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#** _____-_____-_____

Is it okay to leave medical information on your voicemail if we are unable to reach you? Yes_____ **No** _____

Email: _____ **Is it ok if we email you? Yes**_____ **No** _____
***Please note: Email correspondence is not considered to be a confidential medium of communication.**

Current Gender Identity: Female _____ **Male** _____ **Transgender female/trans woman** _____ **Transgender male/trans man** _____
Neither exclusively male nor female _____ **Other** _____ **Preferred Pronouns**_____

Relationship Status: Single _____ **Married** _____ **Divorced** _____ **Widowed** _____

Spouse's name _____ Date of birth _____

Phone _____

Emergency Contact

Name _____ Relationship _____ Phone _____

Medical Insurance Information

Primary Insurance _____

ID Number _____ Group Number _____

Insured name _____ Date of birth _____

Secondary Insurance _____

ID Number _____ Group Number _____

Insured name _____ Date of birth _____

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Central Point, OR 97502
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NAME: _____

REFERRAL INFORMATION

Referred by (if any):

Doctor Pastor Family Member Friend Website

Other :_____

CURRENT FAMILY/LIVING SITUATION

In order to assist us in helping you reach your goals and move forward in the direction you would like to be going in your life, it will be important for us to understand your current difficulties as well as past experiences. We kindly request that you please answer the questions that follow. Please note: The information you provide here is protected as confidential information.

Marital Status (Circle One):

Single/Married: How long ? _____

Cohabitating/Living Together: How long? _____

Divorced: How Long? _____ Number of Marriages: _____

Do you have any children? Yes No

If **yes**, please list their names, gender, ages, and with whom they live:

Name	Age	Gender	With whom they live
1.			
2.			
3.			
4.			
5.			
6.			

SOCIAL HISTORY

What are your living arrangements? (Please check one)

☐ Own house ☐ Renting a house ☐ Rent an apartment ☐ Living with relative ☐ Living with friend/roommate

☐ Homeless -- If homeless, where do you stay? _____

Have you been homeless in the past? Yes/ No If yes, please list dates._____

Are you using any community resources/services currently? Yes/ No

If yes, please describe. _____

What do you do for fun? (Hobbies & interests)_____

_____

What goals do you think we should be working on?

1. _____
2. _____
3. _____
4. _____
5. _____

REFERRAL/PRESENTING PROBLEM INFORMATION

In order to understand your situation, I would like to ask you some questions, if that is okay?

Can you take a few minutes and describe what you see as the problem(s)? What would you like help with? _____

_____

_____

_____

How often does problem occur? _____

How long does it last? _____

How serious a problem is this as far as you are concerned? _____

Who in your home (workplace, etc) is most bothered by this problem or most wants this behavior to change? _____

_____

Have you ever sought assistance for these or other problems? Yes/ No

If yes, please describe below:

Dates	Where	Diagnosis/Reason	Focus of Treatment

Have you ever been *hospitalized* on an inpatient psychiatric unit? Yes / No

Dates	Where	Diagnosis/Reason	Focus of Treatment

Please list any psychiatric medications you are currently taking, the reason they were prescribed, and medication effectiveness. Please list:

Medication(s)	Prescribed for? (mood, anxiety, etc)	Are you taking it?	Is it helping?

Are you satisfied with the treatments received? Yes/ No

Was it difficult to follow the treatment regimen? Yes/ No

Have you ever seriously considered harming/killing yourself? Yes/ No

Have you ever attempted suicide? Yes/ No If yes, please provide details.

Do you have problems controlling violent behavior/impulses? Yes/ No If yes, please give details.

FAMILY/CHILDHOOD HISTORY- DEVELOPMENTAL INFLUENCES

I'd like to know more about your history and what impacted you most growing up.

Place of birth? _____ Who raised you? _____

Who else lived at home when you were growing up? (e.g., siblings, extended family, others?)

Were you ever made to feel ashamed (embarrassed, humiliated)? What happened?

Has anyone in your family ever been treated for a psychiatric disorder or emotional problem? If yes, who? And for what?

EDUCATION

Did you graduate from High School? Yes/ No If not, what was your highest grade completed in school? _____

Did or are you attending Trade/Technical School or a College/University? Yes/ No
If yes, what did you study? _____

What was your highest year completed in tech school or college? _____
Did you earn a degree? Yes / No
If so, what is the degree? _____

Are you in school now? No Part-time Full-time

MEDICAL HISTORY

Do you have any chronic medical problems (e.g., diabetes, high blood pressure, heart problems)?

_____

_____

_____

DRUG AND ALCOHOL HISTORY

Below are listed most substances that some people may use and/or abuse. For each substance you have previously or are currently using, please fill in the requested information so that we can be aware of possible interactions with your medications and provide better treatment.

Tobacco (cigarettes or chew)

Age started: _____ # of years used: _____ Date last used: _____

Pattern of use: Continuous / Off and on/ Other: _____ Amount of typical daily use: _____

How often do you currently use this substance? _____

Do you feel you have a problem with this substance? Yes / No/ Not sure

Alcohol

Age started: _____ # of years used: _____ Date last used: _____

Pattern of use: Continuous / Off and on/ Other: _____ Amount of typical daily use: _____

How often do you currently use this substance? _____

Do you feel you have a problem with this substance? Yes/ No/ Not sure

Marijuana

Age started: _____ # of years used: _____ Date last used: _____

Pattern of use: Continuous/ Off and on/ Other: _____ Amount of typical daily use: _____

How often do you currently use this substance? _____

Do you feel you have a problem with this substance? Yes/ No/ Not sure

Other: _____

Age started: _____ # of years used: _____ Date last used: _____

Pattern of use: Continuous/ Off and on/ Other: _____ Amount of typical daily use: _____)

How often do you currently use this substance? _____

Do you feel you have a problem with this substance? Yes/ No/ Not sure

Have you had treatment/rehabilitation for addictions? Yes / No If yes, when, and where? Do you attend AA or NA? Yes No

EMPLOYMENT HISTORY

Are you currently employed? Yes/ No

If **yes**, what is your job? _____When did you begin this job? _____

Are you having any difficulties with your job? Yes/ No

If **yes**, please describe:

_____

_____

_____

If unemployed, when & what was your last job?

Period of Last Employment Description of Last Job

What kind of work would you like to do in the future?

Do have you enough money to cover your basic expenses? Yes/ No

SPIRITUAL/PERSONAL INFORMATION

Who or what gives meaning to your life now?

_____

Do you have family and/or friends that you can trust and rely on for emotional support? If so, who and why? _____

_____

What helps you get through difficult situations? _____

Is there anything else that would be important to know that would help in planning your treatment?

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Therapy Agreement & Informed Consent

Leslie Rheault, LPC, Shannon Modjeski, LPC, Bronson Dull, LCSW,
Kacy Mullen, PhD

Before starting mental health therapy, it is important to know what to expect, and to understand your rights as well as commitments. This consent form is an attempt to be as transparent with you as I can about the therapy process, so you are fully informed prior to starting treatment. I will give you a copy to take home.

Treatment Philosophy

- Mental health therapy is a process of opening up about your life experiences and your genuine thoughts and feelings in order to increase your self-awareness of psychological and emotional conflicts that keep you stuck in unwanted patterns. This means we will focus on helping you uncover the root causes, thought patterns, emotions, and actions that contribute to current life distress. For the therapy to be most successful, you will have to work on things we discuss both during our sessions and at home. I may also make other appropriate referrals if I find it necessary (I.e., psychiatric evaluation; neuropsychological evaluation). Remember, you always retain the right to request change in treatment or to refuse treatment at any time.

- The therapy may involve temporary periods of discomfort as you begin to work through past trauma or confront psychological conflicts you have previously been avoiding. You may experience uncomfortable feelings like sadness, guilt, anger, frustration, loneliness and helplessness. On the other hand, therapy has been shown to have many benefits. Therapy often leads to better relationships, solutions to specific problems, and significant reductions in feelings of distress.

- Your psychotherapy sessions will be approximately 50-60 minutes in length and are generally conducted once per week. We will discuss if a different meeting frequency (i.e., once every two weeks) will work best depending on your specific situation.

- Treatments supported by research to help people with specific problems are generally shorter-term in nature (e.g., 16-20 sessions). By learning helpful skills and ways of thinking about your concerns in treatment, clients often find they are well equipped to manage on their own or with occasional support.

- **APPOINTMENT RESCHEDULING OR CANCELING**: Once an appointment is set, that time is reserved for you. I cannot typically fill that time within 24 hours. Therefore, APPOINTMENTS MUST BE RESCHEDULED OR CANCELED **48 HOURS IN ADVANCE**; I may make an exception for a true emergency.

- I can be reached at the clinic by calling (541) 423-8151. I am often not immediately available by telephone. I do not answer my phone when I am with clients or otherwise unavailable. At these times, you may leave a message on the clinic's confidential voicemail and your call will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear from me or I am unable to reach you, and you feel you cannot wait for a return call or if you feel unable to keep yourself safe: 1) contact Jackson County Mental Health Crisis Line (541-774-

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Therapy Agreement & Informed Consent Continued:

8201); 2) go to your Local Hospital Emergency Room; 3) Contact the Mental Health National Helpline at 1-800-662-4357; or 4) call 911 and ask to speak to the mental health worker on call.

- According to the laws in many states and all professional ethics codes, any kinds of sexual conduct or asking for sexual conduct, or sexual misconduct by a mental health provider with a client is illegal, as well as unethical.

Initial Intake/Evaluation

- The purpose of the intake process is to fully evaluate your needs and ensure you receive the best treatment possible. The evaluation itself may vary across clients and may include activities such as completing a structured interview (i.e., every client is asked the same questions to ensure comprehensiveness), questionnaires, or several other options.

- By the end of this intake period (first 1-2 sessions), I will be able to offer you an initial impression of your needs and a plan for what treatment might include if you decide to continue with therapy. If we are unable to work together, I will provide you with a list of referrals.

Scope of My Services

- I am qualified to work with a wide variety of clients and problems, but sometimes I may not have the training needed to address a particular concern. If this is the case, I will discuss it with you and make sure that you receive a referral to another professional who is better qualified to serve you.

- Also, if you are having current hallucinations/ delusions, severe thoughts of suicide or self- harm, or extreme mood swings, you may need more support than I can offer you through weekly psychotherapy, and I reserve the right to refer you to a different or more intensive treatment if I believe you exceed the level of care I can offer.

LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. However, there are limits to this confidentiality that you should know about.

Duty to Warn and Protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to the legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

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Therapy Agreement Continued…

Abuse of Children and Vulnerable Adults

If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/ or legal authorities.

Minors/ Guardianship

Parents or legal guardians of non-emancipated minor clients may have the right to inspect the clients records unless the health care provider determines that access to the client's record would have a detrimental effect on the providers' professional relationship with the minor client, or the minor's physical safety or psychological wellbeing.

GENERAL CONSENT TO DO PSYCHOTHERAPY

- I have read and fully understand these client policies and give my full-informed consent.
- I apply for and consent to psychotherapy with Dr. Kacy Mullen,PhD, Leslie Rheault, LPC , Shannon Modjeski, LPC, Bronson Dull, LCSW
- I further understand that I am responsible for payment even though my insurance company may or may not reimburse me at a later time.
- I understand any conversations over five (5) minutes in duration will be charged in fifteen (15) minute increments.

_____ _____

Client Signature Date

_____ _____

Parent or Guardian Date

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Scheduling Agreement

Welcome to Pinnacle Health Services. We look forward to partnering with you in your care. It is our priority to make our clinic an environment where patients will receive the highest quality of professional care. The providers with Pinnacle Health Services are committed to maintaining a cooperative and effective relationship with their patients who have entrusted their care with us. Please review the scheduling conditions below.

❖ Coordination of care

- Should my care **lapse for 30 days** or more between sessions without my provider's recommendation, I will be transitioned to an inactive patient status.
- I understand that I can resume my care at any time but may be asked to re-establish with my provider depending on the length of absence.

❖ Scheduling

- I understand that I am responsible for scheduling and rescheduling my appointments.
- I understand that appointments cannot be scheduled for **more than 1 month in advance** without my provider's recommendation.
- I understand that should I reschedule often, even with notice; I may be limited to how many appointments can be scheduled at a time and/or be limited to scheduling too far in advance.

❖ No-Show/Late Cancellation Policy

- Should I need to cancel or reschedule my appointment, I understand I am required to give Pinnacle Health Services a full **48 hours' notice**.
- I understand that should I not give 48 hours' notice; my cancellation may be considered a late cancellation or no notice occurrence.
- I understand that a late cancellation or no notice appointment *may* incur a fee of $50 per occurrence.
- I understand that I am limited to **3** no notice or late cancellations before I will be **discharged** from Pinnacle Health Services.

❖ Payment Authorization

- I give permission to Pinnacle Health Services to hold my credit card on file and authorize automatic payments should I incur any cancelation/no show fees.
  - I have given the **credit card ending in: _____ (last 4)** and agree to maintain a valid card on file as long as I remain an active patient.

- I understand my card will be charged on the same day as the occurrence.

Please read the following statements and initial:

_____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.

_____ 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.

My signature acknowledges that I understand and agree to the terms listed above. I understand my responsibility as a patient with Pinnacle Health Services.

Printed Name _____ _____

Date

Signature: _____

Pinnacle Health Services Screening Questionnaire*

Name: _____

In order to help you move forward in the direction you would like to be going in your life, we would appreciate learning more about what problems or difficulties you might be experiencing as well as what you would like to see change in your life.

Over the ***last two weeks***, how often have you been bothered by any of the following problems?
(please circle your answer & **check the boxes that apply to you**)

	Not at all	Several days	More than half the days	Nearly Every day
1. Little interest or pleasure in doing things	0	1	**2**	**3**
2. Feeling down, depressed, or hopeless	0	1	**2**	**3**
3. ☐ Trouble falling or staying asleep, or ☐ sleeping too much	0	1	**2**	**3**
4. Feeling tired or having little energy	0	1	**2**	**3**
5. ☐ Poor appetite or ☐ overeating	0	1	**2**	**3**
6. Feeling bad about yourself or that you are a failure or have let yourself or your family down	0	1	**2**	**3**
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	**2**	**3**
8. ☐ Moving or speaking so slowly that other people could have noticed, or ☐ the opposite - being so fidgety or restless that you've been moving around a lot more than usual	0	1	**2**	**3**
9. ☐ Thoughts that you would be better off dead, or ☐ hurting yourself in some way	0	**1**	**2**	**3**

Total

(10)

add columns: _____ _____ _____ _____

1. Feeling nervous, anxious or on edge	0	1	**2**	**3**
2. Not being able to stop or control worrying	0	1	**2**	**3**
3. Worrying too much about different things	0	1	**2**	**3**
4. Trouble relaxing	0	1	**2**	**3**
5. Being so restless that it is hard to sit still	0	1	**2**	**3**
6. Becoming easily annoyed or irritable	0	1	**2**	**3**
7. Feeling afraid as if something awful might happen	0	1	**2**	**3**

Total

(8)

add columns: _____ _____ _____ _____

*adapted from PhQ 9, GAD7, PC-PTSD and AUDIT 1/24/11

Please also complete back side →

Are you currently in any physical pain?	No	Yes

In your life, have you ever had any experience that was so frightening, horrible, or upsetting that, ***in the past month***, you:

1. Have had nightmares about it or thought about it when you did not want to?	No	Yes
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	No	Yes
3. Were constantly on guard, watchful, or easily startled?	No	Yes
4. Felt numb or detached from others, activities, or your surroundings?	No	Yes

What are the top 1-3 things you would like to see change in your life right now?

1. _____
2. _____
3. _____

What are the most important reasons why you want to make the changes above?

What goals would you like to work on with a counselor/therapist, if any?

Thank you for taking the time to complete this questionnaire. We look forward to working with you on your goals!