PICACS CLINIC

10634 E Riverside Drive, Suite 130, Bothell, WA. 98011
Tel: (425) 806 5021Fax: (425) 486 3949

PATIENT INFORMATION

Patient's Name	Birth Date	Social Security Number

Residence address	City	State	Zip	Home Phone

If child, Biological parent or guardian's name	Parent's Birth Date	Parent's Social Security #
If child, Biological parent or guardian's name	Parent's Birth Date	Parent's Social Security #

Name of Patient's Employer (if applicable)	Business Phone

Name of Patient's Spouse (if applicable)	Birth Date	Social Security Number

Race/Ethnicity (this is optional!) (Please circle one) Decline to report American Indian Asian African American Hispanic White Yes / No	Preferred Language

INSURANCE INFORMATION

Primary Insurance Company

Subscriber Name	ID Number	Group Number

Secondary Insurance Company	ID Number	Group Number

Whom may we thank for referring you?

I acknowledge that the above information is correct and true:
Signature of Patient over 18 years old/ Parent/Legal Guardian____________ Date ______

I hereby fully authorize PICACS Clinic and/or their agent to bill, receive, release, and exchange information with my insurance carrier.

Signature of Patient over 13 years old ________________________Date: _________

Signature of Parent if patient under 13 years old/Legal Guardian__________Date:_____

What telephone number do you wish us to leave messages at? ____________________
Email address: ____
Medication Allergies: ____

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www.pspc.org

PATIENT DISCLOSURE

Office Appointment Policies:

1.	**Co-Pays are due at the time of service.** a) If you choose not to pay the co-pay at that time you may be charged $50.00 service fees.
2.	**Appointment should be made by contacting the office staff.** a) To ensure the highest level of quality care and to monitor treatment plans, follow-up appointments should be made and kept as recommended by the clinician. b) However, it is recognized that problems can arise between appointments, in these circumstances it is advised to go to your nearest ER for any life threatening emergency; or to call to make an earlier appointment.
3.	The PICAS Clinic is a teaching and training institution. For treatment appointment you may be seen by a student as well as the Attending Provider, who is responsible for treatment decision. At times there may be a student attending your appointment with your permission. If you feel uncomfortable you may ask for the student not to be present in the appointment.
4.	If an appointment is cancelled by the patient, the office reserves the right to charge a cancellation fee, at the following rates; a) **NO FEES**: Un-foreseen emergencies. b) **No FEES**: Cancellation more than 48 hours prior to the appointment. c) **$35.00** : Cancellation between 24 to 48 business hours before the start of the appointment. d) **$55.00** : Cancellation within 24 hours of start of the appointment e) **$55.00** : No Show
5.	**Multiple Cancelations or No-Shows** Please be aware that if you have a multiple cancelations or no-shows, the office reserves the right to discharge from the clinic.
6.	**Requests for Letters:** a) **NO FEES**: Medical necessary/ relevant to facilitate continuity of care. b) **$150.00** & up (depending on the time required to complete the letter): All other letters (must be approved and paid for in advance)

For information regarding closures due to inclement weather please refer to this website http://www.nsd.org/Page/6483 as we run off North Shore School District.

PICACS Clinic is not an Emergency Treatment Facility.

In case of an Urgent or Life threatening emergency;

1. **Call 911 or proceed to the nearest ER.**
2. **Do not call the office in an emergency (Calling the office may result in unforeseen and unnecessary delays in receiving appropriate emergency treatment)**

Name of Patient:	Signature of Patient over 13 years old
______________________	______________________
Date:	**Signature of Parent if patient under 13 years old/Legal Guardian**
______________________	______________________

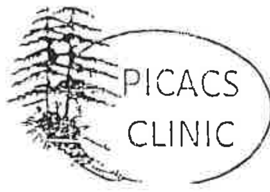
PICACS CLINIC

AS A COURTESY TO VERIFY YOU'RE BENEFITS.

PLEASE BE AWARE THAT THE INSURANCE COMPANIES AND MANAGED CARE COMPANIES DO NOT GUARANTEE THAT THE INFORMATION THEY GIVE US IS CORRECT, THEBEFORE WE CAN NOT GUARANTEE THIS INFORMATION EITHER.

Signature of Patient over 13 years old ____ Date: ___________

Signature of Parent if patient under 13 years old/ Legal Guardian __________________ Date: __________



PICACS CLINIC

10634 East Riverside Drive, Suite 300
Bothell, Washington 98011
Tel (425) 272-2286
Fax (425) 486-3949

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND FINANCIAL AGREEMENT

(Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA)

PICACS Clinic ("Covered Entity") keeps a record of the health care services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us t o do so. You may see your record or get more information about it by contacting our Privacy Officer, at (425) 863 2818. Written requests should be made to the Privacy Officer at the following address:

Privacy Officer
PO Box 1287
Bothell, WA 98272
Tel: (360) 863-2818

Our **Notice of Privacy Practices** describes in more detail how your health information may be used and disclosed, and how you can access your information.

PATIENT ACKNOWLEDGMENT:

BY MY SIGNATURE BELOW I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES.

VERIFICATION OF MEDICAL CONSENT: I, the undersigned, hereby agree and consent to the plan of care proposed to me by the Covered Entity. I understand that I, or my authorized representative, have the right to decide whether to accept or refuse medical care. I will ask for any information I want to have about my medical care and will make my wishes known to the Covered Entity and/or its staff. The covered Entity shall not be liable for the acts or omissions of independent contractors.

AUTHORIZATION TO RELEASE INFORMATION: I, the undersigned, hereby authorize the Covered Entity and/or its staff, to the extent required to assure payment, to disclose any diagnosis and pertinent medical information to a designated person, corporation, governmental agency or third party payer which is liable to the Covered Entity for the Covered Entity's charges or who may be responsible for determining the necessity, appropriateness, or amount related to the Covered Entity's treatment or charges, including medical service companies, insurance companies, workmen's compensation carriers, Social Security Administration, intermediaries, and the State Department of Health and Human Services when the patient is a Medicaid or Medicare recipient. This consent shall expire upon final payment relative to my care.

FINANCIAL AGREEMENT:

PRIVATE PAY: I, the undersigned, hereby agree, whether signing as agent or as a patient, to be financially responsible to the Covered Entity for charges not paid by insurance. I understand this amount is due upon billing.

INSURANCE COVERAGE: I certify that the information given to me in applying for payment under government or private insurance is correct. I hereby assign payment directly to the Covered Entity for benefits otherwise payable to me. Any portion of charges not paid by the insurance company will be billed to me and is then due and payable within thirty (30) days of invoice. I understand the Covered Entity will verify my insurance coverage but that this does not guarantee payment by the insurance company and I will be responsible for all non-covered charges. I understand that it is my responsibility to determine the coverage limits of my insurance.

I understand a minimum monthly fee of 1% (annual rate of 12%) may be charged for late payment on all balances not covered by insurance. This is in addition to a charge for reasonable attorney fees, court costs, and collection agency expenses incurred to collect the amount due.

Name of Patient:	Patient, Parent, or Guardian (Please circle) Signature:
If patient is 13 through 18 years old Signature:	Date:

Patient Name:______________________________

I give permission for my appointment date(s), time(s) to be shared with the following people:

______________________________	______________________________
Please print	Relationship to patient
______________________________	______________________________
Please print	Relationship to patient
______________________________	______________________________
Please print	Relationship to patient
______________________________	______________________________
Please print	Relationship to patient

______________________________	______________________________
Signature	Date
______________________________	______________________________
Parent or Guardian	Date

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Patient's Name: ______________
DOB: ______________
Date: ______________
Person Filling Form: ______________

- Please take a moment of your time to fill out the following information as it will help the doctor in the initial assessment.
- Filing out this questionnaire will also help in identifying treatment goals.
- Please out all information pertaining to the patient.

1. Please describe your (the patient's) PRIMARY TREATMENT GOAL of seeking psychiatric consultation:

2. Please describe what you (the patient) need help with:

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Patient's Name:	
DOB:	
Date:	
Person Filling Form:	

3. Have you (the patient) ever consulted a **PSYCHIATRIST** before? If yes, please give us the name and address of the psychiatrist and the approximate that dates that you saw the psychiatrist. We will also ask you to sign consent to exchange information. However you do have the right to refuse to give consent for contact.

4. Are you or have you (the patient) ever been **in THERAPY/COUNSELLING**? If yes, please give us the name and address of the counselor and the approximate that dates of therapy. We will also ask you to sign consent to exchange information. However you do have the right to refuse to give consent for contact.

5. Are you (the patient) currently taking ***PSYCHIATRIC MEDICATIONS*** or have you ever taken medications in the past? If yes please give us the names and the exact dosages of the medications that you take.

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DOB: ______
Date: ______
Person Filling Form: ______

6. Do you (the patient) currently use SUBSTANCES or have in the past used any substances. Please also list if you have ever been habituated to or addicted to any medication/prescription drug or street drugs. Have you ever been in any Chemical dependency treatment setting (either inpatient or outpatient)?

7. Please provide the name of your(the patient's) PRIMARY CARE PHYSICIAN (primary prescribing nurse practitioner). When was your most recent physical examination? When was the last time you had a lab exam?

8. Do you (the patient) have any ALLERGIES TO MEDICATIONS? environmental agents or any other agents? If yes please give us a detailed list of all known agents that you are allergic to.

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DOB:	
Date:	
Person Filling Form:	

9. Do you (the patient) have any CURRENT AND ACTIVE MEDICAL PROBLEMS? If yes please give all details possible, including when diagnosed, current treatment etc.

10. Have you (the patient) ever had any PREVIOUS MEDICAL CONCENRNS that no longer need treatment or monitoring? Please give details of the conditions and how treated and cured?

11. Is there a FAMILY HISTORY OF PSYCHIATRIC ILLNESSES, please describe any psychiatric conditions exist biological maternal and paternal families. Please also describe if there is any history of substance use or abuse in the family. Any history of suicidal gestures, attempts or completion should also be listed.

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Patient's Name:	____________
DOB:	____________
Date:	____________
Person Filling Form:	____________

12. Is there a **FAMILY HISTORY OF MEDICAL PROBLEMS** in either your maternal or paternal family?

13. Is there any history of **ABUSE OR TRAUMA** that you (THE PATIENT) have suffered in the past? If yes please describe how it effects your functioning at present and if you have been in treatment for it in the past or are in treatment at present.

14. Please describe if you (the Patient's) have ever been in any **LEGAL PROBLEMS** (if applicable).

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DOB: ____________
Date: ____________
Person Filling Form: ____________

15. Please describe your (The Patient's) EDUCATION AND OCCUPATION (as applicable); please give details if schooling has been or is a problem, or if you are experiencing problems in your occupation.

16. Please describe your (The Patient's) SOCIAL HISTORY such as your current housing/living situation, and relationships. Please include an account of your immediate family, parents, siblings and children (as applicable); please also give an account of social supports, friends, significant relationships etc.

17. Please tell us if there are other concerns that are important to you that have not been addressed in the questions above.

PIHCR Symptom Questionnaire & Tracking Form (PSQ 50 TF)

Patients Name:	
Date:	Date Of Birth:
Name and Relationship of Person Completing Form:	

Instructions:

Does the patient present with problems in any of the following domains..........? If so please rate the severity of the symptoms by circling a number beside that situation that best describes how severe the problem is for the patient. If the patient does not have a problem in a situation circle None and go on to the next situation on the Form.

		None	Mild	Moderate	Severe	Extreme
1	Aggressive Outburst	1	2	3	4	5
2	Agitation	1	2	3	4	5
3	Anger	1	2	3	4	5
4	Appetite High	1	2	3	4	5
5	Appetite Low	1	2	3	4	5
6	Avoiding Familiar Situations	1	2	3	4	5
7	Carelessness	1	2	3	4	5
8	Crying Spells	1	2	3	4	5
9	Decreased Concentration	1	2	3	4	5
10	Decreased Interests	1	2	3	4	5
11	Distractibility	1	2	3	4	5
12	Eating Less	1	2	3	4	5
13	Eating More	1	2	3	4	5
14	Energy High	1	2	3	4	5
15	Energy Low	1	2	3	4	5
16	Excessive Involvement in Pleasurable activity	1	2	3	4	5
17	Fatigue	1	2	3	4	5
18	Feeling Detached	1	2	3	4	5
19	Feeling Numb	1	2	3	4	5
20	Feeling Worthless	1	2	3	4	5
21	Feeling Hopeless	1	2	3	4	5
22	Flashbacks	1	2	3	4	5
23	Focus Decreased (Distractibility)	1	2	3	4	5
24	Focus Increased (Hyper focus)	1	2	3	4	5
25	Hallucinations	1	2	3	4	5
26	Impulsivity	1	2	3	4	5
27	Insecurity	1	2	3	4	5
28	Irritability	1	2	3	4	5
29	Isolation	1	2	3	4	5
30	Memory	1	2	3	4	5
31	Mood High	1	2	3	4	5
32	Mood Low	1	2	3	4	5
33	Nightmares	1	2	3	4	5
34	Odd Beliefs	1	2	3	4	5
35	Peer Interactions	1	2	3	4	5
36	Poor Socialization Skills	1	2	3	4	5
37	Recurrent thoughts of Death	1	2	3	4	5
38	Repetitive thoughts	1	2	3	4	5
39	Restlessness	1	2	3	4	5
40	Self Esteem Increased	1	2	3	4	5
41	Self Esteem Low	1	2	3	4	5
42	Sleep Decreased	1	2	3	4	5
43	Sleep Increased	1	2	3	4	5
44	Talkative (Faster than usual)	1	2	3	4	5
45	Talkative (More than usual)	1	2	3	4	5
46	Vomiting to lose weight	1	2	3	4	5
47	Weight Decrease	1	2	3	4	5
48	Weight Increase	1	2	3	4	5
49	Worries (Excessively)	1	2	3	4	5
50	Worries (Unrealistic)	1	2	3	4	5