Psychiatric Patient Practices and Consent

Welcome to Creekside Counseling. In anticipation of your upcoming appointment I'd like to provide you with information regarding patient practices that I maintain. Please review the following and sign, indicating your understanding and consent to the following as a patient under my care.

Emergency or Crisis

If there is an emergency, or if you feel you are having a safety crisis, I advise you to **call 911** and or go to the emergency department of the closest hospital. Another resource is the Behavioral Health Crisis Center of East Idaho, located at 1650 N Holmes Ave, Idaho Falls (on the corner of Holmes and Anderson). A further option is to utilize the Creekside Counseling answering service by calling 208-529-5777, listen to the end of the recorded message for the answering service number.

Communication

You may contact me at 208-529-5777. Please leave a detailed message with my office staff who will communicate your message to me. I will do my best to respond to calls within 24-48 hours. If you have a non-urgent issue occurring after office hours, you may call the office, 208-529-5777, and leave a recorded message. Recorded messages will be reviewed and addressed on the following regular office day. Again, if you feel that your issue is urgent, an emergency or crisis, call 911 and or go to the emergency department of the closest hospital, to the crisis center, or utilize the Creekside Counseling answering service by calling 208-529-5777 and listening to the end of the recorded message for the answering service number.

Prescription Refills

When you need a refill: contact your pharmacy. Your pharmacy will send a refill request to my office.

Medications will not be refilled for patients who have not attended follow up appointments as directed.

Prescription refills are not an emergency. It is your responsibility to follow your medications closely and to contact your pharmacy with enough notice for your refill to be processed without running out of medication. Refills will be addressed as soon as possible, during regular business hours only, but may take up to 2-3 business days. Refill requests are not processed after 5pm, or on weekends, holidays, days the office is closed, or days that I am not in the office.

Refills will be considered only for established patients who have been seen by the prescribing provider within the past 12 months; however, some conditions and medications require more frequent evaluation, such as every 1 to 3 months. For safety reasons, certain prescriptions may require an office visit in order to be refilled; in those cases you will be contacted to schedule an appointment.

E-Prescribing and Prescription Record History consent

To prescribe safely and conveniently, I utilize an electronic prescribing system to send your prescriptions and communicate with your pharmacy. This communication may also communicate with your Pharmacy Benefits Manager (PBM: a third party administrator used by companies and insurances to process and pay prescription drug claims). In order to prescribe to you safely, it is important that I am aware of any and all medications currently being prescribed to you, by reviewing your prescription drug history. Please sign below, indicating your consent to E-Prescribing, communicating with your PBM (if applicable), and for viewing your prescription drug history.

Patients who currently take or anticipate taking controlled substances

(such as medications for pain, sleep, anxiety, and/or ADHD)

It is my policy to obtain prescription records from pharmacies as well as review your history of controlled substance usage through the Idaho Prescription Monitoring Program, or through the controlled substance databases in states you have resided.

I do not prescribe opiate or pain medications.

Documentation

If you do require paperwork to be filled out regarding your psychiatric treatment, there may be a charge for completing the documentation, depending on the time involved.

Sign below indicating you have read, understand, agree and consent to the above

Print patient name | Print guardian name (if applicable) | Patient/Guardian signature | Date

PSYCHIATRIC INTAKE INFORMATION

CREEKSIDE COUNSELING

PLEASE DESCRIBE THE PROBLEM(S) WHICH HAVE LED YOU TO SEEK TREATMENT OR EVALUATION TODAY:

PLEASE INDICATE ANY PSYCHIATRIC DIAGNOSES THAT YOU HAVE RECEIVED OR BELIEVE YOU MAY BE STRUGGLING FROM:

☐ DEPRESSION ☐ BIPOLAR DISORDER ☐ PSYCHOTIC DISORDER ☐ ADHD ☐ PERSONALITY DISORDER ☐ AUTISM ☐ IMPULSE CONTROL
☐ ANXIETY ☐ OCD ☐ PTSD ☐ HAIR PULLING/SKIN PICKING ☐ EATING DISORDER ☐ SUBSTANCE USE ☐ OTHER: _____

PLEASE DESCRIBE ANY RECENT STRESSFUL LIFE EVENTS:

PAST OR PRESENT COUNSELING

PROVIDER	REASON	DATES AND DURATION OF TREATMENT

PREVIOUS OUTPATIENT PSYCHIATRIC TREATMENT

PROVIDER	REASON	DATES AND DURATION OF TREATMENT

PREVIOUS INPATIENT PSYCHIATRIC TREATMENT (INCLUDING DRUG OR ALCOHOL TREATMENT)

FACILITY	REASON	DATES AND DURATION OF TREATMENT

MEDICATIONS: PLEASE CIRCLE THE NAME OF ANY OF THE MEDICATION LISTED BELOW THAT HAS BEEN PRESCRIBED TO YOU:

ANTIDEPRESSANTS		MOOD STABILIZERS	ANTI-ANXIETY	SLEEPING AGENTS	STIMULANTS/ADHD	OTHERS
PROZAC	VIIBRYD	LITHIUM	XANAX	AMBIEN	RITALIN	RISPERDAL
ZOLOFT	FETZIMA	DEPAKOTE	KLONOPIN	SONATA	ADDERALL	INVEGA
PAXIL	BRINTELLIX	TEGRETOL	ATIVAN	TRAZODONE	VYVANSE	ZYPREXA
CELEXA	SERZONE	LAMICTAL	VALIUM	LUNESTA	CONCERTA	GEODON
LEXAPRO	WELLBUTRIN	NEURONTIN	TRANXENE	RESTORIL	PROVIGIL	SEROQUEL
LUVOX	AMITRIPTYLINE	TOPAMAX	LIBRIUM	HALCION	NUVIGIL	ABILIFY
EFFEXOR	NORTRIPTYLINE	GABATRIL	BUSPAR	ROZEREM	STRATTERA	LATUDA
PRISTIQ	DESIPRAMINE	TRILEPTAL	PROPRANOLOL	BELSOMRA	CLONIDINE	HALDOL
REMERON	CLOMIPRAMINE	LYRICA			INTUNIV/GUANFACINE	THORAZINE
CYMBALTA						CLOZAPINE
						ANTABUSE
OTHER:		OTHER:	OTHER:	OTHER:	OTHER:	NALTREXONE

WHAT HAS BEEN YOUR RESPONSE TO THESE MEDICATIONS IN THE PAST?

SUBSTANCE USE/ABUSE

ALCOHOL

DO YOU DRINK ALCOHOL?
☐ NO, I HAVE NEVER DRUNK.
☐ YES, IN THE PAST.
☐ YES, NOW.
☐ OCCASIONALLY ____X/MONTH
☐ I DRINK_____DAYS/WEEK
☐ I QUIT_____YEARS AGO

☐ I, OR SIGNIFICANT OTHERS, BELIEVE I HAVE, OR HAVE HAD, A DRINKING PROBLEM.

DRUGS

HAVE YOU EVER USED ILLICIT DRUGS OR MISUED PRESCRIPTION DRUGS?
☐ NEVER
☐ YES, IN THE PAST.
☐ YES, NOW.

DATE OF LAST USE: ____/____/_____
IF YES, WHAT DRUGS AND AGES WITH USE:
_____
_____

TOBACCO

DO YOU USE TOBACCO PRODUCTS?
☐ NEVER
☐ YES, IN THE PAST.
☐ YES, NOW.

TYPE: _____
HOW MUCH PER DAY?
_____

CAFFEINE

DO YOU DRINK SODA, COFFEE, ENERGY DRINKS, OR TEA?
☐ I DO NOT DRINK CAFFEINE.
☐ I DRINK _____ COFFEE/DAY.
☐ I DRINK _____ SODA/DAY.
☐ I DRINK _____ ENERGY/DAY.
☐ I DRINK _____ TEA/DAY.

HAVE YOU EXPERIENCED ANY NEGATIVE CONSEQUENCES OF YOUR SUBSTANCE USE (I.E. LEGAL, HEALTH, RELATIONSHIP PROBLEMS, JOB LOSS, ETC.)?
☐ NO ☐ YES IF YES, DESCRIBE:

PRINT PATIENT/YOUR NAME: _____

PSYCHIATRIC INTAKE INFORMATION

CREEKSIDE COUNSELING

MEDICAL HISTORY

WHAT LOCAL PHARMACY DO YOU WANT YOUR PRESCRIPTIONS SENT TO/DO YOU FILL AT? _____

☐ I HAVE NO KNOWN DRUG ALLERGIES ☐ I HAVE DRUG ALLERGIES TO:

☐ MY PRIMARY CARE PROVIDER IS: ☐ I DO NOT HAVE A PRIMARY CARE PROVIDER LAST PHYSICAL EXAM: /

PAST AND PRESENT MEDICAL CONDITIONS:

SURGERIES:

DO YOU OR HAVE YOU HAD ANY PROBLEMS WITH: (IF SO, DESCRIBE ↓)

☐	DIZZINESS/BALANCE		☐	NEUROLOGIC
☐	HEADACHE		☐	REPRODUCTIVE
☐	EAR/NOSE/THROAT		☐	MUSCLE/BONE/JOINT
☐	HEART		☐	SKIN
☐	RESPIRATORY		☐	BLOOD/IMMUNE SYSTEM
☐	GASTROINTESTINAL		☐	PAIN
☐	URINARY		☐	OTHER

HAVE YOU EVER EXPERIENCED ANY OF THE FOLLOWING:

☐	SEIZURES
☐	HEAD TRAUMA
☐	LOSS OF CONSCIOUSNESS
☐	AMNESIA
☐	OTHER PERTINENT ISSUE:

FOR FEMALE PATIENTS ONLY (PLEASE COMPLETE ALL APPLICABLE)

☐	POST-MENOPAUSAL	AGE AT ONSET OF MENSTRUATION:
☐	HYSTERECTOMY	DATE OF LAST MENSTRUAL CYCLE / /
☐	PREGNANT	
METHOD OF BIRTH CONTROL?		DATE OF LAST PELVIC/PAP EXAM: / /

CURRENT MEDICATIONS

(ALL MEDICATIONS USED IN LAST 3 MONTHS INCLUDING PRESCRIBED, OTC, HERBS, VITAMINS, ETC. ATTACH ADDITIONAL SHEETS IF NEEDED)

MEDICATION	DOSE	TIME(S) TAKEN	WHAT CONDITION IS THIS MEDICATION FOR?	PRESCRIBER

FAMILY MEDICAL HISTORY

RELATIVES WITH: (IF YES, MARK BOX)

☐ HIGH BLOOD PRESSURE ☐ HIGH CHOLESTEROL ☐ STROKE ☐ HEART ATTACK ☐ OTHER CARDIAC:

☐ DIABETES ☐ THYROID PROBLEMS ☐ CANCER ☐ NEUROLOGIC DISORDERS ☐ OTHER:

FAMILY PSYCHIATRIC HISTORY: PLEASE IDENTIFY ANY PSYCHIATRIC PROBLEMS IN YOUR BIOLOGICAL RELATIVES, SUCH AS DEPRESSION, BIPOLAR (MANIC-DEPRESSION), PANIC, ANXIETY, PTSD, SCHIZOPHRENIA, ADD/ADHD, ALCOHOL OR DRUG ABUSE, ANGER, SUICIDE

RELATIVE	YES	NO	UNCERTAIN	TYPE OF PROBLEM
MOTHER	☐	☐	☐	
MOTHER'S PARENTS AND SIBLINGS	☐	☐	☐	
FATHER	☐	☐	☐	
FATHER'S PARENTS AND SIBLINGS	☐	☐	☐	
YOUR SIBLINGS	☐	☐	☐	
YOUR CHILDREN	☐	☐	☐	

PERSONAL PSYCHOSOCIAL HISTORY

WHERE WERE YOU BORN?	DID YOU GRADUATE HIGH SCHOOL? ☐ YES ☐ NO ☐ GED
WHERE DID YOU LIVE WHILE GROWING UP? DID YOU MOVE OFTEN?	DID YOU ATTEND COLLEGE? ☐ YES ☐ NO WHAT IS YOUR HIGHEST DEGREE OF EDUCATION?

PRINT PATIENT/YOUR NAME: _____

PSYCHIATRIC INTAKE INFORMATION

WHAT WERE YOU LIKE AS A CHILD? (I.E. HAPPY, ANXIOUS, MOODY, HYPERACTIVE, ETC.)	DESCRIBE YOUR WORK EXPERIENCE (PAST AND PRESENT).
HOW MANY SIBLINGS DID YOU HAVE? WHERE DID YOU FIT IN THE ORDER OF YOUR SIBLINGS? DID YOU GET ALONG WITH THEM?	DESCRIBE ANY PAST OR PRESENT PROBLEMS WITH YOUR SEXUAL LIFE (LOW LIBIDO, PROMISCUITY, DIFFICULTY ACHIEVING ORGASM OR ERECTION, FEAR, ETC.).
DESCRIBE YOUR **FAMILY CONSTELLATION** WHILE GROWING UP (I.E. DIVORCES, REMARRIAGES, STEP-PARENTS, ETC.).	DESCRIBE YOUR ROMANTIC RELATIONSHIPS. ☐ MARRIED ☐ SINGLE ☐ DIVORCED ☐ WIDOWED MARRIED HOW MANY TIMES? _____ DO YOU OFTEN GO FROM RELATIONSHIP TO RELATIONSHIP? ☐YES ☐NO
DESCRIBE YOUR **FATHER'S OR STEP-FATHER'S PERSONALITY** AND YOUR **RELATIONSHIP** TO HIM.	HAVE YOU HAD ANY LEGAL PROBLEMS (PAST OR PRESENT)? ☐ NO ☐ YES IF YES, DESCRIBE: HAVE YOU EVER BEEN IN JAIL OR PRISON? ☐ NO ☐ YES IF YES, DESCRIBE:
DESCRIBE YOUR **MOTHER'S OR STEP-MOTHER'S PERSONALITY** AND YOUR **RELATIONSHIP** TO HER.	DID YOU EXPERIENCE **ANY TRAUMATIC EVENTS OR ABUSE** (SEXUAL, PHYSICAL, VERBAL, EMOTIONAL, NEGLECT) AT ANY TIME IN YOUR LIFE?
DESCRIBE YOUR **FAMILY RELATIONSHIPS WHILE GROWING UP** (TOO STRICT, HARSH, DIFFICULT, AFFECTIONATE, CLOSE, TOO LOOSE ETC.).	DO YOU HAVE A **RELIGIOUS OR SPIRITUAL AFFILATION**?
HOW DID YOU DO ACADEMICALLY, SOCIALLY, AND BEHAVIORALLY DURING **GRADE SCHOOL YEARS**?	WHAT ARE YOUR **HOBBIES AND INTERESTS**? ARE YOU PARTICIPATING IN THEM MUCH LATELY?
HOW DID YOU DO ACADEMICALLY, SOCIALLY, AND BEHAVIORALLY DURING **TEENAGE YEARS**?	WHAT ARE YOUR **STRENGTHS**?
DESCRIBE YOUR CURRENT SOCIAL RELATIONSHIPS. (SHY, OUTGOING, ABLE TO MAINTAIN FRIENDS, STRONG SUPPORT, FEW FRIENDS, ETC.)	WHAT ARE YOUR **WEAKNESSES**?
WHAT DO YOU HOPE TO ACCOMPLISH IN TREATMENT?	

I,_____(PATIENT NAME), DATE OF BIRTH:____/_____/_____, HEREBY AUTHORIZE CREEKSIDE COUNSELING, TO ☐RELEASE OR ☐OBTAIN MY HEALTH CARE RECORDS AS NECESSARY RELATING TO CARE THAT I ANTICIPATE TO RECEIVE OR AM CURRENTLY RECEIVING.

INFORMATION IS TO BE RELEASED OR EXCHANGED TO/WITH:

PRINT PATIENT/YOUR NAME: _____

AUTHORIZATION FOR RELEASE OF INFORMATION

(PLEASE COMPLETE AND BRING TO YOUR APPOINTMENT)

PROVIDER/FACILITY:	PROVIDER/FACILITY:	PROVIDER/FACILITY:
_____	_____	_____
TEL: _____	TEL: _____	TEL: _____
FAX: _____	FAX: _____	FAX: _____
ADDRESS: _____	ADDRESS: _____	ADDRESS: _____
_____	_____	_____
CITY ST ZIP	CITY ST ZIP	CITY ST ZIP

FOR THE FOLLOWING PURPOSES, USES OR NEEDS:

(CHECK ALL APPLICABLE)

- ☐ COORDINATION OF TREATMENT
- ☐ PROVISION OF INFORMATION TO OTHER PROFESSIONALS
- ☐ OTHER _____

THE FOLLOWING INFORMATION FROM MY RECORDS MAY BE DISCLOSED:

(CHECK ALL APPLICABLE)

- ☐ GENERAL PROTECTED HEALTH INFORMATION (PHI) (DEMOGRAPHIC DATA, DATES OF SERVICE, PSYCHIATRIC AND/OR MENTAL HEALTH ASSESSMENT AND EVALUATION, DIAGNOSIS, TREATMENT PLAN, GENERAL ASSESSMENT OF TREATMENT PROGRESS)
- ☐ TREATMENT NOTES (INCLUDING PSYCHIATRIC AND OR PSYCHOTHERAPY NOTES)
- ☐ VERBAL EXCHANGE OF PHI

MY SIGNATURE BELOW INDICATES THAT:

☐ I UNDERSTAND THAT THIS AUTHORIZATION MAY BE WITHDRAWN BY ME AT ANYTIME. REVOCATION OF THIS AUTHORIZATION WILL NOT AFFECT ANY INFORMATION ALREADY RELEASED. UNLESS THIS FORM IS PREVIOUSLY REVOKED IN WRITING, THIS RELEASE OF INFORMATION WILL REMAIN IN FORCE UNTIL SIX (6) MONTHS FROM DATE OF SIGNATURE.

☐ I UNDERSTAND THIS DISCLOSURE MAY INCLUDE PSYCHIATRIC/MENTAL HEALTH AND DRUG & ALCOHOL INFORMATION.

PRINT PATIENT NAME | PATIENT SIGNATURE (MUST BE SIGNED IF OVER 14 YEARS OF AGE) | DATE

PRINT WITNESS NAME | WITNESS SIGNATURE | DATE

CONSENT BY PERSON OTHER THAN PATIENT

IF PATIENT IS UNDER 18 YEARS OF AGE OR OTHERWISE UNABLE TO CONSENT, THE FOLLOWING MUST BE COMPLETED:

I, _____, HEREBY CERTIFY THAT I AM THE LEGAL GUARDIAN OF THE PATIENT; THAT THE CLIENT IS UNABLE TO CONSENT BECAUSE HE/SHE IS A MINOR (_____YEARS OF AGE) OR UNABLE TO CONSENT DUE TO THE FOLLOWING REASON(S): _____.

PRINT PARENT/GUARDIAN NAME | PARENT/GUARDIAN SIGNATURE (MUST BE SIGNED IF OVER 14 YEARS OF AGE) | DATE

PRINT WITNESS NAME | WITNESS SIGNATURE | DATE