MARIANNE STRAUMFJORD, 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. Straumfjord 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

Marianne Straumfjord, M.D.

Patient	Today's Date
☐New ☐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 your 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: ☐Self ☐Spouse ☐Child ☐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: ☐Self ☐Spouse ☐Child ☐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 Marianne Straumfjord, M.D. and/or her 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**

Patient History Form (continued) Patient Name _____

Have you ever been hospitalized? _____ If yes, for what reason? _____

_____

Have you ever had surgery? _____ If yes, type of surgery & dates _____

_____

Have you been under medical care for any length of time? _____ If yes, dates of treatment and for what reason? _____

_____

Past counselors/psychiatrists and dates of treatment _____

_____

Past psychiatric medications taken dose and frequency _____

_____

INJURIES:

Have you ever been seriously injured in a motor vehicle accident? No Yes
Have you had any head concussions? No Yes
Have you ever had loss of consciousness? No Yes

SOCIAL HISTORY: Circle one: Single Married Divorced Separated Widowed Significant Other
With Whom Do You Live?

_____

Are you employed? _____ Full time _____ Part time _____
Are you exposed to fumes, dusts or solvents? _____
Foreign travel within last year:

_____

If employed, how much time have you lost from work because of your health during the past
Six months _____ One year _____ Five years _____?

Circle One:

Caffeine Use **No** **Yes (If yes, please list amount _____cup(s) per day)**

Tobacco Use **No** **Yes (If yes, please list amount _____ pack(s) per day or Quit _____mths/yrs ago)**

Alcohol Use **No** **Yes (If yes, please list amount _____, type _____)**

Recreational Drug Use **No** **Yes (If yes, please list amount _____, type _____)**

Do you have any problems with sexual function? No Yes

What are the top three things you would like help with?

_____

_____

_____

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**

Marianne Straumfjord, M.D.

339 SW Century Drive Suite 101 Bend, OR 97702
Phone: 541-382-1395 Fax: 541-382-6576

MEDICAL RECORDS AUTHORIZATION TO RELEASE INFORMATION

I, _____ (DOB: _____) hereby authorize **Marianne Straumfjord, 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:

- ☐ Labs
- ☐ Other
- ☐ Progress Notes
- ☐ 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: _____

Marianne Straumfjord, 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: _____

Bend Psychiatry
Informed Consent for Telehealth Visits

Health care services are available by two-way interactive video communications and/or by the electronic transmission of information. Referred to as "telemedicine" or "telehealth," this means that I may be evaluated and treated by a health care provider or specialist from a different location. Since this is different than the type of consultation with which I am familiar, **I understand and agree to the following:**

1. The consulting health care provider or specialist will be at a different location from me.
2. The presenting practitioner may transmit or share electronically details of the visit
3. I will be informed if any additional personnel are to be present other than myself, individuals accompanying me, the consultant and presenting practitioner. I will give my verbal permission prior to additional personnel being present.
4. The physician or health care provider for whom the onsite examination or treatment is performed will keep a record of the consultation in my medical record.

Noting all the above, I understand that my participation in the process described (called "telemedicine" or "telehealth") is voluntary and constitutes a waiver of the usual right to physician-patient privacy and may possibly increase the risk of disclosure of my medical data.

I further understand that I have the right to:

1. Refuse the telehealth consultation or stop participation in the telehealth consultation at any time.
2. Limit any physical examination proposed during the telehealth consultation
3. Request that the presenting practitioner refrain from transmitting my information if I make the request before the information is transmitted.
4. Request that nonmedical personnel leave the room at any time.
5. Request that all personnel leave the room to allow a private consultation with off site specialist

I acknowledge that the health care providers involved have explained the consultations in a satisfactory manner and that all questions that I have asked about the consultations have been answered in a manner satisfactory to me or to my representative. Understanding the above, I consent to the telehealth process described above.

Patient: _____ Date: _____

Patient Representative: _____ Date: _____

Witness: _____ Date: _____

Patient Name: _____

Provider: _____

Marianne Straumfjord, 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 canceling or rescheduling appointments. There is a charge of $50 for a 15 minute appointment, $100 for a 30 minute appointment and $150 for a 45 minute appointment for late cancelation, 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	$377.00	$325.00
Psychotherapy (45 min)	$201.00	$175.00
Medication Management Low Complexity	$176.00	$140.00
Medication Management Moderate Complexity	$260.00	$210.00
Medication Management High Complexity	$349.00	$280.00

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: _____