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 or past psychiatric diagnosis:_____

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 lasting more than 3 days? More than 1 week?

Anxiety: Nervous, anxious, rapid heartbeat, shortness of breath, shaky, sweaty, on edge, nervous, trouble sleeping, racing thoughts, muscle tension

Triggers:_____

Relieved by:_____

Panic Attacks: Rapid heartbeat, shortness of breath, shaky, sweating

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 use:	How much?	How often?	At most?
Opiate use:	How much?	How often?	At most?
Other narcotics use:	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: (Include dose and frequency)	**Past psychiatric medications:**	**All medication/ allergies:**

Past psychiatric hospitalizations:_____

Other medical conditions:_____

Blood related psychiatric diagnosis (include how you're related):_____

I live with:_____ **I work at:**_____

Major stressors:_____

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

Date of last menstrual period (females only):_____ **Contraception**:_____

Patient Information (Please Print)

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

Last Name:_____ First Name:_____ Preferred Name: _____

DOB:_____ Birth/Legal Sex :_____ Gender Identification:_____ Pereferred Pronoun(s):_____

Email:_____ Phone:_____ Marital Status:_____

Home Address:_____ City:_____ State:_____ ZIP:_____

Primary Care Provider:_____ Pharmacy:_____

Please provide 1-2 Emergency Contacts

Emergency Contact:_____ Emergency Contact Phone:_____

Contact Address:_____ City:_____ State:_____ ZIP:_____

Emergency Contact:_____ Emergency Contact Phone:_____

Contact Address:_____ City:_____ State:_____ ZIP:_____

Responsible for Bill

Entity which is responsible for patient balances and any payments not covered by insurance

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:_____ M/F:____ DOB:_____ Phone:_____

Home Address:_____ City:_____ State:_____ ZIP:_____

Secondary Plan:_____ Member #:_____ Group #:_____

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:

Confidentiality and Consent Agreement

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Information gathered in the course of 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 was 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 others 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 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 providers/staff. I hereby give my consent for myself or my child/dependents to receive prescriptions for medications from my provider.

_____ PMH can not prescribe opioids at any time.

_____ PMH does not use benzodiazepines for treatment unless there is a “weaning contract” put in place.

_____ If you are currently taking any controlled substances, a treatment plan will be made prior to any continued medication management. PMH may introduce urinalysis protocols to your plan of care.

Your provider will discuss the medication's risks and benefits and provide additional information and resources if needed. Additionally your pharmacy should provide you information when you pick up prescriptions. If you have concerns, please promptly share them with the clinic, and we will assist you with answers and resources.

Patient Name:_____ Signature:_____ Date:_____

Guardian Name:_____ Signature:_____ Date:_____

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

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_____ **Consent for Treatment**

I or my minor child/ward wish to receive mental health/psychiatric/ psychology and treatment at 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**

PMH 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. This email is not a secured network. Send personally identifying information at your own discretion.

_____ **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. Three business days notice is required on all refill requests. 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.

_____ **Sick Policy**

I acknowledge that PMH will assess illness-related inquiries individually. I acknowledge the possibility of being requested to switch to a Telehealth appointment to maintain my original schedule.

_____ **Printing Policy**

I acknowledge that if I request PMH to print any documents related to my care, including medical records, I will incur a charge of 10 cents per page.

_____ **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.

_____ **Acknowledgement**

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:_____

I have read this consent and I am the patient, 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.

_____ **Late Cancellation and Missed Appointment Fee**

I agree to take full responsibility for all costs associated with missed or late-canceled appointments, which will only be covered by my insurance if permitted by my plan. PMH requires clients and/or parents to notify the provider at least 24 hours in advance of any appointment cancellations. Reminders from the provider should not be expected, and in the event of missing an appointment without proper notice or failing to cancel within 24 hours, a $50 fee will be automatically charged, and rescheduling will be prohibited until the fee is paid. Additionally, repeated no-shows or missed appointments may result in the cancellation of future appointments.

_____ **Patient Balance Policy**

I understand that if I accrue a patient balance below $100, I will need to make a 20% upfront payment, and if my balance exceeds $100, a 10% upfront payment is required before scheduling appointments. If I cannot meet these conditions, PMH will introduce a payment plan to ensure continued access to care.

_____ **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.

_____ **Acknowledgement**

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:_____

Telehealth Agreement Form

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

Whether or not you plan on utilizing telehealth please review and initial the following…

_____ I understand that my insurance copayment 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 copayment, my appointment will be canceled and I will be considered a no show for that appointment.

_____ I understand that I must make and fulfill at least two in person appointments per year.

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

Patient Name:_____

Patient Signature:_____ Date;_____

Credit Card Payment Authorization

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

By signing below, you authorize regularly scheduled charges on your credit card. You will be charged the amount indicated below to your credit card each appointment/no show. 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 charges.

I, _____, authorize **PERMA Mental Health, PLLC** to charge my credit card for my copay in the amount of $_____ at every visit and a $50 NO SHOW FEE if the appointment is not kept.

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 orientation of Credit Card transactions to my account must comply with the provisions of the 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 Printed Name:_____

Cardholder Signature:_____

Date:_____