Julie Ryder P.M.H.N.P.
409 Pine Street Suite 304
Klamath Falls, OR 97601
541-273-0515

Patient Registration

Consent for Treatment

I am voluntarily seeking psychiatric consultation, evaluation, treatment, counseling, therapy, medication management, and/or education from Julie Ryder, PMHNP as pertains to my symptoms and diagnosis.
Notification of Practice Policies and Procedures

Patient Information

Full Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Birth date: _____ Sex: M F Marital Status: _____

Employer: _____ Occupation: _____

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Email Address: _____

Emergency Contacts

Name: _____ Relationship to patient: _____

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Name: _____ Relationship to patient: _____

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

Protected Health Release

1. If we need to call you, what number should we use? (_____)_____

2. May we leave a confidential message on voice mail or answering machine? YES NO

3. If the phone is answered by family or co-workers, with whom may we leave a confidential message?
_____ OR _____ OR _____

4. Would you prefer information be sent to your email? if yes, email address: _____

Financial Agreement

I understand and agree that I am ultimately responsible for payments in full for all services received. I understand that unpaid balances may be sent to collections if other arrangements are not make to assure payment within 90 days of receipt of first request for payment. Outstanding balances of six months or more will accrue interest fees of 6% per month. I understand that insurance claims and account collections will be managed by Basin Billing, and that a Release of Information will be required for them to speak with anyone other than myself about my account.

Guarantor Information ***(person responsible for the bill)***

Full Name: _____ Relationship to Patient: _____

Address: _____ City: _____ State: _____ Zip: _____

Social Security Number: _____ Birth date: _____ E-Mail: _____

Employer: _____ Occupation: _____

Home Phone: (___)_____ Cell Phone: (___)_____ Work Phone: (___)_____

**** INCLUDE A COPY OF INSURANCE CARD(S) when returning paperwork. The receptionist can make a copy for you. ****

Primary Insurance Information

Insurance Name: _____ Phone: (_____)_____

Subscriber's Name: _____ Employer: _____

Policy Number: _____ Group Number: _____

Subscriber's SSN _____ Subscriber's DOB: _____Relationship to Patient: _____

Secondary Insurance Information

Insurance Name: _____ Phone: (_____)_____

Subscriber's Name: _____ Employer: _____

Policy Number: _____ Group Number: _____

Subscriber's SSN _____ Subscriber's DOB: _____Relationship to Patient: _____

I guarantee payment of all applicable co-payments, payments of deductibles, and charges for services not covered by insurance. I understand that I am responsible to discuss any problems with insurance coverage with Julie Ryder, PMHNP or her office manager in a timely manner should problems, misunderstanding, or difficulties arise. 3% fee will be added to debit/credit payments to offset administrative fees.

Julie Ryder, PMHNP may bill my primary and if applicable secondary insurance. I request payment of authorized benefits to Julie Ryder, PMHNP.

I have read and understand the policies, procedures, financial responsibilities and legalities of confidentiality as outlined in the Letter to New Patients.

(X) Signature: _____ Date: _____

Print Name: _____

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New Patient Agreement

HIPPA Notice of Privacy Practices:
I am required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. This means that I will not collect nor provide any information about you to anyone without your written consent. This form acknowledges that you were offered a copy of the HIPPA regulations sheet and you are aware this office is HIPPA compliant. Your signature below is acknowledgement that you have read the policies and procedures of my practice. A copy of the HIPPA notice is also available to read or download on our website: www.jryderpsychnp.com **INITIALS:** _____

Medication Refills:
Allow 72 hours for medication refills, NOT including holidays and weekends. **INITIALS:** _____

Controlled Substance
If my treatment plan includes prescriptions of controlled substances, I understand that **early refills WILL NOT** be provided, and that I may be monitored with urine drug screens and/or the Oregon Prescription Drug Monitoring Database. **INITIALS:** _____

Billing:
I understand that insurance claims and account collections will be managed by Basin Billing, and a Release of Information will be required for Basin Billing to speak with anyone other than myself about my account. I understand there is a 3% fee added to credit/debit card payments. **INITIALS:** _____

Dismissal & Late Fees:
Office policy states there is a **24 hour cancellation notice**. Please be courteous of my time and to those patients who could benefit from the time slot if you are unable to make your scheduled appointment. If you repeatedly miss appointments, or do not call within the 24 hour notice of cancellation time period, termination at my discretion may be the consequence. I understand that a fee will be assessed (not billable to insurance) for missed appointments, late cancellations and no shows. I understand that I may be dismissed, at provider's discretion, for missing three or more appointments without notice. Oregon Health Plan/Medicaid prevents providers from charging fees for missed appointments, and late cancellations. **INITIALS:** _____

Administration Fees:
Administration fees may be billed to you for copying/faxing/mailing your records to other providers or insurance companies (when you request and authorize my office to do so), conferencing or communicating with other providers on your treatment team (when you give consent.) Administration fees range from $10-$25, depending on complexity and time involved. **INITIALS:** _____

Signature: _____ Date: _____

Printed Name: _____

Julie Ryder PMHNP
Psychiatric Nurse Practitioner
409 Pine Street Suite 304
Klamath Falls OR 97601
541-273-0515

NEW PATIENT QUESTIONNAIRE

Name:_____ Date:_____ DOB: _____

Referred by:_____ Reason for referral:_____

Presenting concerns: (Please circle all that apply to you.)
depression anxiety sleep disturbances panic attacks phobias moodiness anger hopelessness crying spells anhedonia low energy impulsivity nightmares low self-esteem helplessness rage eating disorder behaviors sadness gambling or spending sprees difficulty making decisions mania obsessive-compulsive behaviors relationship problems loneliness financial concerns addictions difficulty with focus or concentration self-harm or high risk behaviors hallucinations paranoia shame suicidal thoughts victim or perpetrator of violence suicidal gestures homicidal or violent thoughts guilt memory loss dissociation or "losing time" traumatic memories irritability hoarding legal problems

Please list 3-4 primary stressors you are currently experiencing.

1.

2.

3.

4.

Current height:_____ Current weight _____

Nutritional level of diet: poor average good How many meals per day do you eat:_____

Average level of physical activity: minimal moderate high

List current psychotropic medications you are currently taking: _____
_____
Prescribing Doctor(s): _____
List other Medications you are taking that are non-psychotropic: _____
_____

Rate your consistency with medication:

missed doses: never rarely occasionally frequently

self-adjusting meds: never rarely occasionally frequently

Obsessive-Compulsive Behaviors: _____

_____

_____

_____

Phobias: _____

_____

_____

_____

Previous Mental Health Providers: _____

_____

Diagnoses: _____

_____

*List previous psychotropic medications and **ANY** side effects you had to them:* _____

_____

If you have chronic thoughts of suicide, what prevents you from acting on them? _____

_____

_____

_____

Past suicide attempts:

Age or year: _____ Methods: _____

Past psychiatric hospitalizations : _____

_____

_____

Treatment programs or methods *(please circle all that apply)*

12-step group therapy individual therapy dual diagnosis alternative/complimentary therapies

Self-injury: YES NO *Methods*: _____

Past: _____ *Current*: _____

High Risk Behaviors: YES NO _____

Eating Disordered Behaviors: binging overeating excessive dieting fear of weight gain "comfort" eating restricting purging abuse of laxatives of appetite suppressants excessive weighing yourself

Chronic Illness:

Personal and Family Medical History: (Indicate: self, mother, father, brother, sister, son or daughter)

Disorder:	***Relation:***	***Disorder:***	***Relation:***
Skin Problems		Heart Disease	
Stroke		Blood Disorders	
Cancer		Gastro-Intestinal	
Respiratory Disease		Diabetes	
Musculoskeletal Disorders		Sexually Transmitted Disease	
Headaches/Migraines			

Disorder:	***Relation:***	***Disorder:***	***Relation:***
Herpes/Shingles		Allergies	
Arthritis		Fibromyalgia	
Chronic Pain		Schizophrenia	
Autoimmune Disease		Suicide	
Sleep Apnea		Personality Disorder	
ADHD		Anxiety/Panic Disorder	
Bipolar Disorder		Depression	
Obesity		Thyroid Problems	
Traumatic Brain Injury		Neurological Disorders	
Chemical Dependence: drug/Alcohol			

Please elaborate on personal illnesses/symptoms:

_____

_____

_____

Surgical History:

_____

_____

Name of your Primary Care Provider: _____ *Date last seen:* _____

Allergies: _____ *Specialists:* _____ *Date last seen:* _____

Have you practiced safe sex? _____

Menstrual history: age at start of menstruation: _____ age of menopause: _____

Contraceptive methods: _____

Monthly cycles: (circle all that apply) regular heavy irregular painful mood changes

Number of pregnancies: _____ *Number of abortions/miscarriages*: _____ *Number of live births:* _____

Name of your Dentist: _____ *Date of last exam*: _____

Substance Abuse History:

Caffeine: YES NO how many cups per day? _____
Cigarettes: YES NO if yes how many per day? _____ Age when you started smoking? _____
Have you ever tried to quit smoking? ___ Number of attempts to quit ____Do you want to quit now? YES NO
Alcohol: Age you started to drink_____ Frequency of alcohol intake _____
Do you get drunk _____ sometimes _____always _____used to get drunk often but not anymore_____
Have you ever been told you drink too much or drink too often or that you should quit drinking? _____
When did you last use alcohol? _____
Have you ever had: _____ blackouts _____ shakes in the morning _____ withdrawal seizures _____
Do you use marijuana? YES NO if yes, date of last use _____
Do you use medical marijuana (OMMP): YES NO if yes, date of last use _____ card exp. _____
Crack cocaine: YES NO if yes, date of last use _____
Methamphetamine: YES NO if yes, date of last use _____if yes, how do you use it?_____
Heroin: YES NO if yes, date of last use_____ if yes, how do/did you use it? _____
Hallucinogens: YES NO if yes, date of last use_____
Ecstasy: YES NO if yes, date of last use? _____
Prescription medication abuse: YES NO

Social History:

Where were you born and raised? _____
Developmental Delays or Concerns? _____
Siblings: Full brothers/sisters _____ Half brothers/sisters _____ Step brothers/sisters _____
Birth order: _____ *First* _____ *Middle* _____ *Youngest*
Parental Separation/Divorce: YES NO *Stepparent(s) Separation/Divorce:* YES NO
Violence in the home? _____
_____
_____
_____
Drug or Alcohol use in the home? _____
_____
What are your current family relationships like? _____
_____

Childhood History: great OK not so great traumatic
Trauma/Abuse: physical sexual emotional verbal neglect bullying witness to violence
Behavioral or learning problems? _____
_____
_____
Highest grade completed: _____ *Were you in the military*? YES NO *Branch:* _____

Occupational History:

Longest job held: _____ *Current job or source of income:* _____

Legal History:

List any Current or Pending charges: _____
_____

Sexual History:

Sexual Orientation: heterosexual lesbian gay bisexual transgendered
Current activity: inactive celibate monogamy multiple partners
Concerns: excessive interest loss of interest or desire difficulty achieving or maintaining erections premature ejaculation difficulty with arousal or reaching orgasm unusual interests

Marital and Parental History:

Number of marriages: _____ *Currently*: single married co-habitating separated divorced
Victim or perpetrator of Domestic Abuse? YES NO
Children: sons _____ daughters _____ stepchildren _____ adopted _____ foster _____
Have there been any issues with custody, visitation, DHS involvement?
_____

Daily Living:

Current Living Situation: own/buying renting homeless living with friends or extended family
Do you feel SAFE in your home? _____
_____
Do you use the internet? YES NO Number of hours per day: _____
Internet Activity: information-seeking social networking blogging gaming dating sites pornography shopping gambling

Spirituality/beliefs: _____
_____
_____
_____
_____
_____
_____
_____

Do you own firearms? YES NO

Do you drive? YES NO

What else would you wish for me to understand about you? _____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Patient Health Questionnaire:

The following has been adapted from Spitzer R et. al. JAMA 1999

How often have you been bothered by each of the following symptoms during the last **TWO (2)** weeks?

Please circle one:

Feeling down, depressed or hopeless? Never once twice three or more

Little interest or pleasure in doing things? Never once twice three or more

Trouble falling/staying asleep, sleeping too much? Never once twice three or more

Feeling tired or having little energy? Never once twice three or more

Poor appetite or overeating? Never once twice three or more

Feeling bad about yourself? Never once twice three or more

Feel you are a letdown to yourself or others? Never once twice three or more

Trouble concentrating on things: newspaper, TV? Never once twice three or more

Feeling that you would be better off dead? Never once twice three or more

Feeling like you want to hurt yourself? Never once twice three or more

Have you been moving or speaking so slowly people notice? Never once twice three or more

Have you felt fidgety or restless moving around a lot more than usual? Never once twice three or more

IF you have experienced any of the problems listed above 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?

Not difficult at all Somewhat difficult Very difficult Extremely difficult

IF these problems have caused you difficulty, have they caused you difficulty for **two** years or more?

_____ YES, I have had difficulty with these problems for two years or more.

_____ NO, I have not had difficulties with these problems for two years or more.

Mood Disorder Questionnaire

The following has been developed by Hirschfield & Spitzer.

Please **CIRCLE** yes or no for what applies to you:

Has there **EVER** been a period of time……..

YES NO Have you felt so good or hyper that other people thought you were not your normal self or you were so hyper that you got into trouble.

YES NO Have you been so irritable that you shouted at people or started arguments.

YES NO Have you felt much more self-confident than usual?

YES NO Have you gotten much less sleep that usual and found you did not really miss it?

YES NO Have you been much more talkative or spoke much faster than usual?

YES NO Have you had thoughts race through your head or you could not slow your mind down?

YES NO Were so easily distracted by things around you that you had trouble concentrating or staying on track?

YES NO Have you had much more energy than usual?

YES NO Have you been much more active or did many more things than usual?

YES NO Have you been much more social or outgoing than usual, for example, you telephones friends in the middle of the night?

YES NO Have you been more interested in sex that usual?

YES NO Have you done things that were unusual for you or that other people might have thought were excessive, foolish, or risky?

YES NO Has spending money got you or your family into trouble?

YES NO Have several of these ever happened at the same time?

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 with family or friends?

No problem Minor problem Moderate problem Serious problem

YES NO Have any of your blood relatives (children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?

YES NO Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?

YES NO Does your mood ever change so rapidly that it's like someone "flipped" a switch?