MindHealth

ERIKA GIRALDO, DNP, ARNP / LEIF BENJESTORF, MN, ARNP

REGISTRATION FORM

Today's date:	Primary Care Name:	Primary Care Phone: ( )

PATIENT INFORMATION

Patient's last name: First: Middle:	❑ Mr. ❑ Mrs.	❑ Miss ❑ Ms.	Marital status (circle one) Single / Mar / DP / Div / Sep / Wid

Is this your legal name? ❑ Yes ❑ No	If not, what is your legal name?	(Former name):	Birth date: / /	Age:	Sex: ❑ M ❑ F

Address:	Email Address:	Home phone no.: ( )

City:	State:	Zip Code:	Cell Phone no.: ( )

Occupation:	Employer:

Chose clinic because/Referred to clinic by (please check one box): ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Family ❑ Friend ❑ Close to home/work ❑ Yellow Pages ❑ Other

Other family members seen here:

INSURANCE INFORMATION

(Please give your insurance card and drivers license to the provider.)

Name of Primary Insured:	Birth date: / /	Address (if different):	Home phone no.: ( )

Please indicate primary insurance ❑ Premera ❑ Regence ❑ Value Options ❑ Group Health ❑ Cigna ❑ Aetna ❑ United ❑ Self ❑ Other:

Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other

IN CASE OF EMERGENCY

Name of friend or relative:	Relationship to patient:	Home phone no.: ( )	Work phone no.: ( )

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any balance. I also authorize Erika Giraldo, DNP, ARNP / Leif benjestorf, MN, ARNP or insurance company to release any information required to process my claims.

I acknowledge receipt of Financial Agreement and Notice of Privacy Practices for MindHealth.

I understand that without a 24 hour notice of cancellation, I will be billed $50 no show fee. Prescriptions outside of appointment times will be charged a $20 fee unless requests go through pharmacy.

_____ _____

Patient/Guardian signature *Date*

MindHealth

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Mindhealth's Notice of Privacy Practices. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Erika Giraldo, DNP, Privacy Officer at (206) 390-1968.

_____

Printed Name of Patient/Client

_____

Signature of Patient/Client **Date**

_____

Signature or Parent, Guardian or Personal Representative * **Date**

_____

* If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

❑ **Patient/Client Refuses to Acknowledge Receipt**:

_____

Signature of Staff Member **Date**

MindHealth

Erika Giraldo, DNP, ARNP Leif Benjestorf, MN, ARNP
(206) 390-1968 (206) 569-7458
19109 36th Ave W Suite#209 Lynnwood, WA 98036
Fax: (425) 673-7586

TREATMENT CONSENT FORM

Please read carefully, initial each page, sign and date on the last page.

We aim to provide the highest quality of care and service. Our policies support you in the best way possible and keep our clinic running smoothly for the benefit of every patient.

SCOPE OF SERVICES

At your initial visit, we will conduct a thorough review of your current concerns and of your background. By the end of the initial visit we will discuss preliminary impressions and your treatment options. Sometimes, psychotherapy alone will suffice. Often times, however, a combination of psychotherapy and medication management is optimal. The initial visit is also your opportunity to determine for yourself if our services are well matched to your needs. If you determine it is not a good match we can provide you referrals to other mental health professionals.

APPOINTMENT FREQUENCY AND DURATION OF VISITS

At your initial visit, we will decide together the structure of your therapy. If medications are prescribed, or changed, we prefer to conduct a 25-minute follow-up visit in two weeks. This is necessary to ensure proper administration, and minimize any side effects you may experience. If your symptoms improve, follow-up visits can be spaced out at monthly intervals. For clients on maintenance therapy, follow-up visits can be held at three-month intervals.

FEES

- Initial Evaluation: Allow 60-90 minutes for this office visit: $275
- Follow up medication management only: 20-30 minutes: $150
- Follow up therapy and/or medication management: 50 minutes $180 - $250
    - Rates vary depending on medical complexity
- Follow up medication management 10-15minutes: $80
- Ancillary services (filling out forms etc., calling in prescriptions without appointment; non-emergent telephone calls) $25 per 15 minutes

CANCELLATIONS AND NO-SHOWS

We respect your time and trust that you respect ours. We require a *minimum of 24 hours notice* when canceling or rescheduling appointments. . If you are unable to provide us with this notice, you will incur a missed appointment/ late cancellation fee as follows:

- $50 for a 30-minute appointment
- $100 for a 50-60 minute appointment

Insurance does NOT cover this fee. Please understand that this policy is in place as a means of respecting the time and efforts of your provider, as well as other patients who would have benefited from a visit during this time.

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PHONE CONSULTATIONS

If you are unable to come to our office, follow-up visits via telephone/Skype are available after an initial in-person visit. Most insurances do not cover telephone/Skype visits. These are billed at the regular in-office rate and payment is due via credit card at the end of each call.

CONTACT INFORMATION

Psychiatric treatments are individualized and often require multiple changes. As such, we do not offer extensive consultations via email or by texting on the phone. You may email your provider with short, concise questions that should be no more that 3-5 lines long and pertain to your current treatment plan. Email or text is not a substitute for an office visit.

To report acute symptoms not requiring emergency care, please call your provider. In an emergency, **do not** email or call us. **Call 911**, call the Suicide Crisis Line 1 (800) 273-8255 or proceed to the ER.

Please note that email and text are not considered to be secure forms of communication and you are accepting the risk that your message may be intercepted or otherwise seen by an unauthorized third party.

INSURANCE & PAYMENT

Please provide full insurance information and your insurance card upon your initial visit. It is your responsibility to determine eligibility of benefits, understand your coverage, and obtain authorization from your insurance provider when necessary prior to your first visit. If the visit is not covered, then you will be responsible for the bill.If you have a change in insurance, please let us know as soon as possible, so we can ensure payment. Many insurances have deductibles and it is your responsibility to pay your balance with us if you have not met your deductible.

It is your responsibility to pay for the copay at the time of the visit. Cash is preferred but we also accept checks and all major credit cards. Bounced checks incur a $25 processing fee.

We reserve the right to bill our standard fees for case coordination, clinical and legal write-ups, and phone consultations exceeding 5 minutes per week.

MEDICATION REFILLS

YOU ARE RESPONSIBLE TO MAKE AN APPOINTMENT BEFORE YOUR MEDICATION RUNS OUT.

*We will **not** renew ADHD medications outside of appointment times.* Schedule II medications are tightly regulated and we take these medications seriously for the safety of your health. We monitor your vital signs and assess side effects and your health while taking these medications.

If the medication is not a controlled substance, you can call your pharmacy to fax a refill request to our clinic. Please allow up to 5 days for medication refills as we are not in the clinic daily. Please do not call or email.

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You will be given refills for your prescriptions during your medication management appointments. If you cancel this appointment, but need a refill, you will be responsible to provide us with 7 days notice prior to you running out of your current prescription, and will need to be seen by your provider for further refills. If we notice a pattern of repeated cancellations and refill requests over the phone, this will be addressed, and a service charge of $50 for phone refill requests will be charged for each occurrence.

CONFIDENTIALITY

Information discussed during the course of therapy is confidential. By law, information concerning treatment may be released only with the written consent of the person treated (or the person's guardian if applicable). In the event where there is suspected child or elder abuse or an imminent danger of harm to one's self or others, the law requires the release of confidential information. In these instances we are required to make a report to the appropriate authorities. In addition, the courts may subpoena treatment records in certain circumstances. Any type of release of confidential information will be discussed with you. However, your insurance company may request records at any time.

We are compliant with the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to personal health care information (PHI). HIPAA requires that we provide you with a Notice of Privacy Practices. This Notice, which is attached to this agreement, explains HIPAA in detail and its application to your personal health care information. An electronic copy can be found on our website.

AGE OF CONSENT

In accordance with RCW 71.34.530: Any minor thirteen years or older may request and receive outpatient mental health treatment without the consent of the minor's parent. Parental authorization, or authorization from a person who may consent on behalf of the minor pursuant to RCW 7.70.065, is required for outpatient treatment of a minor under the age of thirteen.

TREATMENT CONSENT

By signing below, you certify that you have read and understand the terms stated in the Treatment Consent Form. You indicate that you understand the scope of services, session structure, fees, cancellation/no-show policies, payment policy, insurance reimbursement, confidentiality, the nature of my practice, and my contact information, and that you agree to abide by the terms stated above during the course of our therapeutic relationship.

Client name (please print): _____ Date: _____

Client's signature: _____

Initials_____

MINDHEALTH ASSOCIATES

CONSENT FOR ELECTRONIC MAIL ("EMAIL" AND TEXT) USE

Leif Benjestorf, ARNP, Erika Giraldo, ARNP and Brooke Gum, ARNP (hereby referred to as MindHealth Associates) offers patient the opportunity to communicate by Email/text for non-urgent matters. This form provides the guidelines regarding Email/text communications, and documents your consent to both the use of Email/text while acknowledging the problems that may arise at any time when Email/text is utilized.

IN CASE OF A MEDICAL EMERGENCY, DO NOT USE E-MAIL. CALL 911

Email/text Use: Email/text communications should be between MindHealth Associates and an adult patient 18 years of age or older, or the parent or guardian of a minor.

Limitations: It is recommended that you do not use Email/text for communicating sensitive medical information such as sexually transmitted diseases, HIV, hepatitis, substance abuse, mental health or presence of malignancy. If you do so, then MindHealth Associates cannot and is not responsible if any such information is inadvertently released or obtained by third parties.

Confidentiality: Although MindHealth Associates believes they have implemented reasonable technical safeguards, they cannot and do not guarantee the privacy, security or confidentiality of any Email/text messages sent or received over the Internet or cell towers. There is a potential that Email/text sent or received over the Internet or cell towers can be intercepted, altered, forwarded, and/or read by others. MindHealth Associates is not responsible for Email/text messages that are lost due to technical failure during composition, transmission, or storage. MindHealth Associates will not forward Emails to independent third parties without your prior written consent, except as authorized or required by law. If any of this is a concern to you, then you should not communicate with MindHealth Associates through Email

Subject: In the "Subject" line of the email, please include general topic of your message, i.e., prescription, appointment, medical advice, billing question.

Body: In the body of the message, please include the patient's name and date of birth. This information is necessary to verify your identity and make sure we pull the correct medical file. It is recommended that **Email/text** should only be used for non-sensitive and non-urgent issues such as:

Appointment scheduling; Prescriptions / refills; General medical advice after an initial face-to-face visit; Billing Questions; Referrals; Lab/Test Results;

Response Time: Although MindHealth Associates will endeavor to read and respond within 24 hours to any Email/text sent during the business week, they cannot guarantee that any particular Email/text will be responded to within any particular period of time. If you have not received a response within 3 days, please call.

Documentation: Email/text communications regarding treatment will be documented in your medical record by placing a copy of the message in your file.

Ending Email/text: You may discontinue using Email/text as a means of communication by sending an Email/text or letter to the Clinic clearly stating that you no longer wish to communicate by email. MindHealth Associates reserves the right to stop communicating with patients by **Email/text** and will notify them of this in writing.

I acknowledge that I have read and fully understand this consent form and that I voluntarily request the use of Email/text as one form of communication with MindHealth Associates.

Printed Name of Patient	Date
Signature of Patient, Parent or Personal Representative	Relationship (If other than patient)

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BROOKE GUM, MN, ARNP
401-830-4486
BROOKEGUMARNP@GMAIL.COM

Patient _____ Score _____ Date _____

THE MOOD DISORDER QUESTIONNAIRE

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? ○ *yes* ○ *no*

…you were so irritable that you shouted at people or started fights or arguments? ○ *yes* ○ *no*

…you felt much more self-confident than usual? ○ *yes* ○ *no*

…you got much less sleep than usual and found you didn't really miss it? ○ *yes* ○ *no*

…thoughts raced through your head or you couldn't slow your mind down? ○ *yes* ○ *no*

…you were so easily distracted by things around you that you had trouble concentrating or staying on track? ○ *yes* ○ *no*

…you had much more energy than usual? ○ *yes* ○ *no*

…you were much more active or did many more things than usual? ○ *yes* ○ *no*

…you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night? ○ *yes* ○ *no*

…you were much more interested in sex than usual? ○ *yes* ○ *no*

…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky? ○ *yes* ○ *no*

…spending money got you or your family in trouble? ○ *yes* ○ *no*

2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time? ○ *yes* ○ *no*

3. How much of a problem did any of these cause you – like being unable to work; Having family, money or legal troubles, getting into arguments or fights?

Please select one response only.

○ No Problem ○ Minor Problem ○ Moderate Problem ○ Serious Problem

PATIENT HEALTH QUESTIONNAIRE-

(PHQ-9)

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 fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING __0__ **+** _____ **+** _____ **+** _____

=Total Score: _____

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**
☐	☐	☐	☐

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

How old were you when these problems first began to occur?_____