Neuropsychology, Psychiatry, and Behavioral Health Services
209 S. Montana St. STE B Ph: (406) 646-2470
Butte, MT 59701 Fax: (406) 299-3911

Information Form

v3.18.21 Office Use: ID verified: _____ Type:_____ Clinician:_____

Legal Name: _____ Date of Birth: _____/_____/_____ Age: _____

Preferred Name: _____ Birth Sex: _____ Gender Identity: _____ Pronoun: _____

Mailing Address: _____City _____, State _____, Zip _____

Home Phone: (____) _____-_____ Cell Phone: (____) _____-_____ Work Phone: (____) _____-_____

Preferred means of communication (when possible): ☐ Home Phone ☐ Cell Phone ☐ Texting Cell Phone ☐ Other: _____

Occupation: _____ Employer: _____

Email Address: _____ @_____ (this email will be used for telehealth)

Providing an e-mail is optional but necessary for telehealth appointments, which requires additional consent. Direct e-mail should not be considered an appropriate means to contact your provider nor confidential.

Whom can we call in case of emergency? _____ Phone # (_____) _____-_____

Are you a minor or have a legal guardian responsible for your legal, medical, financial, or other matters? ☐ No ☐ Yes
Name: _____; Relationship: _____; Contact: _____

We are asked by governmental agencies to collect this information, and your clinician wants to ensure that they are providing the best care based on your cultural and language preference. Please check one (*optional*):

☐ Asian ☐ American Indian or Alaska Native ☐ Black or African American ☐ Native Hawaiian or Pacific Islander

☐ White/Caucasian ☐ More than one race Are you Hispanic or Latino? ☐ Yes ☐ No

Billing and Insurance Information

Social Security Number: _____--_____--_____

***Why we need your Social Security Number* (SSN)**: If you (or your legal guardian) is not paying cash in full at the time of each visit, your clinician becomes a business offering credit and carrying outstanding balances on your behalf. This is true even if you are using insurance or if you do not expect to have any co-payments to make. Having your SSN allows correct identification when submitting claims or filing collections for past due balances. Your SSN is kept secure. Not providing this assumes services will be paid in cash at time of service.

Is there another person who will be making payments on your behalf who should receive the billing statement?

☐ No ☐ Yes; Name: _____ Relationship: _____ Phone # (_____) _____-_____
Address: _____

☐ No ☐ Yes; I give permission for my Provider (and/or MWPR affiliate) to discuss my billing matters with this identified person, who has agreed to making these payments on my behalf.

(You, as the Client, remain legally and financially responsible for any and all unpaid balances on your account – not the person you identified to receive the billing statements or pay on your behalf – unless you are a minor or have a legal guardian, then this person is financially responsible and will need to provide all signatures below.)

How do you prefer to cover your healthcare costs?

☐ Cash ☐ Insurance + Copay/Deductible ☐ DPHHS ☐ Attorney ☐ Other_____

If you are using insurance, be sure to provide our staff with insurance cards for photocopying. If you have a secondary insurance, please list below and present that card as well. ***You must have your insurance cards and ID at time of initial appointment or your appointment will be cancelled and rescheduled.***

If your insurance is provided through a parent, spouse, or other person – please complete Subscriber Information

Name of **Primary** Insurance Carrier: _____

Name of Insurance Subscriber: _____Subscriber's Birthdate: ___-___-_____ Subscriber's SSN: ____-____-____

Subscriber's Employer: _____ Policy Number: _____

Name of **Secondary** Insurance Carrier: _____

Name of Insurance Subscriber: _____Subscriber's Birthdate: ___-___-_____ Subscriber's SSN: ____-____-____

Subscriber's Employer: _____ Policy Number: _____

If you do not know what your insurance covers, please call them to obtain this information before your first appointment. A customer services representative should be able to explain your deductibles and expected co-pays.

Would you like to keep a secured credit card number on file to charge for co-pays and balances due? ☐ Yes ☐ No

Keeping a credit card on file is completely optional. It can be a convenient way to pay future balances, pay your co-pay at time of service, or if you prefer not having to come by the office or mail in a payment. It can also prevent interest from accruing on past-due accounts, as well as avoid costly collection actions. If you would like to have this on file, our staff will have you complete one additional form.

Important Information & Places for You (or your guardian) to Sign

There are ***several*** areas where we need your signature – or your legal guardian's signature. These include 1) allowing your clinician to speak with your medical providers or others you or your legal guardian deem appropriate, 2) allowing us to bill your insurance for services, 3) assuring you or your legal guardian understands billing procedures, and 4) acknowledging you or your legal guardian received information about your clinician, office policies, limits of confidentiality, protecting the privacy of your healthcare record, etc.

1. ***I give my permission for my clinician to speak with my primary/other care providers under the following conditions***:
Check one box

☐ I *do not have a primary care physician, this doesn't apply, or I prefer my primary care provider not be contacted.*

☐ *My clinician can communicate information about my visits, as needed, to*: _____,

☐ *My clinician can also communicate with the following individuals (e.g., spouse, children, friend, other providers):*

_____, _____, _____

_____ _____

Signature of Patient - or Parent / Guardian Date

BILLING PROCEDURES, PAYMENTS, AND COLLECTIONS

If you plan to use insurance benefits to help cover evaluation and treatment costs, you will need to allow us to communicate with your insurer. Your signature below allows: 1) your clinician to release basic, confidential information about you, such as date and type of service, diagnosis, and other information required to process your claim, 2) your insurance company to pay benefits directly to your clinician to be applied to your account, and 3) your clinician to bill your insurance company in the future without you having to sign for each time. Your signature allows your MWPR provider to provide basic information to third party companies (e.g., Square, TherapyNotes, AdvancedMD) to process claims, challenge disputes, and obtain current and/or outstanding balances. This authorization is valid until withdrawn by you in writing; you can revoke this release at any time except to the extent that action has already been taken with your consent.

_____ _____

Signature of Patient - or Parent / Guardian Date

If you are using your health insurance, and on your Provider's behalf, MWPR submits charges to your insurance company and accepts the allowable amount. It is important that you are aware of your coverage, benefits, and eligibility prior to your first appointment. Your relationship is with your Provider and not your insurance company. You are ultimately responsible for the fees regardless of insurance payment or non-payment.

<u>If you are paying cash for services, or have a patient balance after insurance adjustments, the following procedures are used</u>:

1) A billing statement will be mailed to you (or whomever you requested above) the following month. Balances are due in full within 30-days from the statement date. All payments are applied in the order that visits occurred (*i.e., applied to oldest balance first*).
2) Your account will be placed in default for failure to pay toward your balance 60 days after the initial statement date.
3) Your account will be sent to a collection agency 30 days after default (i.e., about 90 days from initial statement date).
4) Should your account default and be sent to collections, you are responsible for all collection fees incurred in getting your account paid, including any attorney's fees.
5) Once your account goes to collections, your treatment may be terminated, with other treatment options provided.
6) It is your responsibility to update your mailing address – billing statements will be sent to address on file.

It is your responsibility to speak with your Provider directly or the Accounts Manager (Darren Hoffman) to set up a payment plan and/or apply for our sliding fee discount program. Payment plans are set up based on the following:

ORIGINAL OUTSTANDING CHARGES	**MINIMUM MONTHLY PAYMENT**
Up to $100	Payment in Full
$101.00 to $300.00	$50.00 per month
$301.00 to $500.00	$75.00 per month
$501.00 to $1000.00	$100.00 per month
$1001.00 to $1500.00	$150.00 per month
$1501.00 to $2000.00	$200.00 per month
$2001.00 or above	Paid in 12 months

All appointments must be cancelled prior to 24 (business) hours of the scheduled appointment. If you cancel in less than 24 business hours, or no-show an appointment, you will be charged a late-cancellation / no-show rate of $100, when applicable. After three (3) missed appointments and/or no-shows, your treatment may be terminated and you will be provided a list of other local providers to pursue treatments.

Your signature indicates your understanding and agreement regarding billing procedures, payments, collections, late cancellations, and no-show appointments:

_____ _____

Signature of Patient - or Parent / Guardian Date

Office Policies, Informed Consent for Treatment, and Protecting the Privacy of Your Health Record

Included with this intake information is a document entitled **Office Policies and Informed Consent for Treatment, as well as the Privacy Notice regarding your health record**. Let us know if you did not get one and it will be provided. Please look over this information and important policies. Governmental regulations require that we verify you received this material. Please print and sign your name below. Your clinician will sign their name and keep this page in your file.

I certify that I have received and understand the copy of "Office Policies, Informed Consent for Treatment, and Privacy Notice."

_____

Printed Name of Patient or Legal Guardian

_____ _____

Signature of Patient or Parent / Guardian Date

_____ _____

Signature of Clinician Date

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INFORMED CONSENT FOR IN-PERSON SERVICES DURING COVID-19 PUBLIC HEALTH CRISIS

This document contains important information about the decision for you to resume in-person services in light of the COVID-19 public health crisis. Please read this carefully and let me know if you have any questions. When you sign this document, it will be an official agreement between you and your provider – not between you and Mountain West Psychological Resources (MWPR) or any of its affiliates.

Decision to Meet Face-to-Face: We have agreed to meet in person for some or all future sessions. If there is a resurgence of the pandemic or if other health concerns arise, however, I may require that we meet via telehealth. If you have concerns about meeting through telehealth, we will talk about it first and try to address any issues. You understand that, if I believe it is necessary, I may determine that we return to telehealth for everyone's well-being.

If you decide at any time that you would feel safer staying with, or returning to, telehealth services, I will respect that decision, as long as it is feasible and clinically appropriate. Reimbursement for telehealth services, however, is also determined by the insurance companies and applicable law, so that is an issue we may also need to discuss.

Risks of Opting for In-Person Services: You understand that by coming to the office, you are making a voluntary decision to attend in-person visits – and as such, you are assuming the risk of exposure to the coronavirus (or other public health risk). This risk may increase if you travel by public transportation, cab, or ridesharing service.

Your Responsibility to Minimize Your Exposure: To obtain services in person, you agree to take certain precautions which will help keep everyone (you, me, and our families, my colleagues and office staff, as well as other patients) safer from exposure, sickness and possible death. **If you do not adhere to these safeguards, it may result in our starting / returning to a telehealth arrangement.**

Initial each to indicate that you understand and agree to these actions:

- You will only keep your in-person appointment if you are symptom free. ___
- You agree to have your temperature taken when you arrive at my clinic – and if your temperature is elevated, you agree to leave immediately. __
- You will wait in your car or outside - you can enter about 5 minutes before. ___
- You will use alcohol-based hand sanitizer when you enter the building. ___
- You will adhere to safe distancing (6 feet) precautions we have in the waiting room and testing/therapy room. For example, you won't move chairs or sit where we have signs asking you not to sit. ___
- You will take steps between appointments to minimize your exposure to COVID. ___
- If you or a resident of your home tests positive for the infection, you will immediately let me and/or my staff know and we will then resume [or begin] treatment via telehealth. ___

I may change the above precautions if additional local, state or federal orders or guidelines are published. If that happens, we will talk about any necessary changes.

My Commitment to Minimize Exposure: My practice has taken steps to reduce the risk of spreading the coronavirus within the office and we have posted our efforts in the office. Please let me know if you have questions about these efforts.

If You or I Are Sick: You understand that I am committed to keeping you, me, my team and all of our families safe from the spread of this virus. If you show up for an appointment and I [or my office staff] believe that you have a fever or other symptoms, or believe you have been exposed, I will have to require you to leave the office immediately. We can follow up with services by telehealth as appropriate.

If I [or my staff] test positive for the coronavirus, I will notify you so that you can take appropriate precautions.

Your Confidentiality in the Case of Infection: If you have tested positive for the coronavirus, I may be required to notify local health authorities that you have been in the office. If I have to report this, I will only provide the minimum information necessary for their data collection and will not go into any details about the reason(s) for our visits. By signing this form, you are agreeing that I may do so without an additional signed release.

Informed Consent: This agreement supplements the general informed consent/business agreement that we agreed to at the start of our work together. Your signature below shows that you agree to these terms and conditions.

_____	_____
Patient/Client	Date
_____	_____
Provider	Date

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CONSENT FOR TELEHEALTH SERVICES ELECTRONIC COMMUNICATION

Please read this carefully, and contact us if you have any questions. When you sign this document, it represents an agreement between you and your specific provider – and not between you and Mountain West Psychological Resources (MWPR) or its affiliates.

Telepsychology is defined as the provision of services using telecommunication technologies, such as telephone communication, the Internet, facsimile machines, and e-mail. Telemedicine is broadly defined as the use of information technology to deliver medical or mental health services and information from one location to another. The technology service that your provider uses to conduct telehealth videoconferencing appointments is http://doxy.me or zoom.us or another application. It is free to you, simple to use, and there are no passwords required to log in.

If you and your provider choose to use information technology for some or all of your treatment, you need to understand the following:

RIGHT TO WITHDRAW CONSENT: You have the right to withhold or withdraw consent to participate in telepsychology at any time without affecting the right to future care or treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

CONFIDENTIALITY: All existing confidentiality protections outlined in the initial consent for treatment are equally applicable when using telehealth services. Your provider will employ HIPAA-compliant telecommunication services and make every attempt to utilize only updated encryption methods, firewalls, and back-up systems to help keep your information private, but there is a risk that our electronic communications may be compromised, unsecured, or accessed by others. For these reasons, and to minimize risk, you will also need to take reasonable steps to ensure the security of communications (for example, only using secure networks for telepsychology sessions and using passwords to protect the device you use for telepsychology).

Similarly, it is equally important to remember the *limits of confidentiality* outlined in the original informed consent documentation, such as the fact that your provider is legally mandated to report the following situations: imminent risk of harm to self or others; imminent risk of mental or physical decompensation; suspected abuse of minors, the elderly and other vulnerable adults; transmission of sexually-transmitted disease; upon receipt of a court order.

RECORD KEEPING: Your provider will maintain a record of the telehealth session in the same way s/he maintains records of in-person sessions. Also, and consistent with HIPPA guidelines, your access to all medical and/or psychiatric information transmitted during a telemedicine consultation is guaranteed and available for a reasonable fee - unless your provider has reason to believe that information could cause you harm.

Your video sessions will not be recorded in any way, unless you provide explicit consent under certain circumstances. Dissemination of any of your personally identifiable images or information from the telemedicine interaction to researchers or other entities shall not occur without your consent either.

FEES: The same fee rates will apply for telepsychology as for in-person services. Based on our preliminary research, and to our knowledge, most all insurance providers allow for telehealth services at this time. However, it is your responsibility to check with you carrier to assure that services are covered. If your insurance, HMO, third-party payor, or other managed care provider does not cover electronic psychotherapy sessions, you will be responsible for the entire fee of the session. Please contact your insurance company prior to engaging in telepsychology sessions in order to determine whether these sessions will be covered.

BENEFITS AND RISKS: There are potential risks, consequences, and benefits of telemedicine.

Potential *benefits* include, but are not limited to, access to care during times of global pandemic (e.g., COVID-19), improved communication capabilities, providing convenient access to up-to-date information, consultations, support, reduced costs, improved quality, change in the conditions of practice, improved access to therapy, better continuity of care, and reduction of lost work time and travel costs.

Potential *risks* and consequences from telehealth, including, but not limited to, the possibility, despite reasonable efforts on the part of the provider, that: the transmission of your personal information could be disrupted or distorted by technical failures; the transmission of your personal information could be interrupted by unauthorized persons; and/or the electronic storage of your personal information could be unintentionally lost or accessed by unauthorized persons. Your provider utilizes secure, encrypted audio/video transmission software to deliver telehealth.

Also, if your provider believes you would be better served by another form of intervention (e.g., face-to-face services), you will be referred to a provider associated with any form of psychiatry or mental health services, and that despite your efforts and the efforts of your provider, your condition may not improve, and in some cases may even get worse.

TECHNOLOGY: If the session is interrupted for any reason, such as the technological connection fails, and you are having an emergency, do not call your provider back; instead, call 911, Montana 24-Hour Lifeline Text Line at 1-800-273-TALK, or go to your nearest emergency room. Call your provider back only after you have called or obtained emergency services.

If the session is interrupted and you are not having an emergency, disconnect from the session and your provider will wait two (2) minutes and then select the link in your email to be re-connected to the doxy.me waiting room. Your provider will then reconnect. If you are unable to reconnect within five (5) minutes, then call your provider on the phone number provided you (406-646-2470).

If there is a technological failure and you and your provider are unable to resume the connection, you will only be charged the prorated amount of actual session time.

EMERGENCIES: Assessing and evaluating threats and other emergencies can be more difficult when conducting telepsychology than during in-person appointments. To address some of these difficulties, you and your provider will create an emergency plan together for using telepsychology services. You will need to provide an emergency contact person who is near your location and who your provider can contact in the event of a crisis or emergency.

INFORMED CONSENT

By signing this form, I certify:

1. I have reviewed the entire consent for telehealth, as stated above.
2. I understand that my health care provider wishes me to engage in a telehealth service. Within this context, I understand that I have the right to revoke my consent to this treatment at any time.
3. My health care provider or a qualified staff member explained to me how the video conferencing technology that will be used will not be the same as a direct client/health care provider visit due to the fact that I will not be in the same room as my provider.
4. I understand the alternatives to counseling through telehealth as they have been explained to me, and in choosing to participate in telehealth, I am agreeing to participate using video conferencing technology. I also understand that at my request or at the direction of my counselor, I may be directed to "face-to- face" services.
5. I understand that the same limits to confidentiality, record keeping, fees, billing practices, and all other matters outlined in the initial informed consent applies to telehealth services.
6. I understand that telehealth has potential benefits, such as easier access to care and the convenience of meeting from a location of my choosing.
7. I understand there are potential risks to this technology, such as interruptions, unauthorized access, and technical difficulties. I understand that my health care provider or I can discontinue the telehealth consult/visit if the videoconferencing connections are not adequate for the situation.
8. By signing this document, I agree that certain situations, including emergencies and crises, are inappropriate for audio-/video-/computer-based psychotherapy services. If I am in crisis or in an emergency, I should immediately call 9-1-1 or seek help from a hospital or crisis-oriented health care facility in my immediate area. The contact for St. James Healthcare is 1-406-723-2500.
9. I have had a direct conversation with my provider, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.
10. I also understand that this agreement is intended as a supplement to the general informed consent that me and my provider agreed to at the outset of our clinical work together and does not amend any of the terms of that agreement. My signature below indicates agreement with its terms and conditions as well.

_____	_____	
Printed Client Name	Signed	Date
_____	_____	
Printed Parent of Guardian Name	Signed	Date
_____	_____	
Printed Provider Name	Signed	Date

Mountain West Psychological Resources

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

NAME:_____ DATE:_____

Over the last *2 weeks*, how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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 figety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns		+	+	

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

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

GAD-7 Anxiety

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
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

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	YES	NO
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?	○	○