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

I understand my or my minor child's/ward's health medical information will be sent to my insurance carrier for billing purposes for any treatment or counseling I may or my minor child/ward may receive at PMH. I understand that this health information may contain entries or information relating to sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnoses, psychiatric impairment and/or drug, alcohol or other substance abuse and other personal information. I understand that according to Idaho law, I may choose to pay for services pertaining to HIV or AIDS treatment 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 of my wishes regarding payment before these services are provided. I also understand that if I fail to pay for the services, the information will be sent to my insurance company.

_____ Financial Agreement

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

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

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

_____ Missed Appointments Fee

I agree 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 the scheduled appointment. I recognize that missed appointments and late cancellations will be charged directly to me unless prohibited by my insurance plan. These fees will not be billed to my insurance.

_____ Late Cancelation Fee

Notify your provider no less than 24 hours in advance of any cancellations. Appointments are the responsibility of the client and/ or parents and reminders from the provider should not be expected. If you miss an appointment without proper notice, or do not call within 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 paid.

_____ Assignment of Benefits

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

_____ Medicare Coverage

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

_____ 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.

Patient Name	Signature	Date:

Guardian Name	Signature	Date:

Authorization for Use and Disclosure of Protected Health Information

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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? _____