Office Location:
15811 Ambaum Blvd. SW Suite 110
Burien, WA 98166
Phone: 206-242-8211
Fax: 206-242-0162
info@buriencenterforhealthandwellbeing.com
www.buriencenterforhealthandwellbeing.com

Psychiatric Intake Form

Please complete all information on this form and bring to your first visit, along with any recent lab results. If you are unable to complete it at home, please come 30-40 minutes prior to your scheduled appointment time to fill out in the office. You may need to ask family members about the family history. Thank you!

Patient Name____ DOB: ____________ Date:____________

Primary Care Physician________________________________ Phone: ____________ Fax:_________________

Current Therapist____________________________________ Phone:_____________ Fax:__________________

What are the problem(s) you are seeking help for?

____

____

What are your treatment goals?

____

____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No
Do you currently feel that you don't want to live? ( ) Yes ( ) No
If YES: On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____
Have you ever attempted suicide? ( ) Yes ( ) No
Do you have the means or a plan to kill yourself? ( ) Yes ( )No

Current Symptoms Checklist

☐ Fatigue or loss of energy ☐ Decreased interest in activities or excessive guilt ☐ Depressed or sad mood
☐ Weight or appetite change ☐ Poor concentration ☐ Worthlessness ☐ Decreased libido ☐ Hallucinations
☐ Panic attacks ☐ Sleep pattern disturbance ☐ Low self-esteem ☐ Suspiciousness ☐ Low motivation
☐ Excessive energy ☐ Excessive worry ☐ Irritability ☐ Other: ____

Medication History

Past Psychiatric Medications

Have you ever taken any of the following? Please circle any you have tried

Antidepressants

Prozac/fluoxetine	Luvox/fluvoxamine	Paxil/ paroxetine	Celexa/citalopram
Lexapro/escitalopram	Effexor/venlafaxine	Cymbalta/duloxetine	Wellbutrin/bupropion
Remeron/mirtazapine	Viibryd/velazadone	Anafranil/clomipramine	Pamelor/nortriptyline
Tofranil/imipramine	Elavil/amitryptiline	Pristiq/desvenlafaxine	Brintellix/vortioxetine

Mood Stabilizers

Tegretol/carbamazepine	Lithium	Depakote/valproate	Lamictal/lamotrigine
Topamax/topiramate	Trileptal/oxcarbazepine	Keppra/levetiracetam	Neurontin/gabapentin

Antipsychotics

Seroquel/quetiapine	Zyprexa/olanzapine	Geodon/ziprasidone	Abilify/aripiprazole
Clazaril/clozapine	Haldol/haloperidol	Prolixin/fluphenazine	Risperdal/ risperidone
Saphris/ asenapine	Latuda/lurasidone	Invega/paliperidone	

Sleeping Medications

Ambien/zolpidem	Sonata/zaleplon	Rozerem/ramelteon	Restoril/temazepam
Desyrel/trazodone	Lunesta/eszopiclone	Seroquel/kquetiapine	Vistaril/hydroxyzine
Neurontin/gabapentin			

ADHD Medications

Adderall/amphetamine	Concerta/methylphenidate	Ritalin/methylphenidate
Strattera/atomoxetine	Vyvanse/lisdexamfetamine	Dexedrine/amphetamine
Intuniv/guanfacine		

Antianxiety Medications

Xanax/alprazolam	Ativan/lorazepam	Klonopin/clonazepam	Valium/diazepam
Tranxene/clorazepate	Buspar/buspirone	Neurontin/gabapentin	Vistaril/hydroxyzine

Allergies: ____

Current Prescription Medications (Include name, dose, and start date):

____

____

____

____

Current Over-The-Counter medications or supplements:

____

____

Other Psychiatric Medications:

____

____

Personal and Family Medical & Psychiatric History

Current Medical Problems:

____

____

____

Women: Date of last menstrual period _____ Are you currently pregnant or think you might be? Yes ( ) No ( )

Are you planning to get pregnant in the near future? Yes ( ) No ( ) Birth control method: __________________

# of pregnancies ________ # of live births __________ # of living children ____________

Medical History

	You	Family	Which family member?
Thyroid Disease	☐	☐	____________________
Anemia	☐	☐	____________________
Liver problems	☐	☐	____________________
Kidney Disease	☐	☐	____________________
Diabetes	☐	☐	____________________
Asthma	☐	☐	____________________
Stomach or Intestinal problems	☐	☐	____________________
Cancer	☐	☐	____________________
Chronic Pain	☐	☐	____________________
Heart Disease	☐	☐	____________________
Epilepsy or Seizures	☐	☐	____________________
High Cholesterol	☐	☐	____________________
High Blood Pressure	☐	☐	____________________
Head Injury	☐	☐	____________________
Other: ____________________	☐	☐	____________________

Bipolar Disorder	☐	☐	____________________________
Depression	☐	☐	____________________________
Anxiety	☐	☐	____________________________
Suicide	☐	☐	____________________________
Schizophrenia	☐	☐	____________________________
Post Traumatic Stress Disorder	☐	☐	____________________________
Alcohol Abuse	☐	☐	____________________________
Other Substance Abuse	☐	☐	____________________________
Other:__________________________	☐	☐	____________________________

Past Psychiatric Treatment: (Include therapy, psychiatrists, hospitalizations, dates)

____

____

____

Substance Use and Addiction History:
Current Use (Please circle):
Methamphetamines Cocaine/crack Speed Heroin Ecstasy/MDMA Benzodiazepines Marijuana Behavioral Addiction (gambling, compulsive behaviors, internet, sexual)

Past Use (Please circle):
Methamphetamines Cocaine/crack Speed Heroin Ecstasy/MDMA Benzodiazepines Marijuana Behavioral Addiction (gambling, compulsive behaviors, internet, sexual)

Hallucinogens (mushrooms, LSD) Tobacco Alcohol

Caffeine

Hallucinogens (mushrooms, LSD) Tobacco Alcohol

Caffeine

Have you ever been treated for alcohol or drug use or abuse? Yes ( ) No ( )
If yes, for which substances?
____ If yes, where were you treated and when? ____

Social History
Family Background
List your siblings/ ages:
____ Were you adopted? Yes( )No( )
Did your parents divorce? Yes ( ) No ( ) How old were you when they divorced? ____________________
Has anyone in your immediate family died? Yes ( ) No ( ) Who and when?
_______________________________ Trauma History

Do you have a history of being abused emotionally, sexually, physically, or by neglect? Yes ( ) No ( )
Other trauma history:
____ Education/ Work History
What is your highest level of education?
____ Are you currently: Working ( ) Not working by choice ( ) Unemployed ( ) Disabled ( ) Retired ( )
What is/ was your occupation?
____ Have you ever served in the military? Yes ( ) No ( ) Were you in combat? Yes ( ) No ( )
Relationship History
Are you currently: Married ( ) Single ( ) Divorced ( ) Widowed ( ) Partnered ( ) Other relationship ( )
Are you sexually active? Yes ( ) No ( )
Describe your relationship with your partner:
____ Do you feel safe in your current relationship? ____ Do you have children?
List ages/ gender ____ Legal History
Have you ever been arrested? Yes ( ) No ( ) Do you have any pending legal problems? Yes ( ) No ( ) Spiritual Life
Do you belong to a particular religion or spiritual group? Yes ( ) No ( )
If yes, what is the level of your involvement?
____ Do you find your spiritual involvement helpful during this difficult time, or does the involvement make things more difficult or stressful for you?
____

Is there anything else that you would like your psychiatric provider to know?
____
____

WELCOME!

Hello and welcome to our center for health and wellbeing where licensed healthcare professional use the center to see clients. The location is designed to meet the needs of the local community and provide professional services for individuals, couples, family, adults of all ages, adolescents and children.

Counseling Services for Wellbeing is an independent service, retained by your healthcare professional to process payment, submit insurance billings and perform a myriad of administrative tasks. Each provider that uses the services of Counseling Services for Wellbeing is a separate and independent business and is responsible for being licensed by the Washington State Department of Health to provide and supervise your care. You can search the individual credentials of any Washington State psychiatric or mental healthcare professional at www.doh.wa.gov or by calling (800) 525-0127.
We are committed to providing you with the highest quality administrative services as well as a warm, clean and professional office setting to receive care directly from the provider of your choice.

If we can do anything to make your experience more enjoyable, please feel free to ask.

Sincerely,
Issy Kleiman, Clinical Director
Counseling Services for Wellbeing

IMPORTANT INFORMATION AND TERMS OF AGREEMENT PLEASE READ CAREFULLY AND SIGN WHERE INDICATED

Fees for Services

Healthcare providers using the services and facilities of Counseling Services for Wellbeing provide their services to clients privately and accept a range of insurance plans. Please make sure your provider is in net- work if you would like to use your insurance, or you may be subject to paying a higher copay, coinsurance or deductible. Private pay rates are determined by each provider and can vary greatly depending on their availability and licensure. Please check with your provider regarding their rates and in- quire if they provide any rates for multiple visits.
If you see a non-prescribing therapist (i.e. social worker or mental health counselor) the copay or coinsurance is usually the same for each visit. However, if you are seeing a psychiatric nurse practitioner, they function similar to a medical doctor. Like visits with other medical specialists, visits with a psychiatric nurse practitioner are billed based on many factors including, but not limited to time, complexity, amount of therapy etc. As a result, your copay/coinsurance and the length of the appointment MAY BE DIFFERENT for each visit.

Financial Responsibility and Insurance Billing Practices

Payment in full is due at the time of each session including private pay amounts, copays, and deductibles. You will be billed for any remaining balance. If your provider is in network with your insurance carrier, your financial responsibility for each visit is determined by your insurance carrier's allowed amount for the service provided.

Insurance

Counseling Services for Wellbeing currently accepts most forms of insurance and can submit out-of-network claims (for therapy only) if your service provider is not covered by your plan and you have out-of- network benefits available. We will make every effort to confirm that your selected provider is contracted with your insurance carrier. In some cases, you may receive a recommendation to see an out- of-network provider. Please provide full insurance information and your insurance card upon your initial visit to determine eligibility of benefits, and obtain authorization from your insurance provider when necessary prior to your first visit. If you have a change in insurance, please let us know as soon as possible,

so we can help you determine if your provider is covered by the new plan. Any claims returned due to lapse in insurance company will be transferred to client responsibility. If your insurance plan requires pre-authorization for services, it is ultimately the responsibility of the patient to obtain this authorization prior to being seen by your provider. If you fail to obtain authorization, any and all charges incurred and not reimbursed, will be your financial responsibility.
Since you cost-share with your insurance company, we do our best to estimate your portion at the time that you check in. Despite our best efforts it is possible that once we get the claim back (usually 3-6 weeks after it is submitted) your cost-share may be higher than originally anticipated. We will notify you about any balance due with a monthly statement. If we overestimated the cost-share, the credit will be applied towards your future visits unless you specify otherwise. At the start of each new calendar year in January, with new insurance plans taking effect along with new deductibles to be met, we will be re-verifying benefits and collecting your full visit fee that will be applied to your deductible, at the time of service.

Collections Efforts

For any outstanding balances on your account, you will receive a statement a minimum of once per month. If an unpaid balance remains after 60 days, you will receive a phone call from our office staff to work out a payment plan. If you believe that there is an error on your statement, please let us know as soon as possible so we can research the issue.
Unpaid balances without a payment plan initiated after 120 days will initiate a phone collections effort by our third-party collections agency for recovery, and some identifying confidential information will be released in this process. This may negatively impact your credit. It is very important that you up- date your contact information with us to ensure that you receive your statements in a timely manner and are aware of your financial responsibility.

Distinguishing between an emergency, urgent, and non-urgent request

If you have an urgent need for consultation (medication side-effects, increase in symptoms, etc.) you should call the main office number and let our administrative staff know it is an urgent request. After hours and on weekends if you have an urgent request you should call the crisis clinic 1-866-4-CRISIS (1-866-437- 4747), and please leave a message on your provider's extension as well as your therapist's extension using the dial by name directory (206-242-8211 selection 6)
Many issues including insurance or billing questions, and appointment changes, can be resolved during normal business hours, Monday through Friday 8 am – 7 pm, and will be handled by our administrative staff.

Confidentiality

We are compliant with the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights with regard to personal health care information (PHI). HIPAA requires that we provide you with a Notice of Privacy Practices. This Notice, which is attached to this agreement, explains HIPAA in detail and its application to your personal health care in- formation. An electronic copy of this notice can be found on our website at www.counselingservicesforwellbeing.com

In the event of an emergency (you feel suicidal, homicidal, or have a medical emergency) you should call 911 or go to the closest emergency room.

Notice of Privacy Practices

This section describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

You have the right to:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice

- Choose someone to act for you
- File a complaint if you believe your privacy rights have been violated

You have choices in the way that we use and share information as we:

- Tell family and friends about your condition
- Provide disaster relief
- Include you in a hospital directory
- Provide mental health care
- Market our services and sell your information
- Raise funds

We may use and share your information as we:

- Treat you
- Run our organization
- Bill for your services
- Help with public health and safety issues
- Do research
- Comply with the law
- Respond to organ and tissue donation requests
- Work with a medical examiner or funeral director
- Address workers' compensation, law enforcement, and other government requests
- Respond to lawsuits and legal actions

Your Rights

When it comes to your health information, you have certain rights. This section explains your rights and some of our responsibilities to help you.

- Get an electronic or paper copy of your medical record: You can ask to see or get an electronic or paper copy of your medical record and other health in- formation we have about you. Ask us how to do this. We will provide a copy or a summary of your health information, usually within 30 days of your request. We may charge a reasonable, cost-based fee.
- Ask us to correct your medical record: You can ask us to correct health information about you that you think is incorrect or incomplete. Ask us how to do this. We may say "no" to your request, but we'll tell you why in writing within 60 days.
- Request confidential communications: You can ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address. We will say "yes" to all reasonable requests.
- Ask us to limit what we use or share: You can ask us not to use or share certain health information for treatment, payment, or our operations. We are not required to agree to your request, and we may say "no" if it would affect your care. If you pay for a service or health care item out-of-pocket in full, you can ask us not to share that information for the purpose of payment or our operations with your health insurer. We will say "yes" unless a law requires us to share that information.
- Get a list of those with whom we've shared information: You can ask for a list (accounting) of the times we've shared your health information for six years prior to the date you ask, who we shared it with, and why. We will include all the disclosures except for those about treatment, payment, and health care operations, and certain other disclosures (such as any you asked us to make). We'll provide one accounting a year for free but will charge a reasonable, cost-based fee if you ask for another one within 12 months.

- Get a copy of this privacy notice: You can ask for a paper copy of this notice at any time, even if you have agreed to receive the notice electronically. We will provide you with a paper copy promptly.
- Choose someone to act for you: If you have given someone medical power of attorney or if someone is your legal guardian, that person can exercise your rights and make choices about your health information. We will make sure the person has this authority and can act for you before we take any action.
- File a complaint if you feel your rights are violated: You can complain if you feel we have violated your rights by contacting us using the information on page 1. You can file a complaint with the U.S. Department of Health and

Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201, calling 1-877-696-6775, or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/ We will not retaliate against you for filing a complaint.

Your Choices

For certain health information, you can tell us your choices about what we share. If you have a clear preference for how we share your information in the situations described below, talk to us. Tell us what you want us to do, and we will follow your instructions. In these cases, you have both the right and choice to tell us to:

- Share information with your family, close friends, or others involved in your care
- Share information in a disaster relief situation
- Include your information in a hospital directory If you are not able to tell us your preference, for example if you are unconscious, we may go ahead and share your information if we believe it is in your best interest. We may also share your information when needed to lessen a serious and imminent threat to health or safety. In these cases we never share your information unless you give us written permission:
- Marketing purposes
- Sale of your information
- Most sharing of psychotherapy notes
- In the case of fundraising:
- We may contact you for fundraising efforts, but you can tell us not to contact you again.
  Our Uses and Disclosures
  How do we typically use or share your health information? We typically use or share your health in- formation in the following ways:
- We can use your health information and share it with other professionals who are treating you. Example: A doctor treating you for an injury asks another doctor about your overall health condition.
- We can use and share your health information to run our practice, improve your care, and contact you when necessary. Example: We use health information about you to manage your treatment and services.
- We can use and share your health information to bill and get payment from health plans or other entities. Example: We give information about you to your health insurance plan so it will pay for your services.
- How else can we use or share your health information?

We are allowed or required to share your information in other ways – usually in ways that con- tribute to the public good, such as public health and research. We have to meet many conditions in the law before we can share your information for these purposes. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/index.html. We can share health in- formation about you for certain situations such as:

- Preventing disease
- Helping with product recalls
- Reporting adverse reactions to medications
- Reporting suspected abuse, neglect, or domestic violence
- Preventing or reducing a serious threat to anyone's health or safety
- Do research
- We can use or share your information for health research.

Compliance with the law

We will share information about you if state or federal laws require it, including with the Department of Health and Human Services if it wants to see that we're complying with federal privacy law.

1. We can share health information about you with organ procurement organizations
2. We can work with a medical examiner or funeral director
3. We can share health information with a coroner, medical examiner, or funeral director when an individual dies

4. Address workers’ compensation, law enforcement, and other government requests
5. We can use or share health information about you for workers’ compensation claims
6. For law enforcement purposes or with a law enforcement official
7. With health oversight agencies for activities authorized by law
8. For special government functions such as military, national security, and presidential protective services
9. Respond to lawsuits and legal actions
10. We can share health information about you in response to a court or administrative order, or in response to a subpoena.

Our Responsibilities

We are required by law to maintain the privacy and security of your protected health information. We will let you know promptly if a breach occurs that may have compromised the privacy or security of your information. We must follow the duties and privacy practices described in this notice and give you a copy of it. We will not use or share your information other than as de- scribed here unless you tell us we can in writing. If you tell us we can, you may change your mind at any time. Let us know in writing if you change your mind. For more information see: www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html. We will not market or sell personal information.

Changes to the Terms of this Notice

We can change the terms of this notice, and the changes will apply to all information we have about you. The new notice will be available upon request, in our office, and on our web site. This notice of privacy practices is effective as of January 1, 2017, and applies to all persons that procure service from a caregiver operating under independent agency agreement with and/or in the facilities of who are you entering into an agreement with:

Counseling Services for Wellbeing
15811 Ambaum Blvd. SW Suite 110
Burien, WA 98166
Privacy Contact: Issy Kleiman, MA, LMFT, Clinical Director Phone: 206-242-8211

Please acknowledge that you:

1. Have carefully reviewed all information in this document
2. Received a printed copy of this document if so requested
3. Received a Notice of Privacy Practices explaining HIPPA
4. Understand that his is an agreement with Counseling Services for Wellbeing, a corporation that is unrelated to your caregiver except as a billing, promotional and facilities service.
5. Understand that your caregiver is an individual business responsible for providing mental healthcare services.

Print name_______________________________________ Signing on behalf of _________________________________
Relationship____ (if patient is unable to consent)
Signature____ Date ________________________________

Print name_______________________________________ Signing on behalf of _________________________________
Relationship____
Signature____ Date ________________________________

Print name_______________________________________ Signing on behalf of _________________________________
Relationship____
Signature____ Date ________________________________

Print name_______________________________________ Signing on behalf of _________________________________
Relationship____
Signature____ Date ________________________________

Financial Responsibility

I authorize my provider and/or Counseling Services for Wellbeing to release information to insurance carrier(s) listed and be paid directly by insurance carrier(s) for services billed. I acknowledge that I am responsible for all charges not paid by my insurance companies including: copays, coinsurance, deductibles, insurance plan refusal to pay for failure to obtain authorization, and missed and late cancellation fees.

Print name____
Signing on behalf of ____ (If patient is not financially responsible party)
Relationship____
Signature____ Date ___________________________