INTAKE QUESTIONNAIRE

"Any **WORD** not circled or **space** left blank will be counted as a 'no' "

Please fill out and circle all of your CURRENT OR PAST symptoms:

Current and past psychiatric diagnoses:_____

Depression: sad mood, suicidal thoughts, past attempts, appetite problems, trouble sleeping

Bipolar Mania: history of manic episodes. Current mania, elevated mood, racing thoughts, grandiosity (inflated sense of abilities, special talents or powers), risky behaviors, impulsiveness, Hypersexual, hyper Spiritual; symptoms lasted more than 3 days? more than 1 week?

Anxiety: nervous, anxious, rapid heartbeat, shortness of breath, shaky, sweaty, triggers: _____ relieved by: _____.

Panic Attacks, how many minutes?____ _____how often?_____

PTSD - history of sexual or physical abuse? traumatic accident? ongoing nightmares, flashbacks, hypervigilance, bad startle response, social avoidance

OCD - obsessions or compulsions, checking, cleaning, rituals, fears

Psychosis: Auditory Hallucinations, Visual Hallucinations, Paranoia.

alcohol use: how much,_____ how often_____ at most_____

thc/weed: how much,_____ how often_____ at most_____

opiates: how much,_____ how often_____ at most_____

other narcotic use history: how much,_____ how often_____ at most_____

legal problems:_____

ADHD - problems focusing, easily distracted, hard to complete tasks, since childhood?

eating disorders - anorexia, restricting, binging, purging, bulimia

current psychiatric medications: past psychiatric medications:
(Include dose and frequency)

_____ _____

_____ _____

_____ _____ psych

_____ _____ med allergies: ____ Past

psychiatric hospitalizations:_____

Other medical conditions:_____

Blood relative psychiatric diagnoses (include how you're related):

I live with: _____ I work at_____

Major stressors: _____

Nicotine: tobacco, vaping, cigarettes, etc.: how much per day? _____

Patient Information (Please Print)

Phone : 208-996-1700 Fax: 208-350-6674 scheduling@permamentalhealth.net www.permamentalhealth.net

Last Name _____ Preferred Name: _____

First Name _____ DOB: _____ Male _____ Female _____

Email _____ Phone: _____ Marital Status _____

Emergency Contact: _____ Pharmacy: _____

Home Address: _____ Primary Care Provider: _____

City, State, ZIP _____ Employer:_____ Employer Phone:_____

Responsible for Bill

Last Name _____ Home Address: _____

First Name _____ City, State, ZIP _____

Relationship to Patient _____ Phone: _____

Medical Insurance

Primary Plan_____ Member# _____ Group# _____

Subscriber Information (if different than patient)

LAST, FIRST Name _____ Phone: _____

DOB: _____ Employer _____ Home Address: _____

Male ____Female ____ Employer Phone_____ City, State, ZIP _____

Secondary Insurance Plan _____Member # _____Group # _____

Confidentiality and Consent Agreement

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Information gathered in the course of PERMA Mental Health's (PMH) work with me will remain confidential, however I understand there are exceptions to this confidentiality as mandated by Law. Please initial the following:

____ If information is shared with PMH that leads staff to believe that I/my minor child will cause injury to another person, PMH is obligated to either contact that person and/or the police in order to warn of a potential threat.

____ In case where PMH is made aware of child abuse, PMH is mandated to contact Child Protective Services.

____ If it were felt that I/my minor child is actively suicidal, PMH will attempt to take reasonable precautions to protect me/my minor child from harm.

____ I understand that PMH does comply with all court ordered subpoenas for medical records.

Consent to Psychotropic Medications

Types of Medications that may be prescribed when being seen by PMH include psychoactive medications including but not limited to antidepressants, antipsychotics, anxiolytics, stimulants and various other to treat certain psychiatric conditions. Your first session is considered an intake and does not indicate providers have agreed to assume your care or responsibility for any medication refills

____ I agree that I will discuss with my provider the name, type, class risk and benefits of any medications prescribed and if I have any concerns or questions, I will make them known to the providers/staff. I herby give my consent to receive prescriptions for medications from my provider or my child/dependent as applicable.

____ PMH can not prescribe opioids at any time.

____ PMH does not use benzodiazepines for treatment unless there is a "weaning contact" put in place.

____ If you are currently taking any controlled substances, a treatment plan will be made prior to any continued medication management.

Your doctor will discuss any risks and benefits in medications prescribed and provide information and other resources as desired and available, in addition to the information provided at your pharmacy. If you do not feel your concerns have been addressed, it is your responsibility to make your concerns and questions known to the clinic in a timely manner. We will work with you to answer any questions and provide informational resources as soon as possible.

Patient Name Signature Date:

Guardian Name Signature Date:

ACKNOWLEDGEMENT OF RECEIPT OF PERMA MENTAL HEALTH'S FACILITY NOTICE OF PRIVACY PRACTICE & POLICIES

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_____ Consent for Treatment

I or my minor child/ward wish to receive mental health/psychiatric/ psychology and treatment at Perma Mental Health, PLLC (PMH). I give consent for any and all mental health services rendered to me or my minor child/ward under the general and specific instructions of the attending provider determined to be appropriate by their professional judgment. I am aware that the practice of medicine/psychiatry, psychology is not an exact science. I acknowledge that this facility has not made any guarantees to me or my minor child/ward as to the results of treatments or examinations. I am also aware that I should ask the therapist/nutritionist any questions that I may have about my or my minor child's/ward's diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.

_____ Email Policy

PERMA can never send any information through email such as diagnosis or medication info. Our scheduling system will automatically email you a reminder and we may email you to get you on the schedule. I consent to email communication and can opt out at any time.

_____ Non-Discrimination Policy

This medical facility will admit and treat patients within its capabilities regardless of race, color, national origin, religious beliefs, sex, sexual orientation, marital status, veteran's status, age, political beliefs, or disability.

_____ Prescription Refills

I understand that controlled substance prescriptions expire 72 hours after being written by the doctor. If I fail to get the prescription filled within the 72 hours I will be charged a fee for my doctor to rewrite the prescription. Three business days notice is required on all refills. It is the patient and/or guardian's responsibility to notify the office with enough time to fill prescriptions, no exceptions. I also understand that my medication refills,quantity, and frequency will be at the providers discretion.

_____ Information to Others

I understand that in the course of my treatment and/or making arrangements for my care, my information may be shared with other providers. If I prefer that PMH not use or share my information for this purpose, I may submit a written request for consideration per this facility's Notice of Privacy Practices.

_____ Acknowledgment

My signature below confirms that I agree to these terms and conditions and that I have received the information on my Rights and Responsibilities as a patient.

_____ I have reviewed a copy of this facilities Notice of Privacy Practice & Financial Agreement

Patient Name Signature Date:

Guardian Name Signature Date:

I have read this consent and I am the patients, or the patients duly authorized representative, on my own behalf (or behalf of the patient) I accept and agree to be bound by all of these terms and conditions

Representative's Name Signature Date:

Relationship to Patient: _____

Describe your authority to act on behalf of the patient: _____

ACKNOWLEDGEMENT OF RECEIPT OF PERMA MENTAL HEALTH'S FINANCIAL AGREEMENT

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___ Disclosure of Information for Payment Purposes

ınderstand my or my minor child's/ward's health medical information will be sent to my insurance carrier for billing purposes for any eatment or counseling I may or my minor child/ward may receive at PMH. I understand that this health information may contain ıtries or information relating to sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) and/or Acquired ımune Deficiency Syndrome (AIDS), mental health diagnoses, psychiatric impairment and/or drug, alcohol or other substance abuse ıd other personal information. I understand that according to Idaho law, I may choose to pay for services pertaining to HIV or AIDS eatment if I do not want my or my child's/ward's health information to be provided to my insurance company. I agree to notify PMH (y wishes regarding payment before these services are provided. I also understand that if I fail to pay for the services, the information ill be sent to my insurance company.

___ Financial Agreement

ınderstand that I will receive a bill from this medical facility for these services. I understand and agree to pay all charges for services ndered and that I am obligated to pay for services in accordance with the regular rates and terms of this medical facility. This medic cility reserves the right to charge a Late Payment Fee and/or a Returned Check fee.

I choose to pay all charges myself, I will notify this medical facility prior to receiving service.

ıould the account be referred to an attorney or collection agency for collections, I agree to pay any reasonable attorney's fees, ollection expenses and interest at the statutory rate on all delinquent accounts, whether or not the account is referred to a collection gency.

___ Missed Appointments Fee

ıgree to pay the full cost for all visits missed or canceled late unless I notify PMH of the cancellation at least 24 hours in advance of e scheduled appointment. I recognize that missed appointments and late cancellations will be charged directly to me unless ohibited by my insurance plan. These fees will not be billed to my insurance.

___ Late Cancelation Fee

otify your provider no less than 24 hours in advance of any cancellations. Appointments are the responsibility of the client and/ or ıarents and reminders from the provider should not be expected. If you miss an appointment without proper notice, or do not call ithin 24 hours to cancel the appt you will automatically be charged a $50 fee, and will not be allowed to reschedule until that fee is ıid.

___ Assignment of Benefits

ıereby authorize the assignment of my medical insurance benefits I am due to this medical facility for application to my bill for edical services I received. I further authorize this medical facility to receive direct payment from all such benefit payments. I agree to main responsible and liable for payments of all amounts due this medical facility and not received from my insurance carrier(s). I ıderstand this medical facility is submitting claims on my behalf as a courtesy. I WILL NOT REVOKE THIS ASSIGNMENT FOR ANY EASON.

___ Medicare Coverage

:ertify that the information I have given in applying for payment under Medicare is correct. 1 authorize the Social Security Administration to release formation about my Medicare effective dates and Medicare claim number to this medical facility. I authorize any holder of medical or related formation about me to release any information needed to process this or a related Medicare claim to the Social Security Administration or its termediaries. I request that payment of benefits be made on my behalf to this medical facility for any services provided to me by this medical facilit

___ Acknowledgment

y signature below confirms that I agree to these terms and conditions and that I have received the information on my Rights and esponsibilities as a patient.

Patient Name Signature Date:

Guardian Name Signature Date:

Authorization for Use and Disclosure of Protected Health Information

Phone : 208-996-1700 Fax: 208-350-6674 scheduling@permamentalhealth.net www.permamentalhealth.net

I authorize Perma Mental Health, PLLC to release/obtain the protected health information of:

Last Name _____ DOB: _____

First Name _____ Phone: _____

Home Address:_____City, State, ZIP_____

Please select one of the following:

_____ Please send/release my medical records to: _____

_____ Please request my medical records from: _____

Address of facility/clinic: _____

Phone/fax of facility/clinic: _____

Information to be disclosed:

_____ Discharge Summary	_____ Consults	_____ At the request of the Individual
_____ ER Report	_____ Xray/Imaging reports	_____ Legal Purposes
_____ History & Physical	_____ Operative Reports	_____ Insurance
_____ Lab Results	_____ Entire Record	_____ Physician Follow-up
_____ Other:		

_____ I agree to the release of the following information even if medical records contain: Acquired Immune Deficiency Syndrome (AIDS) or HIV, Alcohol and/or drug abuse treatment, or behavioral or mental health services.

_____ Unless otherwise revoked, this authorization will expire on the following date or event: _____.If a date or event is not specified, this authorization will expire one year from my date of signature below.

_____ This authorization is voluntary. I understand that I can refuse to sign this authorization and Perma Mental Health, PLLC will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws for: (i) research-related treatment; or (ii) health care provided solely for disclosure to a third party or (iii) health plan initial enrollment/eligibility determinations, underwriting or risk rating determinations.

_____ I understand that I may revoke this authorization at any time by notifying Perma Mental Health Clinic, in writing, of my revocation. I understand that the revocation will not apply to any information that already was released in reliance on this authorization.

_____ I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

_____ I hereby release Perma Mental Health, PLLC from all liability and all claims of any nature whatsoever pertaining to the disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Perma Mental Health, PLLC

Patient Name Signature Date:

Guardian Name Signature Date:

Background Information and Psychosocial Intake

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Please select any of the following that apply to you

___ Chest Pain	___ Crying Spells	___ Alcohol/Drugs	___ Difficulty Concentrating
___ Nausea	___ Family Concerns	___ Medical Illness	___ Behavior Problems
___ Dizziness	___ Family Conflict	___ Fears/Phobias	___ Domestic Violence
___ Low Energy	___ Chills/Hot Flushes	___ Poor Appetite	___ Heart Palpitations
___ Feel Guilty	___ Nightmares	___ Sleeping Problems	___ Excessive Sweating
___ Anger	___ Distractibility	___ Feel Worthless	___ Trembling/Shaking
___ Anxiety	___ Hyperactivity	___ Indecisiveness	___ Numbness/Tingling
___ Hoplesness	___ Suicidal Feelings	___ Excessive Worry	___ Shortness Of Breath
___ Head Injury	___ Recent Loss/Death	___ Low Self-Esteem	___ Problems At Work
___ Panic Attacks	___ Eating Disorder	___ Unusual Thoughts	___ Strange Experiences
___ Depression	___ Thoughts Of Suicide	___ Memory Problems	___ Relationship Problems
___ Sexual Concerns/Problems		___ Thoughts Of Harming Others	

Other Concerns/Stressors Not Listed:

_____

Are you currently in counseling or receiving mental health services?

Are you currently receiving substance abuse services form another provider?

Have you ever received psychiatric hospitalization?

Institution and approximate dates:

Have you ever tried to kill yourself?

If so, when:

Have you ever physically injured or killed someone

If so, when:

List any PSYCHIATRIC medications you have taken *in the past*: _____

_____

List any PSYCHIATRIC medications you are *currently taking*: _____

_____

Family & Social History

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Current Height: _____ Current Weight:_____

Females only: Age of first period: _____ Date of last period: _____

Are you menopausal? _____ Age of menopause: _____

List any concerns about menturation and/ or symptoms: _____

List any past serious illness, injuries, hospitalizations, loss of consciousness and approximate age at the time:

_____

_____

Have you ever been in trouble with the law, inclined arrest, charges, jail, or other sentencing for a crime? _____

If so, explain. Please include probation or parole officer name and phone number. _____

_____

_____

Substance Abuse History

List any substance use such as alcohol, tobacco, or any other legal or illegal substances

Substance	Amount and Frequency	Date of first and last usage

Family Psychiatric History

List any relatives who have/ had emotional difficulties or psychiatric illnesses, including substance abuse or criminal offenses.

Substance	Amount and Frequency	Relationship

Partner/Marital Status

Parents marital status: _____ How long have/were your parents together? _____

If divorced, how old were you? _____ How old were you when you left home? _____

Do you have a significant other? _____ How long have you been together? _____

Are you married? _____

Telehealth Agreement Form

____ I understand that my copay is due at the time of my visit before I am seen by my provider.

____ I understand and agree that Perma Mental Health PLLC may charge my card on file for my copay at the beginning of all Telehealth appointments. This will occur as soon as I login to my appointment through the secure video system.

____ I understand that if I do not pay that copay, my appointment will be canceled, and I will be considered a no show.

____ I understand that for any missed appointments through Telehealth, that I will be responsible for the $50 no show fee.

____ I would like to be notified via chat in secure video once my card has been charged for each copay.

Patient Name: _____

Patient Signature: _____

Date:_____

CREDIT CARD PAYMENT AUTHORIZATION

You authorize regularly scheduled charges to your credit card. You will be charged the amount indicated below to your Credit Card each billing period. A receipt for each payment will be provided to you, and the charge will appear on your Credit Card statement. You agree that no prior notification will be provided unless the date or amount changes, in which case you will receive notice from us at least ten (10) days before the payment is collected.

I, _____ , authorize Perma Mental Health to charge my credit card.

BILLING INFORMATION

Billing Address: _____ City, State, ZIP:_____
Phone #: _____ Email: _____

CREDIT CARD INFORMATION

Card Type: ☐ Mastercard | ☐ VISA | ☐ Discover | ☐ AMEX | ☐ Other _____
Cardholder Name: _____
Card Number (#): _____
Expiration: _____ CVV: _____ Cardholder ZIP:_____

CARDHOLDER SIGNATURE

I (the Cardholder) understand that this authorization will remain in effect until I cancel it in writing. I agree to notify the Merchant in writing of any changes in my account information or termination of this authorization at least fifteen (15) days before the next billing date. If the above-noted payment dates fall on a weekend or holiday, I understand that the payments may be executed on the next business day. I acknowledge that the origination of Credit Card transactions to my account must comply with the provisions of U.S. law. I certify that I am an authorized user of this Credit Card and will not dispute these scheduled transactions; so long as the transactions correspond to the terms indicated in this authorization form.

Cardholder Signature: _____ Date: [_____]

Printed Name: [_____]