Optimum Mental Health Services
15 South Grady Way Suite 625
Renton, WA 98057 425-233-0431
www.opmhs.com

New Patient Intake Packet

- Please enter information in "Box" provided.
- All information is "Confidential", and is used to develop your "Treatment Plan."
- Completed forms to be emailed to: **drtony@opmhs.com**

Patient and Billing Information

Name	
Date of Birth	
Age	
Gender (male or female)	
Race Ethnicity	

Contact Information

Address	
Phone	
Email	
Emergency Contact: Relationship / Phone #	

Insurance Information

Primary Insurance	
Member ID	
Group Number	
Social Security #	
Secondary Insurance	

* Have you contacted your insurance company and verified your eligibility for mental health benefits?

	Yes		No

Signature Page Form

- By Signing or by completing “Electronic Signature” section on this form, you have acknowledged, understand, and agree with all information, and terms of all policies included in this New Patient Intake Packet.
- Policies are included at the end of this packet.

Signature

Patient Name	
Date of Birth	
Signature	
Date Signed	

Electronic Signature

Patient Name	
Date of Birth	
Electronic Signature (Re-Type your name here)	
Date Signed	

Provider History

Primary Care Provider	
Location	

Preferred Pharmacy	
Location	

Psychiatrist	
Therapist	
Attending Support Groups? (i.e. AA meetings)	

Reason for Visit

- Example:

"Medication management for depression, anxiety, etc."

Reason for Visit?	

Briefly: In your own words

Symptoms?	
Started When?	
How often in the past year?	
Last episode?	
Past Treatments? (i.e. Medications, therapy)	
Current Treatment?	

Patient Treatment Goal(s)?

- Example:

"I want to start a certain medication:____________"
"I want to continue my medications."

Personal Medical History

Allergies: • List Medications, food, Latex, seasonal, etc.	

Date of last Physical Exam	
Last Menstrual Period (if applicable)	

Height & Weight	

Place "X" if you have a History of:

	Seizures
	Diabetes
	Hypertension
	Hepatitis
	HIV
	Head Injury
	Loss of consciousness
	Chronic Pain
	Migraines
	MRSA
	COVID-19

	[Problems with]
	Eyes
	Ears/Nose/Throat
	Heart
	Lung
	Stomach
	Muscles / Strength
	Skin
	Neurological
	Immune
	Thyroid

	Depression
	Anxiety
	Panic Attacks
	PTSD
	Bipolar
	Mania
	OCD
	Schizophrenia
	Eating Disorders
	ADHD
	Autism
	Learning Disabilities
	Borderline Personality Disorder
	Other Personality Disorders

Hospitalizations

Past Surgical History	
Hospitalizations (Facility, Date/Year, and Reason)	

Suicide and Trauma History

Suicide Attempts	
Homicidal Attempts	
Domestic Violence History	
Trauma History: (Witnessed or Experienced)	

Medications and Supplements

Current Medications: Dose, Frequency, Reason	
Vitamins & Supplements	
Past Psych Meds	

Substance use / Abuse History

If Yes: Briefly list

- When first started
- How often and amount
- Last used

"Yes"		
	Caffeine / Tea	
	Smoking, Nicotine products, and/or Vaping	
	Alcohol	
	Opiate	
	Marijuana	
	Methamphetamine	
	Cocaine	
	Sedatives Benzodiazepines	
	Other	

Family Medical History

- Please place "X" in appropriate box:

	Mom	Dad	Mom'/mom	Mom's/dad	Dad's/mom	Dad's/dad	Siblings
Depression							
Anxiety							
Bipolar							
Schizophrenia							
Substance Abuse							
Medical History							

- If "yes" for Medical History, briefly describe below:

Relationship	Medical Condition

Social History

Marital Status?	
Significant Other's Name? How long together? Issues?	
Children: Names, Age, Gender	

Born Where? Raised Where?	
Currently Residing?	
Parents Residing?	
Siblings Residing?	

Sexual Identity	
Religion	
Cultural Preferences	
Military History	

Highest Education Completed	
Occupation Employer	
Any current Legal Issues	

When Your Mom was pregnant with you, did she have any complications? (i.e. C-section, Smoked? Drank?)	
Did you meet developmental milestones? (i.e. walked, talked on time?)	
Childhood issues: i.e. Bullied? Lived in poverty? Special Education?	

The next Section will include
6 Screening Forms.

Forms:

1) CAGE
2) PHQ-9
3) GAD-7
4) MDQ
5) ADHD
6) PCL-5

Form #1: CAGE

- Directions: Please place "X" in appropriate box.

Question	Yes	No
Have you ever felt you should cut down on your drinking / drug use?		
Have people annoyed you by criticizing your drinking / drug use?		
Have you ever bad or guilty about your drinking / drug use?		
Have you ever drank / used drugs in the morning to steady your nerves or relieve a hangover?		

Form #2: Patient Health Questionnaire (PHQ-9)

- Directions: Please place “X” in appropriate box.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More than half the days	Nearly Every day
1. Little interest or pleasure in doing things?				
2. Feeling down, depressed, or hopeless?				
3. Trouble falling or staying asleep, or sleeping too much?				
4. Feeling tired or having little energy?				
5. Poor appetite or overeating?				
6. Feeing bad about yourself, or that you are a failure or have let yourself or your family down?				
7. Trouble concentrating on things, such as reading the newspaper or watching television?				
8. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual?				
9. Thoughts that you would be better off dead, or of hurting yourself?				

10. If you checked off any problems, how “difficult” have these problems made it for you to do your work, take care of things at home, or get along with other people?

	Mark 1 box only below
Not difficult at all	
Somewhat difficult	
Very difficult	
Extremely difficult	

Form #3: GAD-7 Anxiety

- Directions: Please place "X" in appropriate box.

Over the last 2 weeks, how often have you been bothered by any of the following problems?

	Not at All	Several Days	More than half the days	Nearly Every day
1. Feeling nervous, anxious, or on edge?				
2. Not being able to stop or control worrying?				
3. Worrying too much about different things?				
4. Trouble relaxing?				
5. Being so restless that it is hard to sit still?				
6. Becoming easily annoyed or irritable?				
7. Feeling afraid, as if something awful might happen?				

8. If you checked off any problems, how "difficult" have these problems made it for you to do your work, take care of things at home, or get along with other people?

	Mark 1 box only below
Not difficult at all	
Somewhat difficult	
Very difficult	
Extremely difficult	

Form #4: Mood Disorder Questionnaire (MDQ)

1. Has there ever been a period of time when you were not your **"usual"** self and…

	Yes	No
a) …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?		
b) …you were so irritable that you shouted at people or started fights or arguments?		
c) …you felt much more self-confident than usual?		
d) …you got much less sleep than usual and found that you didn't really miss it?		
e) …you were more talkative or spoke much faster than usual?		
f) …thoughts raced through your head or you couldn't slow your mind down?		
g) …you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
h) …you had more energy than usual?		
i) …you were much more active or did many more things than usual?		
j) …you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
k) …you were much more interested in sex than usual?		
l) …you did things that were usual for you or that other people might have thought were excessive, foolish, or risky?		
m) …spending money got you or your family in trouble?		
2. If you checked "YES" to more than one of the above, have several of these ever happened during the same period of time?		

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?

	Mark 1 box only below
Not difficult at all	
Somewhat difficult	
Very difficult	
Extremely difficult	

Form #5: Adult ADHD Self-Report Scale, Symptom Checklist

Place an "X" in the box that best describes how you have felt and conducted yourself over the past 6 months.	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?					

	Never	Rarely	Sometimes	Often	Very Often
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?					

Form #6: PTSD (PCL-5)

Is there a trauma that you "*Witnessed*" or "*Experienced*", and is now a "*Problem*"? If so, place an "X" to the response that indicates how much you have been bothered by that problem in the "***past month***".	Not at All	A Little Bit	Moderately	Quite aBit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?					
2. Repeated, disturbing dreams of the stressful experience?					
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?					
4. Feeling very upset when something reminded you of the stressful experience?					
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating?					
6. Avoiding memories, thoughts, or feelings related to the stressful experience?					
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?					
8. Trouble remembering important parts of the stressful experience?					
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?					
10. Blaming yourself or someone else for the stressful experience or what happened after it?					
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?					
12. Loss of interest in activities that you used to enjoy?					
13. Feeling distant or cut off from other people?					
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?					
15. Irritable behavior, angry outbursts, or acting aggressively?					
16. Taking too many risks or doing things that could cause you harm?					
17. Being "super-alert" or watchful or on guard?					
18. Feeling jumpy or easily startled?					
19. Having difficulty concentrating?					
20. Trouble falling or staying asleep?					

The next section is a copy of our Policies

[For your Review and Reference]

Policies: Informed Consent for Appointments and Fees

Updated: April 4, 2020

Scheduled Appointments

- It is the client's responsibility to attend their scheduled appointments.
- In the event of a missed appointment or a late cancellation, Optimum Administrative Staff will contact you by phone, email, or send you a letter as a friendly reminder of our policies.
- Late cancellations and missed appointments will be charged a fee per occurrence (details in the Cancellations and Reschedule section below).
- Unfortunately, as a group practice, we are unable to accommodate multiple missed appointments.
- That said, three no shows or late cancellations for appointments may result in the closure of your account and Treatment Services with Optimum.
- At that time, you will have 30 days to request a 2-month refill. Also, we will make an effort to provide referrals to other health care providers prior to final closure of your care.

Cancellations and Rescheduling

- Cancellations must be made by email or by phone within 48 business hours.
- This policy does not include weekends. For example, a 9:00am Monday appointment must be cancelled by Thursday.
- A fee will be incurred for appointments that at missed or cancelled without a 48-hour prior notice. Follow-up appointments First incident--$50; Second--$75; Third--$100. Missed initial evaluation appointment--$100.
- Please note that insurance companies will not reimburse for missed appointment fees, and clients will be responsible for payment.
- Fees must be paid prior to making a new appointment.
- More than three missed appointments and/or late cancellations may result in the client being discharged from their provider's service.

Fees and Charges

- Clients are ultimately responsible for all payment obligations arising out of their treatment of care, as such, they guarantee payment for these services.
- Not all medical and/or mental health services are covered by all insurance policies.
- Some plans pay fixed allowances for each office visit, while others pay only a percentage of the cost.
- It is the client's responsibility to understand their insurance coverage; they should contact their insurance company if they have any questions with regards to their policies.
- As a courtesy, we will help you process your insurance claim form for reimbursement; however, the patient or responsible party is ultimately responsible for the charges.
- Also, any co-payments, co-insurance, or deductible amounts are due at the time of service.
- If we do not participate in your insurance plan, you may still choose to be seen by the practice, but we will require payment in full at the time series are rendered.

Refills

- Refills should be requested during regular appointments. Each provider has their own refills policies.
- Please note that a refill fee of $25-$50 may be applied for a refill service request outside of an in-person appointment.
- The fee depends on the number of prescriptions that are refilled.
- The provider reserves the right to not provide a refill service outside of an in-person appointment.

Policies: Informed Consent for Evaluation and Treatment

Right to Choose the Best Treatment and Provider

- It is your right and responsibility to select the treatment and provider that best matches your needs.
- You also have the right to a detailed explanation of any treatments or procedures that your provider establishes in your treatment plan; this includes the risks and benefits, if any.
- Please discuss with your provider if you believe that you are not receiving the treatment that you require so that they can work with you to revise your treatment plan or to refer you to other professionals who may be able to meet your needs.

Qualifications and Training

- Your provider can provide you with information with regards to their education, training, and certifications.

Risks & Benefits

- Each client responds to treatment and therapy differently; that said, improved and/or positive results cannot be guaranteed.
- Providers will partner with clients to develop individualized and realistic treatment plans that will be based on evidence-based practice.
- Providers will also consult with other professionals to improve upon the treatment plan with a goal of better client satisfaction, safety, and outcomes.

Right to Refuse or Stop Treatment

- All adult clients, ages 18 years and up, have the right to stop treatment at any time and for any reason.
- For minors, the parent(s) or legal guardian(s) has the right to refuse or stop treatment for the minor.
- Providers reserve the right to refuse and terminate treatment at any time and for any reason. If this occurs, the client will be provided with a discharge letter. If a client is being discharged, providers reserve the right whether medication(s) refills are to be issued; if applicable, up to a 2-month supply may be issued.
- Please bring up any concerns immediately with your provider so a discussion can be initiated to mitigate any issues.

Medication Management

- Medications used in a client's treatment plan may be FDA approved and/or prescribed as "off-label".
- Please note that in psychiatry, medication management involves the treatment and management of psychiatric symptoms; that said, some medications are prescribed for other reasons that the FDA originally approved the medication(s).

Pregnancy and Medication Management

- Please discuss with your provider if you are pregnant or considering pregnancy while on a medication management.
- Noe that all medications have potential risks and benefits; that said, the medication(s) in the client's medication management treatment plan may have adverse effects, and may be potentially dangerous to the baby and/or the pregnancy.
- If the client is considering pregnancy or is pregnant, it is their responsibility to immediately inform their provider to discuss the potential risks and benefits of continuing a medication management treatment plan before, during, and after pregnancy.

Treatment Length and Type

- Initial evaluation may take 60-90 minutes or longer. Depends on completion of forms and client's readiness and participation.
- It may take several visits before a diagnosis is made and an individualized and realistic treatment plan is developed.
- Follow-up visits may take 30-60 minutes. Follow-up appointments may range from weekly to every 3-months, depending on the patient's condition, status, and needs.
- Psychotherapy is a vital part of good outcomes; supportive therapy and psychoeducation may be provided during your session.
- If clients are not already working with a therapist, a referral may be made to other licensed providers who can provide more extensive psychotherapy, with whom your provider(s) can also collaborate to help meet your mental health needs.
- Clients who haven't been seen greater than 90-days within the practice will be placed in an "in-active" status, unless the provider has been notified beforehand. A request will need to be generated by the client to have their care re-opened with the practice and/or with their provider; accepting the client back into the practice and / or with their provider is not guaranteed.

Confidentiality Limits

- Contents of an intake, medication management, and counseling or assessment session are considered to be confidential.
- Both verbal and written information and records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian.
- It is the policy of this office to not release any information about a client without a signed release of information.
- Exceptions may include, but are not limited to: insurance billing, and other exceptions listed below:

Duty to Warn and Protect; Abuse of Children and Vulnerable Adults; & Court Orders

- Providers are required by law to warn the intended victim and to notify legal authorities if a client discloses intentions and/or a plan to harm others.
- In cases where a patient discloses and plans to harm themselves, the provider is required to notify legal authorities and make reasonable attempts to notify the client's family.
- If a client discloses incidences and/or plans that they have or are abusing a child and/or vulnerable adult, and/or those persons are in danger of harm, the provider is required to report this information to the appropriate social services and/or legal authorities.
- Health records can be released with a court order.

Crisis Management

- This office does not provide on-call services.
- Clients must use their established social supports and call National Suicide Prevention Lifeline (1-800-273-8255) during a crisis, such as feeling suicidal and/or homicidal; if necessary, please call 911.
- If clients are in need of emergency services (such as experiencing a potentially life threatening event, etc.) they must call 911, and/or go to the nearest emergency department if it is safe to do so.

Provider Availability

- Check with your provider for their availability as some providers are at the office for limited days of the week.
- Messages left with the office are relayed to your provider; defined time-lines for replies cannot be specified nor guaranteed.
- Please try to address issues and concerns during your regular appointments.

Text Messages and Email

- Appointment reminders and billing information can be sent via text and/or email.
- You should be aware that text messages charges from your cell phone provider may apply.
- Authorization for text message and email alerts may be revoked in writing.
- Note that text messages and emails are not always secure; therefore, this office will limit information that is sent.
- Note that emergencies, such as COVID-19 has allowed for relaxed communication restrictions via email, Teleheath, etc.

Please direct any questions/concerns about the aforementioned policies with your provider or Optimum staff. Please keep these pages for your review and reference.

Notice of Privacy Practices

Updated: April 4, 2020

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

- We understand that your medical and health information is personal. Protecting your health information is important. We follow strict federal and state laws that require us to maintain the confidentiality of your health information.
- When you receive care from Optimum, we may use your health information for treating you, billing services, and conducting our normal business known as health care operations. Examples of how we use your information include:
- **Treatment**: We keep records of the care and services provided to you. Health care providers use these records to deliver quality care to meet your needs. For example, your doctor may share your health information with a specialist who will assist in your treatment.
- **Payment**: We keep billing records that include payment information and documentation of the services provided to you. Your information may be used to obtain payment from you, your insurance company, or other third party. We may also contact your insurance company to verify coverage for your care or to notify them of upcoming services provided to you to claim and obtain payment from your insurance company or Medicare.
- **Health Care Operations**: We use your health information to improve the quality of care, train staff, provide customer service, manage costs, conduct required business duties, and make plans to better serve our patients.
- To use your health information for other than the above uses require your sign authorization.
- There are limited situations when we are permitted or required to disclose health information without your signed authorization. These situations include:
  - For public health purposes such as reporting communicable diseases, work-related illnesses, or other diseases or injuries permitted by law reporting births and deaths; and reporting reactions to drug problems with medical devices.
  - To protect victims of abuse, neglect, or domestic violence.
  - For health oversight activities such as investigations, audits, and inspections.
  - For lawsuits and similar proceedings.
  - When otherwise required by law.
  - When requested by law enforcement as required by law or court order.
  - To coroners, medical examiners, and funeral directors.
  - To reduce and prevent a serious threat to public health and safety.
  - For other limited situations, see the fully copy of our Notice of Privacy Practices.

We are required by law to:

- Maintain the privacy of your health information.
- Provide this notice that describes the ways we may use and share your information.
- Follow the terms of the notice currently in effect.
- We reserve the right to make changes to this notice at any time and make the new privacy practices effective with all information we maintain. You may request a copy of any notice from our Privacy Officer.

You have the right to:

- Request restrictions on how we use and share your health information. We will consider all requests for restrictions carefully but are not required to agree to any restrictions.
- Request that we use a specific telephone number of address to communicate with you.
- Inspect and copy your health information, including medical and billing records. Fees may apply. Under limited circumstances we may deny you access to some portion of your health information and you may request review of the denial.
- Request amendments or additions to your health records.
- Request an accounting of certain disclosures or your health information made by us.

All of the above requests must be made in writing through our Privacy Officer.

This notice summarizes our Privacy Practices. If you would like further information about your privacy rights, are concerned that your privacy rights have been violated, or disagree with a decision that we make about access to your health information, please contact our Privacy Officer. Current office manager assumes the role of Privacy Officer.

We will investigate all complaints and will not retaliate against you for filing a complaint. You may also file a written complaint with the Office of Civil Rights of the U.S. Department of Health and Human Services. We are required by law to have you sign an Acknowledgment of Receipt of Notice of Privacy Practices.