PATIENT REGISTRATION - PAGE 1

Midtown Psychiatry Offices

1222 NE 4th Street, Bend, OR 97701 | Phone: 541-640-5460 | Fax: 541-648-5771 | www.midtownmh.com

Provider: ☐ Kimberly Butler, PMHNP ☐ Margaret Lang Smith, PA-C ☐ Other _____

PATIENT INFORMATION

Last Name _____ First Name _____ Middle Name _____

Home Address _____ City _____ State _____ ZIP _____

Date of Birth _____ Gender ☐ F ☐ M ☐ Other Marital Status _____

Cell Phone _____ Home Phone _____ Email _____

May we leave voicemail? ☐ Yes ☐ No

EMERGENCY CONTACT

Name _____ Phone _____ Relationship _____

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

EMPLOYMENT / PROVIDER INFORMATION

Employment Status _____ Occupation _____ Employer _____

Referring Provider / Counselor _____ Primary Care Provider _____

PATIENT REGISTRATION - PAGE 2

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Patient Name _____ DOB _____

PHARMACY & REMINDERS

Preferred Pharmacy _____

Reminder preference ☐ Email ☐ Text ☐ Phone

PRIMARY INSURANCE

Insurance Company _____ Member / ID # _____

Subscriber Name _____ Subscriber DOB _____

Relationship _____ Group # _____

SECONDARY INSURANCE

Insurance Company _____ Member / ID # _____

Subscriber Name _____ Subscriber DOB _____

Relationship _____ Group # _____

FINANCIAL RESPONSIBILITY - IF OTHER THAN PATIENT

Responsible Party _____ Relationship _____

Address _____ Phone _____

FINANCIAL AGREEMENT

I authorize the selected provider and/or designee to provide treatment and release information needed for insurance purposes. I understand that I am financially responsible for services and for applicable charges related to missed or late-cancelled appointments.

Patient / Responsible Party Signature _____ Date _____

PATIENT HISTORY FORM - PAGE 1

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Patient Name _____ DOB _____

CURRENT MEDICATIONS

ALLERGIES

FAMILY HISTORY

☐ Cancer ☐ Heart disease ☐ Diabetes

☐ Stroke ☐ Suicide ☐ Mental illness

☐ Drug/alcohol abuse

PAST MEDICAL HISTORY

☐ Cancer ☐ Heart disease ☐ Diabetes ☐ Stroke

☐ Thyroid ☐ Seizures ☐ Head injury ☐ Concussion

☐ Migraines ☐ Vision problems ☐ Hearing problems ☐ GI problems

☐ Liver disease ☐ Kidney disease ☐ Musculoskeletal pain ☐ STD

Other medical history / details

PATIENT HISTORY FORM - PAGE 2

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Patient Name DOB

MEDICAL / TREATMENT HISTORY

Medical hospitalizations - reason and dates

Past psychiatric hospitalizations - reason and dates

Surgeries - include dates

Past psychiatric providers / counselors

PAST PSYCHIATRIC MEDICATIONS

Medication	Max Dose	Side Effects	Benefit

SOCIAL HISTORY

Relationship status Living with

Employment Time lost from work

Caffeine / tobacco / alcohol / cannabis / other substances

TOP 3 THINGS YOU WOULD LIKE HELP WITH

1.

2.

3.

MOOD SCREENING

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Patient Name _____ DOB _____

CHECK ALL THAT APPLY

- ☐ I'm often restless and irritable
- ☐ I no longer enjoy hobbies, leisure activities, friends, or family
- ☐ I'm having trouble managing a chronic illness
- ☐ I have persistent aches or pains
- ☐ I'm sleeping too much
- ☐ I'm not sleeping enough
- ☐ Digestive problems
- ☐ Headaches or backaches
- ☐ Chest pain or dizziness
- ☐ Trouble concentrating or making decisions
- ☐ People have commented on my mood
- ☐ My weight has changed considerably
- ☐ Symptoms have lasted more than 2 weeks
- ☐ My daily functioning is suffering
- ☐ Family history of depression
- ☐ I've thought about suicide

HAVE THERE BEEN TIMES WHEN YOU WERE NOT YOUR USUAL SELF AND...

felt unusually good, hyper, or got into trouble because of it?	☐ Yes	☐ No
needed much less sleep without missing it?	☐ Yes	☐ No
were so irritable that you started fights or arguments?	☐ Yes	☐ No
felt much more self-confident than usual?	☐ Yes	☐ No
had racing thoughts you could not slow down?	☐ Yes	☐ No
were unusually distractible?	☐ Yes	☐ No
had much more energy or activity than usual?	☐ Yes	☐ No
were much more social or outgoing than usual?	☐ Yes	☐ No
were much more interested in sex than usual?	☐ Yes	☐ No
did unusual, excessive, foolish, or risky things?	☐ Yes	☐ No
spending caused trouble for you or your family?	☐ Yes	☐ No

FINANCIAL POLICY - PAGE 1

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HEALTH INSURANCE

- It is your responsibility to keep us updated with current primary and secondary insurance information.
- It is your responsibility to understand your benefits, including covered services, copays, coinsurance, and deductibles.
- You are responsible for services not covered by your insurance plan and for applicable patient responsibility.

FINANCIAL RESPONSIBILITY

- Copayments are due according to practice policy. Prior balances must be paid according to agreed payment arrangements.
- Filing insurance claims is a courtesy. Charges not covered by your insurance plan remain your responsibility.
- If your provider does not participate with your plan, or if you do not have insurance, payment is due according to the self-pay policy.
- Balances may be referred to collections if they remain unpaid, and persistent nonpayment may result in dismissal from the practice.

APPOINTMENTS

- Please provide at least 24 hours' notice to cancel or reschedule. A $100 fee may be charged for late cancellations, late rescheduling, or missed appointments. Multiple missed appointments may result in dismissal.

RETURNED PAYMENTS

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

FINANCIAL POLICY - PAGE 2

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SELF-PAY / CASH RATES

Service	Fee
New Patient Psychiatric Evaluation - 90 minutes	**$500**
Established Patient Follow-Up - 20 minutes	**$225**
Extended Follow-Up - 40 minutes	**$350**
Extended Follow-Up - 60 minutes	**$425**

Fees are based on the type and length of the scheduled appointment. Services provided during follow-up appointments may include medication management, psychiatric assessment, and supportive psychotherapy when clinically appropriate.

OTHER FEES

Late Cancel or No Show (not covered by insurance)	$100
Returned Check Fee	$25

CREDIT / DEBIT CARD ON FILE POLICY - EFFECTIVE OCTOBER 1, 2026

Beginning October 1, 2026, all patients will be required to keep a valid credit or debit card securely on file. Copays will be processed within two business days after your appointment. Coinsurance and deductible balances of $350 or less will be processed after your insurance determines your responsibility. For balances over $350, we will notify you before processing payment. This change will help simplify billing and reduce administrative delays.

Patient / Responsible Party Name _____ Relationship _____

Signature _____ Date _____

AUTHORIZATION FOR RELEASE OF RECORDS

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Patient Name _____ DOB _____

AUTHORIZATION

☐ Exchange information ☐ Disclose information only ☐ Receive information only

RELEASE / RECEIVE INFORMATION TO / FROM

Name / Organization _____

Address _____

Phone _____ Fax _____

INFORMATION AUTHORIZED

☐ Initial Psychiatric Evaluation

☐ Psychological Testing / Evaluation Reports

☐ History & Physical Exams

☐ Laboratory Data

☐ Progress Notes

☐ Treatment Plans / Summaries

☐ Discharge Summaries

☐ Other

☐ I also authorize release of drug/alcohol abuse and mental health information if part of the record.

EXPIRATION / REVOCATION

I understand that I may revoke this authorization at any time except to the extent action has already been taken in reliance on it. Unless revoked earlier, this authorization expires one year after the date signed.

Patient Signature _____ Date _____

Authorized representative / reason if patient cannot sign

_____

CONSENT TO RECEIVE SMS TEXT MESSAGES

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I consent to receive SMS text message communications from Midtown Psychiatry Offices, using Spruce Health as its SMS text messaging service provider, at the mobile phone number I provide. Messages may include appointment reminders, appointment changes or cancellations, account or care-related notifications, and administrative messages related to services provided to me. Consent is not a condition of receiving care.

TEXT MESSAGE DETAILS

Message frequency may vary, and standard message and data rates may apply based on my mobile carrier and plan. SMS messages may be used for scheduling, administrative activities, and care-related communications. SMS opt-in and consent data will not be shared with third parties.

OPT-OUT AND HELP

I may revoke my consent at any time by texting "STOP" to 541-640-5460. After opting out, I will receive a confirmation message. For assistance, I may text "HELP" or contact Midtown Psychiatry Offices at 541-640-5460.

CONSENT ACKNOWLEDGMENT

☐ Yes, I consent to receive SMS text messages. ☐ No, I do not consent.

Mobile Phone Number _____

Printed Name _____ Date _____

Signature _____

CONSENT FOR AI-ASSISTED CLINICAL DOCUMENTATION

Midtown Psychiatry Offices

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Provider: ☐ Kimberly Butler, PMHNP ☐ Margaret Lang Smith, PA-C ☐ Other _____

INTRODUCTION

As part of our commitment to maintaining a high standard of care, your provider may use a digital session assistant to support required clinical documentation. This tool is intended to reduce manual note-taking and assist with summarizing relevant session content for documentation.

PURPOSE AND POTENTIAL BENEFITS

Use of the digital session assistant may allow your provider to focus more fully on the visit by reducing manual note-taking. Capturing essential aspects of the session may also support accurate documentation and continuity of care.

PRIVACY AND SECURITY

The consent describes the digital session assistant as HIPAA-compliant and designed to support documentation while maintaining privacy and confidentiality. Please ask your provider any questions you have about how the tool is used before signing.

CONSENT ACKNOWLEDGMENT

☐ I consent to the use of AI-assisted clinical documentation. ☐ I do not consent.

Printed Name _____ Date _____

Signature _____