Please fill out and return this packet of information to Kim Butler at least a week prior to your appointment.

Our office requires that you call 541.382.1395 option 1 the day before the appointment to confirm and secure the appointment.

We are located at:
339 SW Century Drive, Suite 101
Bend, OR 97702

We ask that you arrive 15 – 20 minutes early to your appointment, bringing your insurance card and photo ID with you. We have a few patient care questionnaires that we will have you fill out in the office when you arrive, if you do not arrive in time to go over the questions please plan some additional time to stay after the appointment.

We are open Monday-Thursday from 8:00AM-6:00PM.

If you need to contact our office with any information or questions pertaining to your new patient appointment, please call 541.382.1395 and press option 1.

Thank you!
PATIENT REGISTRATION FORM
Kimberly Butler, PMHNP

☐ New  ☐ Existing  ☐ Today's Date

PATIENT INFORMATION

Last Name  First Name  Middle

Home Address  Mailing Address

City  State  Zip Code  City  State  Zip Code

Gender  Date of Birth  Age

☐ M  ☐ F

Home Phone  Cell Phone  Work Number

Email Address (optional)

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

☐ 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)

<table>
<thead>
<tr>
<th>Primary Insurance Company</th>
<th>Group Number</th>
<th>ID Number</th>
<th>Co-Pay</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient's Relationship To Subscriber: □ Self □ Spouse □ Child □ Other: ____________________________

Subscriber Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Date of Birth</th>
<th>Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

INSURANCE INFORMATION

Secondary Insurance Company | Group Number | ID Number | Co-Pay |
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
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<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Patient's Relationship To Subscriber: □ Self □ Spouse □ Child □ Other: ____________________________

Subscriber Information

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
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<th>Employer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FINANCIAL RESPONSIBILITY
(If other than patient)

<table>
<thead>
<tr>
<th>Last Name</th>
<th>First Name</th>
<th>Middle</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Mailing Address

<table>
<thead>
<tr>
<th>City</th>
<th>State</th>
<th>Zip Code</th>
<th>Relationship to Patient</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

FINANCIAL AGREEMENT- SIGNATURE REQUIRED

I hereby authorize Kimberly Butler, PMHNP 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.

<table>
<thead>
<tr>
<th>Cancer</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Diabetes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Stroke</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Suicide</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Illness</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Drug or Alcohol Abuse</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Children</th>
<th>Siblings</th>
<th>Mother</th>
<th>Father</th>
</tr>
</thead>
<tbody>
<tr>
<td>M</td>
<td>F</td>
<td>M</td>
<td>F</td>
</tr>
</tbody>
</table>

Age/Health

If deceased, age at death

Cause of death

YOUR PAST MEDICAL HISTORY: Circle appropriate answer.

<table>
<thead>
<tr>
<th>Cancer</th>
<th>No</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Heart Disease</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Diabetes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Stroke</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Thyroid Problem</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Seizures</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>High Blood Pressure</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Ulcer or Gastritis</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Liver Problems</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Kidney Problems</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Venereal Disease</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Musculoskeletal Pain</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>
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/ys 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?
AUTHORIZATION FOR RELEASE OF RECORDS

Patient Name: __________________________

Birth Date: ____________________________

I hereby authorize:
Kimberly Butler, PMHMP
339 SW Century Drive, Suite 101
Phone: 541-382-1395  Fax: 541-382-6576

☐ Exchange Information  ☐ Disclose Information only  ☐ Receive Information Only
(initial one or more boxes above)

Release/Receive Information to/from: ___________________________________________
(More than one may be listed.
If available provide address & phone number)

Release of information is to provide the following information – please initial which can be sent to or received from the above named party:

☐ Initial Psychiatric Evaluation  ☐ Progress Notes
☐ Psychological Testing & Evaluation Reports  ☐ Treatment Plans/Summaries
☐ History & Physical Exams  ☐ Discharge Summaries
☐ Laboratory Data

☐ I also authorize the release of information pertaining to drug and alcohol abuse and mental health, if such is part of the medical record.

I understand that I may revoke this authorization at any time, except to the extent that action has been taken based on this authorization before it is revoked. I understand this authorization will expire one year after the date it is signed.

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 have received.

________________________________________  __________________________
Patient Signature                           Date Signed

*****************************************************************************************

If the patient is unable to sign, indicate reason: ________________________________________

________________________________________  __________________________
Signature of Person Authorized to Sign for Patient                    Relationship
Kimberly Butler, PMHNP
Practice Policies & Treatment Consent

This form is meant to familiarize you with my practice policies. By signing, you indicate you have read, understood and agreed to abide by these policies. You are welcome to ask for a copy to keep at any time.

Confidentiality: Our communication during the course of your treatment, the treatment plans we develop, and any personal information you permit me to gather to aid in our work together will be kept confidential. Your information will not be shared without your written consent. Your signature will be required before I can share information with, or receive information from, others.

There are a few exceptions to this policy for which I am legally required to breach confidentiality. These exceptions are:
- If there is reason to believe you are in imminent danger of harming yourself or another person
- If there is reason to believe child or elder abuse has occurred/is occurring
- If an emergency situation requires sharing of information to protect your well-being
- If a breach of confidentiality is court-ordered

Client Participation/Rights:
Treatment will only be effective you are engaged and actively involved. I believe in working together toward treatment goals. It is important to ask questions about treatment if you are unclear about any aspect of treatment plans or goals.

Fees:
60-90 min Initial Meeting/Intake Assessment $350-$425
30-60 min Individual Follow-up Therapy and Med Management $275-$475
50-60 min Family or Couples Appointment $150-$275
15-30 min Medication or Brief Therapy Follow-up $175-$250
No show/late cancel fee (<24 hours’ notice) $275-$475
**We are unable to bill insurance for missed appointments**
Telephone Appointment $50-$100
**Phone appointments are not covered by insurance**

Payment: Payment in full is expected at the time of service. I accept checks, debit and credit cards. Please make checks payable to Oregon Psych, LLC. If payment is not received, our work together will be discontinued. For self-pay patients, a 20% discount will be applied.

Insurance: I am currently contracted with Providence, Optum Health, United Behavioral Health, Medicare, Regence Blue Cross, First Choice Health, MODA, Pacific Source and Tricare. Until I am contracted with your insurance company, I am considered an out-of-network provider and payment in full is required at each appointment. I will provide you with a superbill if you intend to request reimbursement from your insurer for any out-of-network benefits you have.

Cancellations: Please call me a minimum of 24 hours in advance if you must cancel your visit. If you fail to cancel within 24 hours you will be charged for the full visit $275-$475. Insurance companies will not reimburse for any part of missed appointments and you will be held responsible for the full (above) cost of the missed appointment.

Inclement Weather Policy: In the event of snow, ice or other inclement weather conditions, my office will follow Bend Public Schools. If your location, my location, or both are closed for the day, we may either have our appointment by phone, or reschedule based on your concern and preference.

EMERGENCIES: If you have an emergency such as a serious side effect to a medication or concerning symptoms, please call my office. Also, please contact me at any time if you are having thoughts of hurting yourself or others, or having scary thoughts. We will work together to ensure your safety. Sometimes I may request that you go to an Emergency Room or call 911. I will make every effort to return your call/message as soon as I possibly can. However, if I have not returned your call/message in a manner you consider timely, please go to the nearest Emergency Room or call 911 to ensure your safety and health.
Kimberly Butler, PMHNP
Practice Policies & Treatment Consent

Prescription Refills:
Refills for medication will typically be written during a visit. If you need a refill between appointments, please contact your pharmacy. The pharmacy will send a refill request to me. Refills are not considered an emergency, and will be reviewed between 8am and 5:30pm during business days, and responded to within 24 business hours.

Grievance Procedure:
Please discuss any complaints with me directly so we can collaborate to resolve your concern. If you find we are unable to resolve your concern together, or if you feel you need additional support in getting your needs met, you may also contact your insurance company or the Oregon State Board of Nursing. If you file a grievance, you will still be entitled to all the contracted services I agreed to provide in your treatment plan. Moreover, you, your advocate, or witness will never be the subject of retaliation and are immune by law from any civil liability.

HIPAA: Notice of Policies and Practices:
I am required by Federal (Health Insurance Portability and Accountability Act known, aka HIPAA) and State Law to protect the privacy of your personal information. Additionally, I am required to give you a notice describing (a) how and when clinical information about you may be used and/or disclosed and (b) how you may access this information. In this intake packet you will find a copy of my HIPAA privacy notice for your review. Your signature below, in addition to giving consent for treatment, and acknowledging you understand the policies of my practice, is assent that you have reviewed and understood how my practice complies with HIPAA.

SIGNATURE
Your signature below indicates that you have read and understood this document, and agreed to all of its terms. If the terms of this agreement are violated, your treatment in my practice may be terminated. Your signature also serves as an acknowledgement that you have reviewed the HIPAA Notice of Policies and Practices handout and that you give consent to participate in treatment.

Name of Client

Signature of Client (or Personal Representative)  Date

Description of Personal Representative’s authority