Dr. Jane Nwankwookoye DNP, ARNP, PMHNP

Divine Behavioral Health Services LLC

Tel: (206) 290 - 7385 | Fax: (425) 970-3305

Patient and Billing Information

Name:____

First Middle Last

SSN: ____________________________ Birthdate: ___________________________ Female Male

Address: ____

____

City State Zip

Phone: ___________________________ Email: ____

Occupation: ________________________________ Employer: ____

Emergency Contact: _____________________ Relationship: _________________ Phone: __________________

Insurance Information:

Primary Insurance: _________________________ Primary Insured: ____________________________________

Relationship to Patient: ____________________ Birthdate: ________________ SSN: ______________________

ID number: ________________________________ Group number: __________________________________

Secondary Insurance: _________________________ Secondary Insured: ______________________________

Relationship to Patient: ____________________ Birthdate: ________________ SSN: ______________________

ID number: ________________________________ Group number: __________________________________

HAVE YOU CONTACTED YOUR INSURANCE COMPANY AND VERIFIED YOUR ELIGIBILITY FOR MENTAL HEALTH BENEFITS? Yes No

Signature of Patient or Guardian: ___________________________________ Date: _______________________

Printed Name: ____

Patient History

This form is to save you and your practitioner's time in the interest of providing you with the best service possible. All information on this form is considered confidential. Please answer as carefully and completely as possible.

Name: ____ Date: ________________________

Referred by: __________________________ Primary care physician: ____________________________

About your current problems:

List the problems of greatest concern to you:

Describe the problems in your own words:

Prior Psychiatric, Physiological, or Chemical Dependency Services

Inpatient/Outpatient:	Practitioner seen:	Date of service:	Were services helpful?

Substance Abuse History

Please indicate yes or no to the following:

Have you ever felt you should cut down on your drinking/drug use? Yes No

Have people annoyed you by criticizing your drinking/drug use? Yes No

Have you ever felt bad or guilty about your drinking/drug use? Yes No

Have you ever drank/used drugs in the morning to steady your nerves or relieve a hangover? Yes No

Family Medical, Psychiatric and Chemical Dependency History

Please check the appropriate box if these conditions are current or have occurred in relatives:

	Children:	Siblings:	Mother:	Father:	Uncles/Aunts:	Grandparents:	Others:
Nervous Problems (Anxiety)							
Depression							
Psychiatric Treatment							
Drinking Problems							
Drug Abuse							
Medical Conditions							
Medical Treatment							
Other:							

Have you had a problem/diagnostic/treatment procedure regarding any of the following?

Please check all that apply:

	Current	Past		Current	Past
Shortness of breath			Asthma		
Coughing up blood			Joint/back problems		
Bleeding from any part of the body			Unintentional weight loss/gain		
Chest pain/palpitation			High blood pressure		
Infection			Diabetes		
Stroke			Kidney disease/stones		
Sudden loss of smell, taste, vision, hearing, sensation			Thyroid/ gland problems		
Convulsions/seizures			Arthritis		
Motor coordination/paralysis			Tuberculosis/exposure		
Hormone replacement therapy			Cancer (within the past 5 years)		
Frequent lingering cough			Heart disease		
Swelling of the hands and feet			Anemia		
Night sweats/fevers			Ulcers		
Dizziness/fainting spells			Epilepsy		
Pain in back or extremities			Skin problems		
Jaundice/hepatitis			Nutrition problems		
Increased thirst/urination			Smoking		
Abdominal pain			Drugs		
Eating disorder			Alcohol		
Bleeding mole			Surgery/Injuries		
Sexually transmitted disease			Other		
Frequent/severe headaches			None		

Adverse/Allergic Drug Reactions:

____

____

Current/ Recent Medications:

Name:	Dose:	Frequency:	Start:	Stop:

Alternative Medications/Vitamins: ____

Highest Weight: _____ Current Weight: ______ Height: ______ Number of Pregnancies: _____

Regular Menstrual Periods: Yes ☐ No ☐ NA ☐

Place of birth: ____

Family Data:

Father: ☐ Living Age if living: ____________ ☐ Deceased

Occupation: ____

Health Status: ____

If deceased, cause of death: ________________________________

Frequency and nature of contact: ____________________________

Mother: ☐ Living Age if living: ____________ ☐ Deceased

Occupation: ____

Health Status: ____

If deceased, cause of death: ________________________________

Frequency and nature of contact: ____________________________

Brothers/Sisters:

Name:	Sex:	Age:	Where Residing:

Did you live with anyone other than your natural parents for any significant amount of time during your childhood years? Yes ☐ No ☐

Relationship History

Marital Status: Single ☐ Married ☐ Divorced ☐ Widowed ☐ Partnered ☐

If married, remarried or partnered, for how long? ______________________________________

If divorced, separated, or widowed, for how long? ______________________________________

If previously married or in a long-term relationship, when? _____________ How long? _____________

Spouse/partner's age: ____________ Spouse/partner's occupation: _________________________________

Spouse/partner's prior marriages: _______________ When: ______________ How long: _______________

Children/ stepchildren:

Name:	Sex:	Age:	Where Residing:

Living Arrangements / Home Environment

With whom do you currently live? ____

Did you receive any special educational services? ____

Education

Highest level of education completed: ____

Did you receive any special educational services? ____

Occupational History

Occupation: _________________________________ Current position held: ____________________________

If not currently working, what was the date you last date worked? ______________ _____________________

Past work history:

Position:	Employer:	Years worked:

Patient Health Questionnaire

Over the <u>last 2 weeks</u>, how often have you been bothered by any of the following problems?
Please circle your answer.

	Not at all	Several days	More than half the days	Nearly everyday
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: ____________ + ______________ + _______________ + ________________

= Total score: ________________

If you checked off <u>any</u> problems, how <u>difficult</u> 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
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kr oenke and colleagues with an educational grant from Pitzer, Inc. No permission to reproduce, translate, display or distribute.

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?

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?

☐ No problem ☐ Minor problem ☐ Moderate problem ☐ Serious Problem

Adapted with permission of Robert M.A. Hirsch MD.

The Generalized Anxiety Disorder 7-Item Scale

Over the last 2 weeks, how often have you been bothered by the following problems?
Please circle your answer.

	Not at all	Several days	More than half the days	Nearly everyday
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Trouble concentrating on	0	1	2	3

Total score: ☐ = Add columns ____________ + ______________ + _____________

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 at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

Interpreting the score:

Total Score:	Interpretation
≥ 10	Possible diagnosis of GAD; confirm by further evaluation
5	Mild anxiety
10	Moderate anxiety
15	Sever anxiety

Adult ADHD Self-Report Scale (ARS-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. *Please give this completed checklist to your healthcare professional to discuss during today's appointment.*	**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 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

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DIVINE BEHAVIORAL HEALTH SERVICES LLC INFORMED CONSENT FOR APPOINTMENTS AND FEES

Scheduled Appointments

It is your responsibility to attend regularly scheduled appointments. Our usual practice is to contact you by phone, email or send a letter if an appointment is missed due to late cancellation or not showing up. Late cancellations and missed appointments will be charged a fee per occurrence (details in the Cancellations and Reschedule section below). If there have been three no shows or late cancellations for appointments, we will need to close your mental health services with Divine Behavioral Health Services, LLC. At that time, you will have 30 days to request refills or referrals to other health care providers prior to final closure of your care. Clearly, we w ant to avoid this if possible, but are unable to accommodate multiple missed appointments.

Patient Initials _________

Cancellations and Reschedule

Late cancellations and missed appointments create unplanned downtime and delays our work. Our goal is to help as many people as possible not just simply live, but to flourish and enjoy their livelihood. In order to do so, cancellations must be made by email or by phone **48 business hours in advance**. The policy does not include weekends, meaning a 9:00 AM Monday appointment must be canceled by Thursday at 9:00 AM. A fee will be incurred for appointments missed or canceled without 48-hour prior notice. For follow-up appointments, the fee is $50.00 for the first incident, $75.00 for the second, and $100.00 for the third. The fee for a missed evaluation appointment is $100.00. Please note that insurance companies will not reimburse for missed appointment fees and you will be responsible for payment. Fees must be paid prior to making a new appointment. More than three missed appointments in a year may result in a referral to an alternate prescriber.

Patient Initials __________

Patient Responsibility

You are ultimately responsible for all payment obligations arising out of your treatment or care and guarantee payment for these services. Not all medical services are covered by all insurance policies. Some plans pay fixed allowances for each office visit, while others pay only a percentage of the cost; It is the patient's responsibility to understand their insurance coverage. As a courtesy, we will help you process your insurance claim form for reimbursement, however the patient or responsible party is ultimately responsible for the charges. Also, any co-payments, co-insurance, or deductible amounts are due at the time of service. If we do not participate in your insurance plan, you may still choose to be seen by the practice, but we will require payment in full at the time services are rendered.

Patient Initials _________

Refills

Refills should be requested during regular appointments. You can call your pharmacy and ask them to send a fax to our office for refills. Please allow three business days for refills to be filled. Any refill request made outside of this policy will be **charged a $25.00 prescription request fee.**

Please ask your health care provider if you have any questions about the information found within this consent.

DIVINE BEHAVIORAL HEALTH SERVICES LLC INFORMED CONSENT

FOR EVALUATION AND TREATMENTS

Right to Choose the Best Treatment and Provider

There are a variety of professionals offering counseling, psychotherapy and psychiatric evaluation. There are also many different approaches to working with human issues. It is your right and responsibility to choose the treatment and provider that best matches your needs. You also have a right to a detailed explanation of any treatment or procedure your provi der may choose to use including the risks involved and the side effects if any. If you believe you are not receiving the treatment you require, please raise this concern with me and I will work with you to revise your treatment plan or to refer you to othe r professionals who may be able to meet your needs.

Risks & Benefits

The therapy methods and medications prescribed have shown to be effective with some but not all clients and possibly for indications other than how they are prescribed for you. I cannot guarantee positive results, though will of course use the best science, experience and collaborative input with you to guide medication decisions. Every patient's brain and body responds differently to each medication; External factors, such as events in the client's life or irregular attendance, can interfere with progress; In addition, at times therapy can also lead clients to experience distress for a time as they are dealing with painful feelings. Please feel free at any time to discuss your questions or concerns with me about the treatment I am providing.

Right to Refuse or Stop Treatment

It is your right to stop treatment at any time and for any reason. If the client is a minor, then the parent(s) or legal guardian has the right to refuse or stop treatment for the minor. I also have the right to refuse or terminate treatment, in which case you will be provided a 30-day notice including medication refills during this time (if applicable). You may choose a new provider of your choice or I can provide you with a recommendation. If you have concerns regarding your treatment or wish to discontinue, you ar e encouraged to discuss this with me.

Medication Management

All medications have the potential for causing side effects in some individuals. Please be advised that medications used in psychiatry are often prescribed "off -label", meaning that they are pres cribed to control symptoms other than those that the FDA originally approved the medication. Despite the need, very few psychiatric medications are tested by pharmaceutical companies for use in children and adolescents.

If you are taking psychotropic medications, please discuss the risks with your provider if you are considering or could become pregnant (i.e.,, are sexually active with a male partner and not using an effective form of birth control). All medications have potential risks and benefits and many are potentially dangerous for fetal development. If you become pregnant, it is your responsibility to inform your provider immediately to discuss the potential risks and benefits of continuing to take psychotropic medications during pregnancy. Many risks are most significant in the first and third trimesters.

Length and Type of Treatment

The initial evaluation is approximately 60 minutes, and up to three visits may be necessary in order for the provider to determine a diagnosis and come up with a treatment plan that is best suited for you. Medication management sessions are also more frequent in the beginning or after changes are made, and then typically occur monthly or every three months. Appointment lengths range from 20-60 minutes (i.e., the last minutes of scheduled time is customarily for completing chart notes or coordinating care). For example, a 30-minute medication management appointment is actually 20-25 minutes. Duration of treatment varies depending on individual client needs. For almost all mental health conditions, participation in psychotherapy is a vital part of long lasting recovery. Generally, we refer therapy to licensed qualified providers who can collaboratively ensure the best quality care for your mental health, unless you are already working with a therapist. Should you not schedule an appointment for 90 days and make no arrangement in writing with this provider for said time, you will no longer be considered an active client and therefore have terminated treatment and need to request to have your care reopened if needed in the future.

Treatment of Minors

I am licensed and certified to provide treatment for all age groups. Patients age 13 years or older may be treated without consent of the parent/legal guardian. However, for efficacy, safety and support, my preference is for parental involvement and co-occurring therapy for the individual and the family, as indicated.

Limits of Confidentiality

The contents of an intake, medication management, counseling or assessment session are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. It is the policy of this office not to release any information about a client without a signed release of information. Noted exceptions are as follows:

Duty to Warn and Protect, Abuse of Children and Vulnerable Adults & Court Orders

When a client discloses intentions or a plan to harm another person, the health care professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client. If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the health care professional is required to report this information to the appropriate social service and/or legal authorities. Health care professionals are required to release records of clients when a court order has been placed.

Call Policy and Emergencies

I do not provide 24-hour call services. If you are in need of emergency services, (i.e., experiencing a potentially life-threatening medication side effect, or are feeling suicidal or homicidal) after hours, call 911, go to the nearest emergency room or call the Care Crisis Line (866-4-CRISIS) as appropriate. During weekday working hours, messages can be left with the office staff and are given to me and returned according to urgency. Most issues should be addressed during your scheduled office visit.

Text Message and Email Account Alerts

We send text message and/or emails for appointment reminders, provider updates/changes, and billing information. You will be able to reply to receive additional account information such as balances and to confirm or cancel future appointments. Individuals associated with your account may receive alerts referencing your information. You should be aware that text message charges from your cell phone provider may apply. Authorization for text message and email alerts may be revoked in writing. Please understand that text message and email communication is not always secure. Text messages and emails can be intercepted, and for that reason, personal health information will not be communicated with you through this method.

Please direct any questions about the information found within this consent to the healthcare provider or staff. Please also keep these pages for your reference.

Notice of Privacy Practices

Effective: March 8, 2021

This notice describes how medical information about you may be used and disclosed and how you can get access to the information. Please review it carefully.

We understand that your medical and health information is personal. Protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information.

When you receive care from us, we may use your health information for treating you, billing services, and conducting our normal business known as health care operations. Examples of how we use your information include:

Treatment: We keep records of the care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. For example, your doctor may share your health information with a specialist who will assist in your treatment.

Payment: We keep billing records that include payment information and documentation of the services provided to you. Your information may be used to obtain payment from you, your insurance company, or other third party. We may also contact your insurance company to verify coverage for your care or to notify them of upcoming services provided to you to claim and obtain payment from your insurance company or Medicare.

Health Care Operations: We use your health information to improve the quality of care, train staff, provide customer service, manage costs, conduct required business duties, and make plans to better serve our patients.

To use your health information for other than the above uses require your signed authorization.

There are limited situations when we are permitted or required to disclose health information without your signed authorization. These situations include:

- For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases or injuries permitted by law reporting births and deaths; and reporting reactions to drug problems with medical devices.
- To protect victims of abuse, neglect, or domestic violence.
- For health oversight activities such as investigations, audits, and inspections.
- For lawsuits and similar proceedings.
- When otherwise required by law.
- When requested by law enforcement as required by law or court order.
- To coroners, medical examiners, and funeral directors.
- To reduce and prevent a serious threat to public health and safety.
- For other limited situations, see the full copy of our Notice of Privacy Practices.

We are required by law to:

- Maintain the privacy of your health information.
- Provide this notice that describes the ways we may use and share your health information.
- Follow the terms of the notice currently in effect.
- We reserve the right to make changes to this notice at any time and make the new privacy practices effective with all information we maintain. You may request a copy of any notice from our Privacy Officer.

You have the right to:

- Request restrictions on how we use and share your health information. We will consider all requests for. restrictions carefully but are not required to agree to any restrictions.
- Request that we use a specific telephone number or address to communicate with you.
- Inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances we may deny you access to some portion of your health information and you may request review of the denial.
- Request amendments or additions to your health records.
- Request an accounting of certain disclosures or your health information made by us.

DIVINE BEHAVIORAL HEALTH SERVICES LLC ACKNOWLEDGMENT AND SIGNATURE FORM

Please sign acknowledging your understanding of the Informed Consent for Appointments and Fees.

Patient's Signature: ________________________________ Today's Date: ___________________

Please sign acknowledging your understanding of the Informed Consent for Evaluation and Treatment.

Patient's Signature: ________________________________ Today's Date: ___________________

Please sign acknowledging your understanding of the Notice of Privacy Practices.

Patient's Signature: ________________________________ Today's Date: ___________________