Pinnacle Health Services

Pinnacle Health Services
547 E Pine Street, Suite 201
Phone (541) 423-8151 Fax (541) 423-8508

CONDITIONS OF SERVICES RENDERED

FINANCIAL AGREEMENT: I agree, whether I sign as agent or as patient, that in consideration of the services to be rendered to the patient, I hereby individually obligate myself to pay the account with Pinnacle Health Services in accordance with the regular rates and terms. Should the account be referred to an attorney or collection agency for collection, the undersigned shall pay actual attorney's fees and collection expenses.

ASSIGNMENT OF INSURANCE BENEFITS: I authorize, whether I sign as agent or as patient, direct payment to Pinnacle Health Services of any insurance benefits otherwise payable to or on behalf of the patient for the visit or for these outpatient services at a rate not to exceed Pinnacle Health Services actual charges. I understand that I am financially responsible for charges, deductibles, and co-insurance not covered by insurance.

HEALTH PLAN OBLIGATIONS: Pinnacle Health Services maintains a list of health plans with which it contracts. Pinnacle Health Services has no contract, expressed or implied, with any plan that does not appear on that list. The undersigned agrees that he/she is individually obligated to pay the full charges of all services rendered to him/her by Pinnacle Health Services if he/she belongs to a plan, which does not appear on the above- mentioned list.

RELEASE OF INFORMATION: I authorize Pinnacle Health Services to release any information necessary to provide medical treatment to me, allow Pinnacle Health Services to bill and be paid for services they provide. I understand that releasing information for any reason other than those listed above requires a separate authorization by me. I also understand that I have the right to request restrictions on the use of my health information, but Pinnacle Health Services is not obligated to honor that request unless required to do so by State or Federal regulations. This consent shall be effective as long as necessary to obtain payment.

The Terms and conditions of this agreement are not binding until the patient receives care and treatment from Pinnacle Health Services. The undersigned certifies that he/she had read the foregoing, received a copy thereof, and is the patient, the patient's legal representative, or is duly authorized by the patient as the patient's general agent to execute the above and accept its terms.

DATE: _____ PRINT NAME: _____

SIGNATURE: _____

(PATIENT/PARENT/CONSERVATOR/GUARDIAN)

If signed by other than patient, indicate relationship: _____

****** ATTENTION PATIENTS ******
Scheduled appointments that are not cancelled 24 hours in advance may incur a fee of: $50.00

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PATIENT ACKNOWLEDGEMENT FORM

Receipt of Joint Notice of Privacy Practices

By my signature below, I hereby acknowledge that I have received a copy of Pinnacle Health Services *Notice of Privacy Practices*. Pinnacle Health Services is permitted to use or disclose my health information to carry out treatment, payment or health care operations. Health information means any and all information relating to health care services provided to me, including information related to services provided to me prior to the date I sign the acknowledgement form.

I understand the Pinnacle Health Services Notice of Privacy Practices explains the types of uses or disclosures that Pinnacle Health Services may make and my rights with respect to my health information. I understand that if I have any questions or concerns about this Notice, I may contact the Office Manager at the telephone number listed below. I further understand Pinnacle Health Services may change the terms of the Notice of Privacy Practices from time to time, and that I may contact the Office Manager to obtain a revised version of the notice at any time.

Patient's Printed Name: _____ Patient's DOB: _____

Signature of Patient: _____ Date: _____

Signature other than patient: _____ Date: _____

If signed by other than patient, indicate relationship: _____

You may contact our office regarding your privacy by calling 541-423-8151

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Patient Registration Form

Please Print

Patient name _____ Date of birth _____

Mailing address _____ City _____ State _____ Zip_____

Home Phone _____ Cell Phone _____ SSN# _____-_____-_____

Email: _____Male ____ Female ____ Single ____ Married ____ Divorced ____ Widowed ____

Employer _____ Phone _____

Spouse's name _____ Date of birth _____

Spouse's SSN# _____-_____-_____ Phone _____

Spouse's Employer _____ Phone _____

Emergency Contact

Medical Insurance Information

Primary Insurance _____

ID Number _____ Group Number _____

Insured name _____ Date of birth _____

Secondary Insurance _____

ID Number _____ Group Number _____

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PINNACLE HEALTH SERVICES CANCELLATION and NO-SHOW POLICY:

Your appointments are very important to Pinnacle Health Services. They are reserved especially for you. We understand that sometimes schedule adjustments are necessary. Therefore, we respectfully request at least 24-hour notice for cancellations or rescheduling of appointments.

Please understand that when you forget, cancel, or change your appointment without giving enough notice, we miss the opportunity to fill that appointment time, and clients on our wait list miss the opportunity to receive the care they need.

A "No-Notice/No-Show" is someone who misses an appointment without notice. We have voicemail which is able to receive messages 24 hours a day.

If arriving late for your scheduled appointment, please understand that our providers require a specific amount of time to treat and provide you with excellent care. Arriving late may result in a loss of appointment and charged a late fee.

Please read the following statements and initial:

_____ If a patient No-Notice/No-Shows their New Patient Appointment the patient must pay a $50 "No Notice/No-Show" fee in order to reschedule New Patient Appointment. If a second New Patient Appointment is "No-Notice/No-Showed", the patient will not be able to establish care.

_____ Patient must arrive to new patient appointment with paperwork completed. If New Patient Paperwork is not complete 10 minutes past appointment start time, patient cannot be seen and will be asked to reschedule. Late arrivals for New Patient Appointment may be subject to a $50 fee.

_____If a patient No-Notice/No-Shows a follow up appointment a $50 fee will be billed out to the patient directly.

_____After 2 statements are sent out (60 days) without payment of fees, the patient will be sent to in-house collections and must pay balance before being allowed to reschedule follow-up appointments.

_____ After missing 3 appointments by either No-Notice/No-Show occurrences or late arrival in a 90 day period, the patient will be discharged from the clinic by manager via phone call and mailed letter.

_____ If patient arrives more than 10 minutes late for a follow up appointment patient is unable to be seen and will be charged as a "No-Notice/No-Show" occurrence. Late arrivals for a follow up appointments may be subject to a $50 fee.

By signing below, I acknowledge that I understand the terms of this form. I understand that these fees have nothing to do with my co-pay or deductible and in fact cannot be billed to my insurance company.

Print Name: _____ Date: _____

Signature: _____

If signed by Representative for patient, indicate relationship: _____

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INTAKE/BIOPSYCHOSOCIAL HISTORY FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) _____May we leave a message? ☐ Yes ☐ No

Cell/Other Phone: ( )_____May we leave a message? ☐ Yes ☐ No

E-mail: _____May we email you? ☐ Yes ☐ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Birth Date: _____ /_____ /_____ Age: _____ Gender: ☐ Male ☐ Female

Relationship Status:
☐ Never Married ☐ Engaged ☐ Domestic Partnership ☐ Married ☐ Remarried
☐ Separated ☐ Divorced ☐ Widowed

Please list any children/age: _____

Referred by (if any): ☐ Doctor ☐ Pastor ☐ Family ☐ Friend ☐ Other _____

GENERAL HEALTH INFORMATION

Describe your current physical health: ☐ Excellent ☐ Good ☐ Average ☐ Poor ☐ Very Poor

Please list any persistent physical symptoms or health concerns (e.g. chronic pain, illness, headaches, hypertension, diabetes, etc.):_____

_____

Are you currently under a doctor's care?_____ (If yes, please describe)_____

_____

_____

Physician's Name:_____ Address:_____

_____

Please list any prescription and/or over-the-counter medication you are currently taking:

_____

_____

How would you rate your current sleeping habits?
☐ Poor ☐ Unsatisfactory ☐ Satisfactory ☐ Good ☐ Very good

Please specify any sleep problems you are currently experiencing:
☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep ☐ Disturbing dreams
☐ Other_____

How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

Are you having any difficulty with appetite or eating habits? ☐ Yes ☐ No
If yes, check where applicable: ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting ☐ Purging

CHEMICAL USE

How many cups of regular coffee do you drink each day? _____ How many cups of tea? _____
How many caffeinated soft drinks? _____ How many "energy drinks?" _____
How often do you use No Doz or similar caffeine pills? _____

How often do you engage in recreational drug use?
☐ Daily ☐ Weekly ☐ Monthly ☐ Infrequently ☐ Never

How much beer, wine, or hard liquor do you consume each week on average? _____

Are there times when you drink to unconsciousness, or run out of money as a result of drinking?
☐ No ☐ Yes

Have you ever felt the need to cut down on your drinking? ☐ No ☐ Yes
Have you ever felt annoyed by criticism of your drinking? ☐ No ☐ Yes
Have you ever felt guilty about your drinking? ☐ No ☐ Yes
Have you ever felt you needed a drink first thing in the morning (eye-opener) to steady your nerves or get rid of a hang-over? ☐ No ☐ Yes

MENTAL HEALTH INFORMATION

Have you previously received any type of mental health services (counseling, psychotherapy, psychiatric services)?
☐ No
☐ Yes, previous therapist/practitioner: _____
Please describe the experience and issues you covered in therapy: _____
_____

Have you ever been prescribed psychiatric medication?
☐ No
☐ Yes
Please list and provide dates: _____
_____

Have you ever attempted suicide or had a plan to harm yourself? When? _____
_____
_____

Do you currently have any thoughts or feelings of wanting to physically harm yourself? If so, please describe your plan. _____
_____

Are you currently experiencing overwhelming sadness, grief, or depression? ☐ No ☐ Yes
If yes, for approximately how long? _____

Are you currently experiencing anxiety, panic attacks, or have any phobias? ☐ No ☐ Yes
If yes, when did you begin experiencing this? _____

PRESENTING PROBLEM(S)

In your own words, briefly describe the main problem which prompted you to seeking counseling at this time:_____

_____

_____

_____

_____

Please check any of the following that are currently troubling you. Put **two** checks by those items which are most important. You may add any comments you would like:

___Abortion/Adoption
___Adjustment Problems
___Anger/Temper
___Anxiety (worry)
___Apathy (the "blahs")
___Assertiveness
___Bitterness (Resentment)
___Breathing Difficulty
___Child Abuse
___Children (Discipline)
___Children (School)
___Communication
___Concentration
___Confusion
___Death of Loved One
___Dependent on Others
___Depression
___Dizziness
___Eating Problems
___Exhaustion
___Family Conflict
___Family Violence
___Father
___Fatigue
___Fear
___Finances
___Forgiveness
___Frustration
___Gambling
___Guilt
___Health
___Headaches
___Honesty
___Inability to Relax
___In-Laws
___Irritability
___Loneliness
___Loss of Interest
___Loss of Pleasure
___Marriage
___Mother
___Muscle Tension
___Occupation Issue
___Perfectionism
___Rape
___Rebellion
___Rejection
___Religion/Spiritual Issues
___Repetitive Ideas
___School Problems
___Separation
___Sex
___Sexual Abuse
___Shy/Awkward
___Single Parenting
___Sleep Problem
___Spouse Abuse
___Stomach/ GI Disturbance
___Stress
___Substance Use/Abuse
___Substance Abuse in Family
___Suicidal Thoughts
___Troubling Memories
___Trust
___Under-activity
___Wish to Hurt Someone
___Withdrawal

What would you like to accomplish out of your time in therapy? _____

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

		List Family Member
Alcohol/Substance Abuse	☐ yes ☐ no	_____
Anxiety	☐ yes ☐ no	_____
Depression	☐ yes ☐no	_____
Domestic Violence	☐ yes ☐no	_____
Eating Disorders	☐ yes ☐no	_____
Obesity	☐ yes ☐no	_____
Obsessive Compulsive Behavior	☐ yes ☐no	_____
Schizophrenia	☐ yes ☐no	_____
Suicide Attempts/Completion	☐ yes ☐no	_____

OCCUPATIONAL/SOCIAL

Are you currently employed? ☐ No ☐ Yes

If yes, what is your current employment situation? _____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

How would you describe your personality? _____

_____

What do you consider to be some of your strengths? _____

_____

What would you say are the three areas you need the most growth in?_____

_____

Are you satisfied with your current social life? Please explain:_____

_____

Are you involved with any social groups, churches, activities, hobbies, sports teams, etc.?

_____