NEW PATIENT INTAKE FORMS

1. *Print out forms (PLEASE PRINT **ONE-SIDED ONLY** FOR FILING PURPOSES)*
2. *Read through forms & complete accordingly*
3. *Bring completed forms with you to your first appointment*

Thank you!

Rachel B. Kelley, PMHNP-BC, MSN
209 N. 4th St.
Highlands, NC 28741
Ph: 828.526.3241 | Fax: 828.482.9019
Email: rachelbkelleyllc@gmail.com
Website: HighlandsPsychiatry.com

Rachel B. Kelley, PMHNP-BC, ARNP, MSN
Nationally Board Certified

PATIENT INFORMATION:

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE INITIAL:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

SEX: _____ **MARITAL STATUS (CIRCLE):** **SINGLE** **MARRIED** **OTHER**

DATE OF BIRTH: _____ **EMAIL:** _____

PHONE (REQUIRED) CELL: _____ **HOME:** _____

PREFERRED PHONE (CIRCLE): **C** **H**

PATIENT EMPLOYER INFORMATION (CIRCLE): **EMPLOYED** **STUDENT** **OTHER**

COMPANY: _____ **JOB TITLE:** _____

RESPONSIBLE PARTY INFORMATION:

LAST NAME: _____ **FIRST NAME:** _____ **MIDDLE INITIAL:** _____

ADDRESS: _____ **CITY:** _____ **STATE:** _____ **ZIP:** _____

PHONE: _____ **TYPE:** _____

DATE OF BIRTH: _____ **RELATIONSHIP TO PATIENT:** _____

PATIENT'S PRIMARY CARE DOCTOR:

DOCTOR: _____ **NAME OF PRACTICE:** _____

PHONE: _____ **ADDRESS:** _____

EMERGENCY CONTACT: _____ **PHONE NUMBER:** _____

I hearby authorize payment to be made at the time services are provided. I also authorize the Provider to release any information acquired in the course of treatment, necessary to process insurance claims.

_____

PATIENT OR RESPONSIBLE PARTY SIGNATURE **DATE**

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SCREENING

Have you ever been treated for…? Check all that apply.

Depression	
Bipolar Disorder	
Generalized Anxiety Disorder	
Post-Traumatic Stress Disorder	
Attention Deficit Disorder	

If yes, did treatment include medication (circle): YES NO

Have you ever been treated for any of the following? Check all that apply.

Alcohol Abuse	
Cancer	
Chronic Pain	
Diabetes	
Drug Abuse	
Heart Disease/ Stroke	
HIV	
Seizure Disorder	
Thyroid Problem	
None of the above	

Have you ever attempted suicide? Please circle. YES NO

THE HANDS DEPRESSION SCREENING TOOL

Over the past two weeks, how often have you:	**None or little of the time**	**Some of the time**	**Most of the time**	**All of the time**	For staff use only
1. been feeling low in energy, slowed down?					
2. been blaming yourself for things?					
3. had poor appetite?					
4. had difficulty falling asleep, staying asleep?					
5. been feeling hopeless about the future?					
6. been feeling blue?					
7. been feeling no interest in things?					
8. had feelings of worthlessness?					
9. thought about or wanted to commit suicide?					
10. had difficulty concentrating or making decisions?					

TOTAL SCORE: _____

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THE MOOD DISORDER QUESTIONAIRE

Please answer each question as best as you can.	**YES**	**NO**	**STAFF USE ONLY**
1. Has there ever been a period of time when you were not your usual self and…			
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?			
...you were so irritable that you shouted at people or started fights or arguments?			
...you felt much more self-confident than usual?			
...you got much less sleep than usual and found you didn't really miss it?			
...you were much more talkative or spoke much faster than usual?			
...thoughts raced through your head or you couldn't slow your mind down?			
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?			
...you had much more energy than usual?			
...you were much more active or did many more things than usual?			
...you were much more social or outgoing than usual, for example, you " " telephoned friends in the middle of the night?			
...you were much more interested in sex than usual?			
...you did things that were unusual for you or that other people might have " " thought were excessive, foolish, or risky?			
...spending money got you or your family into trouble?			
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?			
3. 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? Please circle one response only. **No Problem Minor Problem Moderate Problem Serious Problem**			
4. Have any of your blood relatives (i.e. children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?			
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?			

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Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
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's 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
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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 _____

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Inern Med.* 2006;166:1092-1097.

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MEDICATION HISTORY:

1. **PLEASE LIST ANY ALLERGIES TO MEDICATIONS:**

2. **PLEASE LIST ALL CURRENT PSYCHIATRIC MEDICATIONS YOU ARE CURRENTLY TAKING, (including time started, dosage, and effectiveness):**

3. **PLEASE LIST ALL PAST PSYCHIATRIC MEDICATIONS YOU HAVE TRIED IN THE PAST, (go back as far as you can remember and be as detailed as possible, time period taken, dosage, and effectiveness):**

4. **PLEASE LIST ANY OTHER NON-PSYCHIATIRC MEDICATIONS YOU ARE CURRENTLY TAKING (you may provide a separate list for these if you have that available):**

Rachel B. Kelley, PMHNP-BC, ARNP, MSN
Phone: 828-526-3241 | Fax: 828-482-9019

CONSENT FOR RELEASE OF CLIENT INFORMATION

Client Name: _____ DOB:_____

I hearby authorize Rachel B. Kelley, PMHNP-BC to… ☐ release ☐ obtain specified information in my medical/client/educational record for the purpose of continued mental health care.
Individual, Facility, or Organization: _____

Address: _____

Phone #: _____ Fax #: _____

This data shall include the available items checked below:

☐ Initial Evaluation
☐ Progress/Treatment Notes
☐ Psychological Testing
☐ Medication Log
☐ Laboratory Results
☐ Other: _____

Dates of Treatment: From: _____ To: _____

Disclosure and/or exchange of the protected health and account information as authorized above may include communication by phone, fax, or mail. This disclosure and/or exchange may include information regarding drug, alcohol or sexual abuse, psychological or psychiatric impairments, HIV and/or AIDS or other physical conditions. If the authorized individual or entity that receives or releases this information is not a health insurance plan or health care provider covered by federal privacy regulations (HIPAA), the released information may be re-disclosed at will by the recipient or sender without the consent of the patient or guarantor and may no longer be protected by federal or state law. *If I refuse to sign this form, I understand that it will not adversely affect my ability to receive health care services, reimbursement for services, enrollment in a health plan or eligibility for health benefits.* Unless otherwise revoked in writing, this authorization will automatically expire one year from the date signed.

☐ Diagnosis of a Substance use disorder

I have read and understood the above statements and I consent to the release of the protected health and account information as indicated above. I also understand that there may be costs incurred with this request. Any such costs will be in compliance with State copying laws.

_____ _____
Client (or Guardian's) Signature **Witness**

Date _____

RETURN FAX: (828) - 482 - 9019

Rachel B. Kelley, PMHNP-BC, ARNP, MSN
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OFFICE POLICIES

"NO CALL – NO SHOW" POLICY

WE RESPECTFULLY REQUEST THAT IF YOU MUST CANCEL OUR SCHEDULED APPOINTMENT, YOU PROVIDE THE OFFICE WITH A MINIMUM OF A 24 HOUR NOTICE VIA PHONE CALL OR ELECTRONIC MESSAGE.

IF FOR ANY REASON YOU DO NOT MAKE YOUR APPOINTMENT AND FAIL TO NOTIFY US, YOUR ACCOUNT WILL BE CHARGED FULL PRICE FOR THE MISSED APPOINTMENT.

IF THERE HAS BEEN A HISTORY OF THREE "NO CALL – NO SHOWS", YOU MAY BE TERMINATED FROM THE PRACTICE.

INITIAL _____

PRESCRIPTION REFILLS

WE ASK THAT ALL REFILLS NEEDED, BE REQUESTED THE TIME OF YOUR SCHEDULED OFFICE VISIT. IF PRESCRIPTION REFILLS ARE REQUESTED BETWEEN OFFICE VISITS, THERE WILL BE A $100 CHARGE FOR EACH SUCH OCCURANCE.

INITIAL _____

FORMAL OR PROFESSIONAL LETTERS

IF A "FORMAL OR PROFESSIONAL" LETTER IS REQUESTED TO BE WRITTEN ON YOUR BEHALF, THERE WILL BE A $150 CHARGE FOR THIS SERVICE.

INITIAL _____

_____

PATIENT SIGNATURE

_____

PRINT NAME

_____

DATE

WE APPRECIATE YOUR CONSIDERATION AND UNDERSTANDING.
KIND REGARDS,
RACHEL B. KELLEY, PMHNP-BC, ARNP, MSN

Rachel B. Kelley, PMHNP-BC, ARNP, MSN
Nationally Board Certified

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES"

THIS ACKNOWLEDGEMENT THAT WE PROVIDED YOU THE OPPORTUNITY TO REVIEW OUR "NOTICE OF PRIVACY PRACTICES" IS REQUIRED BY FEDERAL LAW. Thank you for your cooperation. **Note: This document is located on highlandspsychiatry.com/forms for you to review, but does not need to be printed.*

I, _____, acknowledge that I have received from Rachel B. Kelley, PMHNP-BC, the "Notice of Privacy Practices" and have adequate opportunity to read and review the document.

MEDICAL RECORDS CONSENT

I, _____, understand that if I have been referred by a Provider, or have been referred to a Provider outside of Rachel B. Kelley, PMHNP-BC, all pertinent information may be shared with the that provider.

CONSENT TO TREATMENT

I, _____, agree to receive treatment from Rachel B. Kelley PMHNP-BC. I understand that I can withdraw this consent to treatment at any time. A withdrawal of consent will be done in writing and I will include the reason for withdrawal.

_____ _____

Patient or Responsible Party Signature **Date**