

JOSEPH BARRETT, M.D.

BOARD CERTIFIED PSYCHIATRY

Please complete and return this packet of information to our office at least one week before your appointment. This will allow Dr. Barrett enough time to review your information prior to your first appointment.

We ask that you call us at (541) 382-1395 the day before your appointment to confirm and secure your time. We are open Monday – Thursday from 8AM – 6PM and are available to answer any questions that you might have pertaining to your upcoming appointment.

Our address is:

1569 SW Nancy Way #2
Bend, OR 97702

Please arrive to your appointment 10 – 15 minutes early and don't forget to bring your insurance card with you as we will need to take a copy of it for your record.

We look forward to meeting you and working with you!

PATIENT REGISTRATION FORM

Joseph A. Barrett, M.D.

Patient		Today's Date	
<input type="checkbox"/> New	<input type="checkbox"/> Existing	/ /	

PATIENT INFORMATION

Last Name	First Name	Middle

Home Address	Mailing Address

City	State	Zip Code	City	State	Zip Code

Date of Birth	Age	Ethnicity (Circle One)	Marital Status (Circle One)
/ /		Hispanic / Not Hispanic	Single Married Divorced Widowed

Gender (please circle)	Cell Phone	Work Number
Male Female Non-Binary		

Preferred Pronouns:

Email Address:

May we leave voicemail messages?

At Home: Yes No At Work: Yes No

IN CASE OF EMERGENCY

Emergency Contact 1	Home Phone	Work Phone	Relationship

May we communicate with this person about your health? Yes No

Emergency Contact 1	Home Phone	Work Phone	Relationship

May we communicate with this person about your health? Yes No

EMPLOYMENT INFORMATION

Employment Status

Full Time Part Time Unemployed Act. Military Self Employed Retired Student Other

Occupation	Employer	Employer Phone

Employer Address (if known)	City	State	Zip Code

PHYSICIAN INFORMATION

Referring Physician	Primary Care Physician

(Continued On Other Side)

What Pharmacy do you use for prescriptions? _____

Would you prefer to be reminded about your appointments by: Email Text Phone call

INSURANCE INFORMATION

(We will need to make a copy of your insurance card when you arrive to the office)

Primary Insurance Company	Group Number	ID Number	Co-Pay
Patient's Relationship To Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____			

Subscriber Information

Last Name	First Name	Date of Birth	Employer

INSURANCE INFORMATION

Secondary Insurance Company	Group Number	ID Number	Co-Pay
Patient's Relationship To Subscriber: <input type="checkbox"/> Self <input type="checkbox"/> Spouse <input type="checkbox"/> Child <input type="checkbox"/> Other: _____			

Subscriber Information

Last Name	First Name	Date of Birth	Employer

FINANCIAL RESPONSIBILITY

(If other than patient)

Last Name	First Name	Middle	
Mailing Address		Phone Number	
City	State	Zip Code	Relationship to Patient

FINANCIAL AGREEMENT- SIGNATURE REQUIRED

I hereby authorize Joseph A. Barrett, M.D. and/or his designate to provide medical treatment and release information pertaining to treatment for insurance purposes. I understand that I am financially responsible for payment of all services at the time they are rendered unless other payment arrangements have been established. I understand that I am responsible for any appointment missed and understand a charge will be incurred for an appointment not kept or cancelled with less than a 24-hour notice.

Patient Signature

Date

Responsible Party Signature

Date

PATIENT HISTORY FORM

Name _____ Date _____

Family Physician _____ Date of Birth _____

Current Psychiatrist/Counselor _____ Age _____

MEDICATIONS: Please list the medications (including over-the-counter), dose and frequency

ALLERGIES: _____

FAMILY HISTORY: Has a parent, sister, brother, child or grandparent ever had? Circle appropriate answer.

Cancer	No	Yes				
Heart Disease	No	Yes	Suicide	No	Yes	
Diabetes	No	Yes	Mental Illness	No	Yes	
Stroke	No	Yes	Drug or Alcohol Abuse	No	Yes	

	Children		Siblings		Mother	Father
	M	F	M	F		
Age/Health						
If deceased, age at death						
Cause of death						

YOUR PAST MEDICAL HISTORY: Circle appropriate answer.

Cancer	No	Yes	High Blood Pressure	No	Yes
Heart Disease	No	Yes	Ulcer or Gastritis	No	Yes
Diabetes	No	Yes	Liver Problems	No	Yes
Stroke	No	Yes	Kidney Problems	No	Yes
Thyroid Problem	No	Yes	Venereal Disease	No	Yes
Seizures	No	Yes	Musculoskeletal Pain	No	Yes

Name: _____

Date: _____

Please circle the one response to each item that best describes you for the past seven days.

Falling asleep:

0. I never take longer than 30 minutes to fall asleep.
1. I take at least 30 minutes to fall asleep, less than half the time.
2. I take at least 30 minutes to fall asleep, more than half the time.
3. I take more than 60 minutes to fall asleep, more than half the time.

Sleep during the night:

0. I do not wake up at night.
1. I have a restless, light sleep with a few brief awakenings each night.
2. I wake up at least once a night, but I go back to sleep easily.
3. I wake up more than once a night and stay awake for 20 minutes or more, more than half of the time.

Waking up too early:

0. Most of the time, I wake up no more than 30 minutes before I need to get up.
1. More than half the time, I wake up more than 30 minutes before I need to get up.
2. I almost always wake up at least one hour or so before I need to, but I go to sleep eventually.
3. I wake up at least one hour before I need to and can't go back to sleep.

Sleeping too much:

0. I sleep no longer than 7-8 hours a night without having to nap during the day.
1. I sleep no longer than 10 hours in a 24-hour period including naps.
2. I sleep no longer than 12 hours in a 24-hour period including naps.
3. I sleep longer than 12 hours in a 24-hour period including naps.

Feeling sad:

0. I do not feel sad.
1. I feel sad less than half the time.
2. I feel sad more than half the time.
3. I feel sad nearly all the time.

Decreased appetite:

0. There is no change in my usual appetite.
1. I eat somewhat lesser amounts of food than usual.
2. I eat much less than usual and only with personal effort.
3. I rarely eat within a 24-hour period and only with extreme personal effort or when others persuade me to eat.

Increased appetite:

0. There is no change in my usual appetite.
1. I feel a need to eat more frequently than usual.
2. I regularly eat more often and/or greater amounts of food than usual.
3. I feel driven to overeat both at mealtime and between meals.

Decreased weight (within the last two weeks):

0. I have not had a change in my weight.
1. I feel as if I've had a slight weight loss.
2. I have lost 2 pounds or more.
3. I have lost 5 pounds or more.

Increased weight (within the last two weeks):

0. I have not had a change in my weight.
1. I feel as if I've had a slight weight gain.
2. I have gained 2 pounds or more.
3. I have gained 5 pounds or more.

Concentration/Decision making:

0. There is no change in my usual capacity to concentrate or make decisions.
1. I occasionally feel indecisive or find that my attention wanders.
2. Most of time, I struggle to focus my attention or to make decisions.
3. I cannot concentrate well enough to read or cannot make even minor decisions.

View of myself:

0. I see myself as equally worthwhile and deserving as other people.
1. I am more self-blaming than usual.
2. I largely believe that I cause problems for others.
3. I think almost consistently about major and minor defects in myself.

Thoughts of death or suicide:

0. I do not think of suicide or death.
1. I feel that life is empty or wonder if it's worth living.
2. I think of suicide or death several times a week for several minutes.
3. I think of suicide or death several times a day in some detail, or I have made specific plans for suicide or have tried to take my life.

General Interest:

0. There is no change from usual in how interested I am in other people or activities.
1. I notice that I am less interested in people or activities.
2. I find I have interest in only one or two of my formerly pursued activities.
3. I have virtually no interest in formerly pursued activities.

Energy level:

- 0. There is no change in my usual level of energy.
- 1. I get tired more easily than usual.
- 2. I have to make a big effort to start or finish my usual daily activities (for example: shopping, homework, cooking, or going to work).
- 3. I really cannot carry out most of my usual daily activities because I just don't have the energy.

Feeling slowed down:

- 0. I think, speak, and move at my usual rate speed.
- 1. I find that my thinking is slowed down, or my voice sounds dull or flat.
- 2. It takes me several seconds to respond to most questions, and I'm sure my thinking is slowed.
- 3. I am often unable to respond to questions without extreme effort.

Feeling restless:

- 0. I do not feel restless.
- 1. I'm often fidgety, wringing my hands, or needing to shift how I am sitting.
- 2. I have impulses to move about and am quite restless.
- 3. At times, I am unable to stay seated and need to pace around.

This section is to be completed by your doctor:

Enter the highest score on any 1 of the sleep items (1-4) _____
Item 5 _____
Enter the highest score on any 1 appetite/weight item (6-9) _____
Item 10 _____
Item 11 _____
Item 12 _____
Item 13 _____
Item 14 _____
Enter the highest score on either of the 2 psychomotor items (15-16) _____

TOTAL SCORE (Range 0-27) _____

Scoring Criteria: Normal 0-5 Mild 6-10 Moderate 11-15 Severe 16-20 Very Severe 21+

Please check all the boxes that apply to you:

- I am often restless and irritable.
- I do not enjoy hobbies, leisure activities or time with friends and family anymore.
- I am having trouble managing my diabetes, hypertension, or another chronic illness.
- I have nagging aches and pains that do not get better, no matter what I do.

My Sleep patterns are irregular:

- I am sleeping too much.
- I am not sleeping enough.

I often have:

- Digestive problems.
- Headaches or backaches.
- Vague aches and pains (joint or muscle pain).

- I have trouble concentrating or making simple decisions.
- People have commented on my mood or attitude lately.
- My weight has often changed considerably.
- I have had several of the symptoms I checked above for more than 2 weeks.
- I feel that my functioning in everyday life (work and my interactions with family and friends is suffering because of these problems).
- I have a family history of depression.
- I have thought about suicide.

Please circle YES or NO after each question:

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, started fights, or arguments? | YES | NO |
| • You felt much more self-confident than usual? | YES | NO |
| • You got much more talkative or spoke faster than usual? | YES | NO |
| • Thoughts raced through your head or you could not 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 so 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 to be excessive, foolish, or risky? | YES | NO |
| • Spending money got you or your family into 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?

(Please circle one response only)

YES

NO

3. How much of a problem did any of these matters cause you – like being unable to work; having family, money, or legal troubles; getting into arguments or fights?

(Please circle one response only)

No problem

Minor Problem

Moderate Problem

Serious Problem

4. Have any of your blood relatives (i.e., children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?

YES

NO

5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?

YES

NO

Joseph Barrett, M.D.

HIPPA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment, or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information, but the practice does not have to agree with those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medication condition with any member of your family? YES NO

If YES, please name the members allowed:

This consent was signed by: _____
(Please Print Name)

Signature: _____

Date: _____

Witness: _____

Date: _____

JOSEPH BARRETT, MD

1569 SW Nancy Way #2
Phone: 541-382-1395 Fax: 541-382-6576

MEDICAL RECORDS AUTHORIZATION TO RELEASE INFORMATION

I, _____ (DOB: _____) hereby authorize **Joseph Barrett, MD** to release information to and/or obtain information from the following individual(s) and/or organizations:

Organization Name (if applicable): _____

Name of Individual: _____ Title/Relationship: _____

Phone: _____ Fax: _____

INFORMATION TO BE RELEASED please **initial** next to box:

- | | |
|--------------------------------|-------------------------------------------------|
| <input type="checkbox"/> Labs | <input type="checkbox"/> Progress Notes |
| <input type="checkbox"/> Other | <input type="checkbox"/> Psychiatric Evaluation |

INFORMATION IS RELEASED FOR THE FOLLOWING PURPOSE:

Continuation of Care Coordination of Care Legal Reasons Other: _____

I voluntarily sign this authorization and I understand that my care will not be affected if I do not sign this form. I understand this consent will expire 12 months from the date it is signed. I understand that I may revoke this consent (in writing) at any time.

I also authorize the release of information pertaining to drug and alcohol abuse if it is included in my medical chart.

I have read and understand this authorization. I have asked questions about anything that was not clear to me and I am satisfied with the answers I received.

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____

If patient is unable to sign, indicate reason: _____

Signature of Person Authorized to Sign: _____ Relationship: _____

Joseph A. Barrett, MD
Financial Policy

We would like to keep you informed of our current financial policies. Please read the following policies carefully and if you have any questions, please do not hesitate to ask a member of our staff.

Insurance and Medicare:

1. It is your responsibility to keep us updated with your correct primary and secondary insurance information. If the insurance information you have designated is incorrect, you will be responsible for payment of services and to submit the charges to the correct plan for reimbursement.
2. It is your responsibility to understand your benefit plan with regard to covered services, copayments, coinsurance percentage, and deductible amounts. You are responsible for services not covered by your insurance plan.
3. Per your contract with your insurance company, you are responsible for any and all co-payments, coinsurance percentages, and deductible amounts.
4. Per your physician's contract with your insurance company, we are required to collect any and all co-payments, coinsurance percentages, and deductible amounts. To not collect these amounts would be at the possible consequence of insurance fraud as defined by the Office of the Inspector General of the Department of Health and Human Services, and subject to civil and criminal liability.

Financial Responsibility:

1. Co-payments are due at time of service, and prior balances must be paid prior to your next office visit.
2. While the filing of insurance claims is a courtesy we extend to our patients, all charges for services not covered by your insurance plan are your responsibility.
3. If your physician does not participate in your insurance plan, payment in full is expected at the time of your office visit.
4. If you do not have insurance, payment for an office visit is to be paid at the time of your office visit.
5. Patient balances are billed upon receipt of your insurance plan's explanation of benefits. Your remittance is due within 10 business days of your receipt of your bill.
6. Account balances over 90 days old will be turned-over to an outside agency and will be subject to interest charges and the terms and conditions of that agency. Accounts turned-over to collections may be subject to dismissal from the practice and termination of relationship between you and your physician.
7. We accept cash, checks, Visa, MasterCard, Discover and American Express credit, and debit cards.

Appointments:

1. Please help us serve you better by keeping your scheduled appointments. If you are not able to keep an appointment, we require 24-hour notice for cancelling or rescheduling appointments. There is a charge of \$50 for late cancellation, late rescheduling, or missed appointments.
2. If you are late for your appointment, we will do our best to accommodate you. However, on certain days it may be necessary to reschedule your appointment and you may be charged the customary fee for a missed appointment.
3. Multiple missed appointments may result in dismissal from the practice and termination of relationship between you and your physician.
4. We strive to minimize any wait time. However, emergencies do occur and may take priority over a scheduled visit. We appreciate your understanding.

Returned Payment:

1. A \$25 fee will be charged for any checks returned for insufficient funds, plus any bank fees incurred.

Please see other side 

Service Fees	Fee	Cash Amount
Psychiatric Diagnostic Evaluation	\$332.00	\$280.00
Psychotherapy (30 min)	\$91.00	\$80.00
Psychotherapy (45 min)	\$149.00	\$125.00
Medication Management Low Complexity	\$155.00	\$130.00
Medication Management Moderate Complexity	\$230.00	\$195.00
Medication Management High Complexity	\$308.00	\$260.00

I have read, understand, and agree to comply with the above listed policies. I have been provided opportunity to ask questions about anything that was not clear to me and I am satisfied with the answers I have received.

Patient Name: _____

Responsible Party's Name: _____ Relationship: _____

Responsible Party's Signature: _____ Date: _____