If someone other than you is going to be paying for your care, please fill this out about that person (example: a parent, family member or friend is covering any care costs for you.) Not an insurance company.

Name: _____ Address _____

Phone Number: _____ _____

Date of Birth: _____ Social Security # _____

I give permission for this office to speak to the responsible party about my bill, if this person is someone other than the patient.

- Signature of Patient (if applicable): _____

Office Policies: Please Read Carefully

Rachael James, APRN is currently in-network with the following insurance companies: Aetna, Blue Cross Blue Shield (Blue KC), United Health Network, Cigna. If you do not receive health insurance from one of these companies, you will pay cash for your services. No provider at Mental Health Partners currently accepts Medicare or Medicaid. If you are paying cash, the first evaluation appointment is typically around $300 with subsequent follow up appointments ranging from $80-$200+ depending on the complexity and length of your appointment. *A 25% discount is applied for patients paying with cash, if the balance is paid in full on the next business day following your appointment.*

We file your insurance as a courtesy to you. If you feel the payment from your insurance company is not correct, you will need to call your insurance company. If you have two insurance carriers, please make sure you know which one is primary. If you change insurance, it is your responsibility to inform us immediately. We are required to file a claim for visits once you have given us a copy of your insurance card. We do not backdate filings, but we will file from the date we receive your (new) insurance information. If you have a visit limit per year (or day), you will need to keep track of this.

Co-pays and all patient balances are due at the appointment time. Please keep your balance at zero. Patients showing no reasonable effort at being responsible for overdue accounts will receive one written warning before being referred elsewhere for care. The overdue account may be turned over to a collections agency. Services that are "non-covered", "non-authorized", "exceeding yearly maximum" or ruled "not medically necessary" by your insurance company are payable to you. For all patients there is a fee for telephone conversations and administrative work longer than 5 minutes, both scheduled and unscheduled, and we do not bill this to insurance.

Missed appointments (or those not cancelled at least 24 hours in advance) will be billed $100. Insurance does not cover for missed appointments or late cancellations. Your provider may refer you elsewhere for treatment after three (3) missed appointments. All reminder calls/texts for upcoming appointments are a courtesy; it is up to you to remember appointment dates and times. Most patients receiving medications will be required to maintain routine follow up appointments every three (3) months at minimum.

Please take care of routine medication refills during regular appointments. When this is not possible, have your pharmacy request an electronic or faxed request. Only if an electronic/faxed refill request from pharmacy is not possible should you email your provider with refill requests. **Controlled substance refills (ex: Xanax, Adderall, Ritalin) outside of appointments will result in a $20 fee**. Think ahead about when you will be close to running out of medicine. Try to plan follow up appointments with your provider in a way that does not result in overlap without medication.

I agree to all policies listed above and I consent to be evaluated and treated by Rachael James, APRN. I authorize payment of medical benefits to the above-named health provider. I authorize release of medical information to my insurance company as needed for benefit certification. I authorize Rachael James, APRN to send a written letter to the referring doctor or therapist about my care (if applicable), and to discuss my case with other doctors and/or therapists (if applicable) whenever necessary for my treatment.

- Signature of Patient: _____ Date: _____

Pre-Appointment Paperwork for patients of Rachael James, APRN

Mental Health Partners

Legal Name (first and last): _____

Name you would you like to be called: _____

Legal Sex: _____ Age: _____ Date of Birth: _____

Gender identity and/or preferred pronouns, if different from legal sex: _____

Place of Employment and Occupation: _____

Primary Care Physician, Location, Phone Number: _____

Allergies to Medication or Food: _____

Primary Phone Number: _____ Social Security number: _____

Emergency Contact Name/Relationship: _____

Emergency Contact Phone Number: _____

Highest level of education you have completed: _____

Home address: _____ Email Address:

_____ _____

_____

Please initial one or more of the following according to your preferences:

____ My provider may email me at the above address about my care or appointment scheduling, if/when appropriate. I understand the privacy limitations of this communication method (ex: my email address may not be secure)

____ My provider may text message me if/when appropriate about my care or appointment scheduling, if/when appropriate. I understand the privacy limitations of this communication method (ex: someone may read my texts)

____ I would rather communicate with my provider over telephone only.

Did anyone (provider or therapist) refer you to this office? If so, who? _____

If you were to be prescribed medicine at your appointment, which pharmacy (name and address) would you like the medicine to be sent to?

_____

Psychiatric History

Briefly describe what problem(s) you are seeking help with.

_____

_____

_____

How long have you had these problem(s)?

_____

Have you ever received treatment from a **mental health specialist** before (ex: psychiatrist, therapist)?

YES / NO

Please list any **psychiatric diagnoses** you have ever been told that you have or may have. (ex: depression, anxiety disorder, bipolar disorder, ADHD, etc.)

_____

_____

Has anyone **prescribed you medicine** for mental illness before?

YES / NO

If yes, **when** was the last time you were prescribed medicine and **who** prescribed it?

_____

Please list any psychiatric medications that you are **currently taking**, dose and how often you take it.

MEDICINE	DOSE AND FREQUENCY TAKEN
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

[If currently on psychiatric medicine] Are these medicines working for you?

YES / MOSTLY / NOT REALLY / NOT AT ALL / I'm not on any psychiatric medicine.

Please list any psychiatric medications you have **tried in the past** and if you had any problems or side effects with them. (example: didn't work, caused too much nausea, etc)

MEDICINE (and dose, if known)	ANY PROBLEMS/SIDE EFFECTS? WHY STOPPED?
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Have you ever been hospitalized for mental health reasons?

YES / NO

If yes, when was the last time you were hospitalized? _____

Have you ever self-harmed in any way?

YES / NO

Have you ever had thoughts to end your life?

YES / NO

Are you currently seeing a therapist?

YES / NO

Would you like to start seeing a therapist?

YES / NO / I already see one.

Please write your current therapist's name and location here if you have one.

_____

Do you give your psychiatric medication provider (Rachael James, APRN) permission to collaborate with the above listed person about your diagnoses or plan of care?

YES / NO / Not Applicable

If yes, sign your name here: _____

Do you have any family members with mental illness that you know of? (examples: mom with depression, sister with ADHD, father with bipolar disorder)

_____

_____

_____

Medical History

Please list any medical conditions you have and any medications you take for those conditions.

MEDICAL CONDITIONS (examples: asthma, high blood pressure, hypothyroidism)

_____

_____

_____

MEDICINE	DOSE AND FREQUENCY TAKEN
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please list any over the counter medications you are currently taking. (Example: sleep aides, vitamins, pain medicine, cold medicine)

_____

_____

Please list any surgeries you have had.

_____

_____

To the best of your knowledge, check any of the following that you have experienced:

____ Major head injury (examples: concussion, bad accident)
____Seizure
____Developmental concerns as a young child (examples: delayed growth, delayed meeting of milestones, complications with your birth)
____ Trouble with learning, reading or writing

____ To my knowledge, I have experienced none of these things.

Please circle any of the following symptoms you have suffered from in the last 2 weeks:

Fevers	Weight loss	Weight gain	New blurry vision	Dry mouth
Ears ringing	Fast heart rate	Chest pain or tightness	Shortness of breath	Cough
Constipation	Diarrhea	Nausea/Vomiting	Urinary problems	Low sex drive
Lethargy	Weakness	Falls	Increased sweating	Memory problems
Headaches	Dizziness	Heat/Cold sensitivity	Tremor / any involuntary movement	Bruising easily or bleeding
Hives, rashes or other skin problems	Pain (anywhere)	Grinding teeth or clenching jaw	Trouble sleeping	Nightmares or night terrors
None of these things have been bothering me.				

___ I am suffering from other physical symptoms that were not listed above, including:

_____

_____

Is there any chance that you could be pregnant?

YES / NO / Not applicable

Are you trying to become pregnant or hoping to do so in the next year?

YES / NO / Not applicable

Social History

Please briefly describe your living situation (example: house with spouse and kids, apartment with roommates, apartment alone, etc.)

_____

Please respond to the following questions with the answer that you feel best fits:

1. Overall, I would say I had a "good" childhood.

AGREE PARTIALLY AGREE/UNSURE DISAGREE

2. I feel like my parents (or primary caretakers) provided me with good physical and emotional support.

AGREE PARTIALLY AGREE/UNSURE DISAGREE

3. I mostly did well in school as a child/teen.

AGREE PARTIALLY AGREE/UNSURE DISAGREE

4. I feel safe in the place I currently live, with the people I live with.

AGREE PARTIALLY AGREE/UNSURE DISAGREE

5. I am happy in my current romantic relationship(s).

AGREE PARTIALLY AGREE/UNSURE DISAGREE NOT APPLICABLE

6. I am happy with my social life and generally feel well-supported by friends and/or family.

AGREE PARTIALLY AGREE/UNSURE DISAGREE

7. I worry about not having enough money to pay for what I need.

AGREE PARTIALLY AGREE/UNSURE DISAGREE

8. I have experienced something (or many things) in my life that I would consider "traumatic", very scary or very sad.

AGREE PARTIALLY AGREE/UNSURE DISAGREE

9. I have experienced abuse in any form at any point in my life.

AGREE PARTIALLY AGREE/UNSURE DISAGREE

Screenings

PHQ9 - Over the last two weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in things	0	1	2	3
Feeling down, depressed or hopeless	0	1	2	3
Trouble falling asleep, staying asleep or sleeping too much	0	1	2	3
Feeling tired or having little energy	0	1	2	3
Poor appetite or overeating	0	1	2	3
Feeling bad about yourself, feeling like you are a failure or feeling like you have let yourself or your family down	0	1	2	3
Trouble concentrating on things, such as reading something or watching TV	0	1	2	3
Moving or speaking so slowly that other people have noticed, or the opposite – being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

My total score is _____

GAD7 - Over the last two weeks, how often have you been bothered by the following problems?

	Not at all	Several days	More than half the days	Nearly every day
Feeling nervous, anxious or on edge	0	1	2	3
Not being able to stop or control worrying	0	1	2	3
Worry too much about different things	0	1	2	3
Trouble relaxing	0	1	2	3
Easily annoyed or irritable	0	1	2	3
Feeling restless and hard to sit still	0	1	2	3
Feeling afraid, like something awful might happen	0	1	2	3

My total score is _____

Rapid Mood Screen – circle "yes" or "no" to the following questions:

Have there been at least 6 different periods of time (at least 2 weeks) where you felt deeply depressed?	YES	NO
Did you have problems with depression before the age of 18?	YES	NO
Have you ever had to stop or change your antidepressant because it made you highly irritable or hyper?	YES	NO
Have you ever had a period of at least 1 week in which you felt more talkative than normal with thoughts racing in your head?	YES	NO
Have you ever had a period of at least 1 week during which you felt any of the following: unusually happy, unusually outgoing or unusually energetic?	YES	NO
Have you ever had a period of at least 1 week where you felt like you didn't **need** to sleep as much as you usually do?	YES	NO

ASRS - Put an X in the box that best describes how you have felt and conducted yourself over the past 6 months.

	NEVER	RARELY	SOME-TIMES	OFTEN	VERY OFTEN
How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
How often do you have difficulty getting things in order when you have to do a task that requires organization?					
How often do you have problems remembering appointments or obligations?					
When you have a task that requires a lot of thoughts, how often do you avoid or delay getting started?					
How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
How often do you feel overly active and compelled to do things, like you were driven by a motor?					

	NEVER	RARELY	SOME-TIMES	OFTEN	VERY OFTEN
How often do you make careless mistakes when you have to work on a boring or difficult project?					
How often do you have difficulty paying attention when you are doing boring or repetitive work?					
How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
How often do you misplace or have difficulty finding things at home or work?					
How often are you distracted by noise or activity around you?					
How often do you leave your seat in meetings or other situations in which you are expected to sit still?					
How often do you feel restless or fidgety?					
How often do you have trouble unwinding and relaxing when you have time to yourself?					
How often do you find yourself talking too much in social situations?					
When you're in a conversation, how often do you find yourself finishing the sentences of people you are talking to, before they can finish them themselves?					
How often do you have difficulty waiting your turn in situations where this is required?					
How often do you interrupt others when they are busy?					

Do you ever feel like you need to check something over and over to make sure it is done properly? YES / NO

Do you ever experience unpleasant, unwanted thoughts that seem silly, nasty or horrible? YES / NO

Are there things you feel you must do excessively or thoughts you must think repeatedly in order to feel comfortable? YES / NO

Alcohol screening questionnaire (AUDIT) – answer the following questions and add up final score.

Scoring	0 points per question	1 point per question	2 points per question	3 points per question	4 points per question
How often do you have a drink containing alcohol?	Never	Monthly or less	2-4 times per month	2-3 times per week	4+ times per week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1-2	3-4	5-6	7-9	10+
How often do you have more than 5 drinks in one sitting?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you have you found that you could not stop drinking once you started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you failed to do something that was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often during the last year have you had a feeling of guilt or remorse about your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, during the last year
Has a relative, friend, doctor or other health worker been concerned about your drinking and suggested you cut down?	No		Yes, but not in the last year		Yes, during the last year
				Total points: _____	

Do you smoke cigarettes? YES / NO, never / NO, I used to

If yes, how much do you smoke? _____ Quit date, if applicable: _____

Do you use marijuana? YES / NO

If yes, how often? _____

Have you used any of the following drugs in your lifetime? Heroin, methamphetamine, ecstasy, cocaine, LSD, PCP, opioids/narcotics or other pain medication (not prescribed).

YES / NO