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: _____

Julie Ryder P.M.H.N.P.
409 Pine Street Suite 200
Klamath Falls, OR 97601
541-273-0515

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: _____

CHILD QUESTIONNAIRE

Patient's Name: _____ **Date of Evaluation:** _____

Name of person completing this form and relationship to child: _____

How long have you known this child? _____ Date form is completed: _____

Your answers to the following questions will allow us to help you and your child more effectively. Please answer all of the questions. If you do not know the answer, write "Don't know". IF the question does not apply to this child's situation, write "N/A". Circle any particularly descriptive words. If your child is over 8, please ask for his/her input, where apprpriate.

Child's Age: _____ Sex: _____ Grade in School: _____ Name of School: _____

Who is living at home, their ages, and how are they related to the patient?

If one of the biological parents does not live with the child, where does that parent live? _____

What kind of problems/symptoms prompted this evaluation to be arranged?

When did these problems first become evident?

What kind of stressful things have been going on in the child's or the parents' lives over the past couple of months or years?

Have there been any problems or changes in your child's sleep pattern recently or in the past? YES NO
If yes, please describe:

What time does the child go to bed? _____ Does the child sleep in his/her own bed? _____

How long does it take for him/her to fall asleep? _____

Is he/she harder to wake than the average child? _____ if so, describe:

How often does the child wake up during the night? _____ What wakes the child up? _____

Has the child had any weight or appetite problems in the past or more recently? YES NO
Describe:

Have there been any problems with or fluctuations of the child's energy level? YES NO
Describe:

Does the child have frequent crying spells? YES NO If yes, How often and since when? _____

What kinds of things does your child enjoy doing when he/she feels well?

Has he/she been doing these things lately? YES NO

Have there been any problems with or a change in grades or the ability to learn? YES NO
Describe:

How long has this been going on?

Circle any frequent school problems your child has had prior to age 7:

fidgeting being a chatterbox listening to the teacher concentrating being "hyper"

forgetfulness feeling dumb losing assignments being disorganized misbehaving

Draw a BOX around the items that continue to be a problem for your child.

Approximately what **percentage** of the time does your child seem to have the following feelings or mood?
Sad? _____

Apathetic, bored, blah, "don't give a hoot about anything"? _____

Nervous, worried, tense, frightened? _____

Irritable, short-tempered, argumentative, easily frustrated? _____

When did these mood problems start? _____

Has your child made statements suggesting that he/she feels hopeless, helpless, worthless or guilty? YES NO
("Nobody love me", etc.) Describe:

Has your child ever talked or written about killing himself/herself (suicide)? YES NO
Describe:

Has he/she ever tried to kill himself/herself? YES NO if yes, How? _____

Does your child have problems with constipation, diarrhea, stomach aches? YES NO
Describe:

Does your child complain of headaches or pain anywhere else? YES NO
Describe:

Has your child had any panic attacks? YES NO
Has your child ever felt scared to death "out of the blue" ? YES NO
Has your child ever felt he/she was losing his/her mind? YES NO
How often does this happen? _____
Has this feeling be accompanied by any of the following;

shortness of breath chest pain heart racing dizziness sweating nausea

numbness headache discomfort around people fear of leaving his/her home or "safety zone"?

Has your child been troubled by nightmares or intrusive memories of upsetting things **that have actually happened** in the past?
Describe:

Does your child seem to worry more than the average kid his/her age? YES NO
If yes, how long has your child been a worrier? _____

What kinds of things does your child worry about?

Has your child done any quirky, repetitive or overly superstitious things? YES NO
Circle and describe:

worries about germs obsessive cleaning excessive hand-washing or bathing touching or tapping checking locks, alarms, etc.

making lists needing things to be perfect counting objects for no reason saving useless items/being a packrat plucking hair

Other: _____

Do any family members have any of the traits listed above? YES NO if yes, who? _____

Has your child shown any worrisome eating behavior? YES NO
circle and describe:

making himself/herself throw up going without food for extended periods diet pills laxatives binge eating

Other: _____

Does your child worry excessively about being separated from you? YES NO
Describe:

Does your child worry so much about his/her appearance that it interferes with school or social activities? YES NO
If yes, what does he/she think is wrong with his/her appearance?:

Is your child abnormally shy? YES NO
Describe:

Has your child ever had any of his/her senses play tricks on him/her? YES NO
(such as hearing a voice call the child's name, or a voice yelling at him/her, or telling him/her that he/she is bad, or to hurt others, seeing things that other people in the room don't see, distorted images, strange tastes or smells or peculiar sensations in the body.)
Describe:

Has your child had any frightening thoughts, or unusual beliefs, or ideas or behavior that seemed peculiar or out-of-touch with reality?
(such as thinking that the radio or TV announcer was talking directly to him/her, or that someone was out to do the child harm when that was not really the case, or that he/she had any special powers, or was cursed, etc.)
Describe:

MOOD DISORDER QUESTIONNAIRE (Modified for Children)

Has there ever been a period of time when your child was not his/her usual self?
Describe:

1. Felt so good or so hyper that other people thought your child was not his/her normal self or he/she got into trouble? --- YES NO

2.. Was so irritable that he/she shouted at people or started fights or arguments?---------- YES NO

3. Felt or appeared to feel much more self-confident than usual?---------- YES NO

4. Got much less sleep than usual and appeared as if he/she didn't really miss it?---------- YES NO

5. Was much more talkative or spoke much faster than usual?---------- YES NO

6. Thoughts raced though his/her head or your child couldn't slow his/her mind or conversation down?---------- YES NO

7. Was so easily distracted by things around him/her that he/she had trouble concentrating or staying on track?---------- YES NO

8. Had much more energy than usual?---------- YES NO

9. Was much more active or did many more things than usual?---------- YES NO

10. Was much more social or outgoing than usual? ---------- YES NO

11. Was much more interested in sex than usual for a child of his/her age?---------- YES NO

12. Did things that were unusual for him/her or that other people might have thought were excessive, foolish, or risky?----- YES NO

13. Spending money or taking things not belonging to the child got him/her or your family into trouble?---------- YES NO

If you checked YES to more than one, have several of these ever occured at the same time? ---------- YES NO

How much of a problem did any of these cause? (like being unable to work or attend school; having family, money or legal troubles; getting into arguments or fights?)

No problem Minor problem Moderate problem Serious problem

Do any of your child's blood relatives (siblings, parents, grandparents) have manic-depressive or bipolar disorder? YES NO

If yes, who?

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

Does your child's mood ever change so suddenly that it's like somebody "flipped a switch"? YES NO

Has your child ever had racing thoughts? YES NO
Circle the words that best describes nature of racing thoughts:

like a hamster on a wheel jumbled confused no logical thread between thoughts noisy mind that won't shut off

Is it possible to predict what your child's behavior will be like from one hour to the next? YES NO

Has your child ever been hospitalized for psychiatric or substance abuse problems? YES NO

if yes, when?_____ where? _____ Name of Doctor: _____

Has your child taken any medications to treat ANY psychiatric disorders? YES NO If yes, please list below:
List meds: Prescribing Dr. Response or side effects Approx. date taken meds

Has your child had any counseling or talk therapy? YES NO
if yes, who was the counselor? _____
Approximate dates

What issues were addressed?

Was it helpful?

Has your child ever suffered a concussion or a blow to the head/face?
Describe:

Has your child ever deliberately inflict pain or injury upon himself/herself? YES NO
if yes, how old was he/she?_____ What did he/she do? Describe:

Has your child ever threatened to kill anyone or deliberately inflicted pain on animals or other people? YES NO
Describe:

Does your child bully his/her peers or younger children/siblings?
Describe:

Has your child been preoccupied with fire or weapons? YES NO
Describe:

Were there any complications with the biological mother's pregnancy or delivery of this child? YES NO
If yes, describe:

Was the developing baby exposed to drugs or alcohol? YES NO

Did this child reach developmental milestones (sitting up, rolling over, walking) within the usual time frame? YES NO
if no, describe:

As a baby, was the child "colicky", "fussy", "average", or "easy"?
Describe:

Who is the child's pediatrician or family physician?

Please list and describe any significant health problems or surgeries the child has had:

For adolescent girls, have menstrual periods started? YES NO if yes, at what age_____

Is she more irritable, anxious, or depressed in the week prior to her period? YES NO

Circle any of the following health problems your child has had:

high blood pressure heart disease lung disease asthma/allergies head injury

blood sugar too high blood sugar too low glaucoma sexually transmitted disease seizures

liver disease thyroid disease unintended pregnancy kidney disease cancer

List all of the prescription, over the counter, supplements, and herbal remedies your child is on or has taken in the past few months:
currently taking: took recently, but has now stopped taking:

Has your child had problems with bedwetting beyond the age of 4 or 5 years old? YES NO
if yes, how often? _____
Have blood relatives on either side of the family wet the bed into teen-age years? YES NO

Is your child allergic to any medications? YES NO
if yes, list them:

Please list any significant *medical* illnesses among blood relatives. Who had what illness?
Specifically any thyroid disease or sleep disorders.

Please list any *psychiatric* illness you feel may have existed among blood relatives, whether evaluated and treated or not. Who had what illness? (anxiety, panic attacks, obsessive-compulsive disorder, depression, mood swings, erratic behavior, manic-depression, bipolar disorder, schizophrenia, ADHD, eating disorders, etc.)

Have any blood relatives struggled with drug or alcohol problems? Who had what problems?

Were this child's biological parents married? YES NO Separated? YES NO Divorced? YES NO

Who has custody? _____

Is there visitation schedule with non-custodial parent? YES NO

Is child support provided? YES NO

Does this child have siblings? YES NO if yes, where do they live? _____

How often does your child see them? _____

How do they get along? _____

Has DFS or foster care been involved with this child's family? YES NO if yes, why?

Please describe any learning or disciplinary problems this child has had, or is having at school:

Is there an IEP Plan at school for this child? YES NO

Has this child worked outside of the home? YES NO if yes, where? _____

Have any disability claims ever been filed on this child? YES NO if yes, what kind?

Please list any juvenile justice or other legal problems your child has had:

Does your child have a juvenile probation officer? YES NO if yes, who? _____

Have there been, or do you suspect that this child has drug or alcohol abuse problems? YES NO
if yes, describe:

Has your child experienced any of the following:

physical abuse emotional abuse sexual abuse witness of violence bullying

How many and what kind of caffeinated beverages does this child drink each day?

Does this child use tobacco products? YES NO if yes, how much? _____ when did he/she start? _____

Where does the tobacco money come from?

Please list any other concerns you wish to share with me that have not been addressed in this questionnaire.