: _____

Summary: _____

_____

_____

_____

The treatment plan consists of the following modalities:

___ Individual psychotherapy ___ Group psychotherapy ___ Family psychotherapy

___ Psychological testing ___ Other (specify) ___ Medication management (see below)

Current medication(s) (dosage, frequency and delivery)

_____

_____

_____

_____

_____

The following medication was or will be started (indicate medication and dosage): _____

_____

Estimated length of treatment: _____

Satu H. Woodland, PMHCNS _____
(Print provider name) (Signature) (Date)

Notice to recipient: This information has been disclosed to you from records protected by federal confidentiality regulations 42 CFR Part 2 and state law requirements. Under such law, the information received pursuant to this document is confidential and prohibits the recipient from making further re-disclosure of this information to any other person or entity, or to use it for a purpose other than as authorized herein, without the written consent of the person to whom it pertains or as otherwise permitted by law. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict the use of the information to criminally investigate or prosecute any alcohol or drug patients.