Kimberly Butler, PMHNP

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

Kimberly Butler, PMHNP

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 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

Kimberly Butler, PMHNP - Bend Psychiatry

PATIENT HISTORY FORM

PATIENT INFORMATION

Name	Date

Date of Birth	Age

Current Psychiatrist/Counselor	Current Primary Care Provider

MEDICATIONS

Please list all medications, including dosage and frequency

ALLERGIES

Please list all allergies including medication, food, and environmental

FAMILY HISTORY

Has a parent, grandparent, sibling, or child ever had the following?

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

	Mother	Father	Sisters	Brothers	Daughters	Sons
Age/Health						
(Good or Poor)						
Age at Death						
Cause of Death						

YOUR PAST MEDICAL HISTORY

Do **you** have any health issues related to the following?

	No	Yes		No	Yes
Cancer	☐	☐	Concussion	☐	☐
Heart	☐	☐	Migraines	☐	☐
Diabetes	☐	☐	Vision	☐	☐
Stroke	☐	☐	Hearing	☐	☐
Thyroid	☐	☐	Stomach or Intestine	☐	☐
Seizures	☐	☐	Liver	☐	☐
Meningitis	☐	☐	Kidneys	☐	☐
Encephalitis	☐	☐	Musculoskeletal Pain	☐	☐
Head Injury	☐	☐	Sexually Transmitted Disease	☐	☐

Patient History Form -Page 2

Patient Name

Have you ever been hospitalized? If so, for what reason?

Have you ever had surgery? If so, what type and date (year)?

Past Psychiatrists (MD)/Psychiatric Nurse Practitioners (PMHNP)/Counselors (PhD, PsyD, LPC, LCSW, MSW)

Past PSYCHIATRIC MEDICATIONS

Medication Name	Maximum Dose	Side Effects?	Benefit?

SOCIAL HISTORY

Circle One:

Single	Married	Divorced	Separated	Widowed	Significant Other

With whom do you live?

Are you currently employed? If so, where and for how long?

If employed, how much time have you lost from work because of your health in the last:

6 months:	12 months:	5 years:

Are you exposed to any harmful fumes, dusts, solvents, or other chemicals? If so, what?

Have you traveled outside of the U.S. in the last 12 months? If so, where and how long?

Please indicate whether you consume each of the following & amount?

	No	Yes	Amount
Caffeine	☐	☐	Cups/Ounces/Day:
Energy Drinks	☐	☐	Ounces/Day:
Tobacco	☐	☐	Packs/Day:
Alcohol	☐	☐	Drinks/Day:
Marijuana/Cannabis	☐	☐	Amount:
Recreational Drug Use	☐	☐	Type & Amount:

What are the top 3 things you would like help with?

1
2
3

Check all of the boxes that apply to you.

- ☐ I'm often restless and irritable
- ☐ I don't enjoy hobbies, leisure activities or time with friends and family any more
- ☐ I'm having trouble managing my diabtese, hypertensioni or other chronic ilness
- ☐ I have nagging aches and painsthat don't get better, no matter what I do

My sleep patterns are irregular:

- ☐ I'm sleeping too much
- ☐ I'm not sleeping enough

I often have:

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

- ☐ I have trouble concentrating or making decisions
- ☐ People have commented on my mood lately
- ☐ My weight has changed considerably
- ☐ I've 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've thought about suicide

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*Check **YES** or **NO** after each question.*

1. Has there ever been a time when you were not your usual self and	**YES**	**NO**
.... you felt so good or hyper that other people thought you were not your usual self or you were so hyper that you got yourself into trouble?	☐	☐
.... you were so irritable that you stsarted fights or arguments?	☐	☐
.... you felt much more self confident than ususal?	☐	☐
.... Thoughts raced through your head and you couldn't slow you mind down?	☐	☐
.... you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
.... you had much more energy than usual?	☐	☐
.... you were much more active or did more thankgs than usual?	☐	☐
.... you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
.... you were much more interested in sex than ususal?	☐	☐
.... you did things that were unusual foryou or other people might have thought were excessive, foolish, or risky?	☐	☐
.... spending money got you or your family into trouble?	☐	☐

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2. If you checked YES to more than one of the above, have several of these happened during the <u>same periond of time</u>? (Check one answer only) ☐ ☐

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3. How much of a problem did any of these cause you - like being unable to work, having family, money, or legal troubles; getting into arguments or fights? (Circle one answer 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? ☐ ☐

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

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

Kim Butler, PMHNP & Bend Psychiatry
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.

Health Insurance:

1. It is your responsibility to keep us updated with your current primary and secondary insurance information. If the insurance information you the 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, and deductible amounts. You are responsible of 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 our 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 our patients 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 $100 (for late cancellation, late rescheduling, or missed appointments). There is a charge of $150 (for late cancellation, late rescheuduling or a missed Psychiatric Evaluation appointment).

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 prlority 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 read and sign the other side (p.2) ---->>>>

Service Fees	Fee	Cash
Psychiatric Diagnostic Evaluation	$525 - $625	$500
Medication Management w/ psychotherapy (30 min) Simple/Complex	$350 - $450	$360
Medication Management w/psychotherapy (45 min) Simple/Complex	$375 - $500	$400
Psychotherapy with Medication Management (30 min)		
Medication Management Only (15 min) Simple/Complex	$225 - $375	$180
Psychotherapy Only (45-55 min)	$250	$200
Late Cancel or No Show (not covered by insurance	$100	
Late Cancel or No Show Initial Evaluation (not covered by insurance	$150	
Returned Check Fee	$25	
*Cash includes 20% discount if pain in full at time of visit		

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: _____

Kimberly Butler, PMHNP
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: _____

Kimberly Butler, PMHNP

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

MEDICAL RECORDS AUTHORIZATION TO RELEASE INFORMATION

I, _____ (DOB: _____) hereby authorize **Kimberly Butler, PMHNP** 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: _____

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: _____

Client Informed Consent

Introduction

As part of our commitment to maintaining a high standard of care, we are incorporating the Digital Session Assistant. This tool is designed to aid in the required documentation of our sessions.

Client Benefits

- **Improved Session Engagement:** The Digital Session Assistant minimizes the distraction of manual note-taking, leading to more attentive and immersive sessions.
- **Personalized Care:** By capturing essential aspects of each session, this tool facilitates a deeper understanding and reflection on the session content, contributing to more personalized and effective progress.
- **Privacy and Security Assurance:** The Digital Session Assistant is HIPAA compliant and designed to capture the essence of our discussions in an anonymized format. No PHI is stored post-session, and only non-identifiable notes are retained to support session enhancement.
- **Enhanced Practitioner Effectiveness:** The reduction in administrative tasks allows the focus to remain consistently on the client, leading to more effective and meaningful sessions.

Consent Acknowledgement

- The undersigned acknowledges the implementation of the Digital Session Assistant in our sessions, a tool designed for summarizing session content for documentation. This process is conducted with a strong emphasis on privacy and confidentiality.

Client Name: _____ Signature: _____

Date: _____