# NEW CLIENT INFORMATION

Please complete **all** (12 pages) of the following new client paperwork prior to your first appointment. Once you have completed all forms please upload them through the Spruce Health app or fax them to our office.

If you have had any lab-work in the past year, please obtain a copy and bring it to your first appointment, or you can have it faxed to our office.

Office Phone: 913-382-8597 | Office Fax: 913-490-1064

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## GENERAL INFORMATION

### CLIENT INFORMATION

**First Name:**_____ **Last Name:**_____ **MI:**_____ **DOB:**_____

**Gender (Sex at birth):** ☐ M ☐ F **| Gender Identity:** ☐ Male ☐ Female ☐ Trans ☐ Non-binary

**Marital status:** ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

**Address:**_____ **City:**_____ **State:**_____ **Zip:**_____

**Cell Phone:**_____ **Work Phone:** _____ **Email:**_____

**Employer Name:**_____ **Employer Phone Number:**_____

**Emergency Contact Name:**_____ **Relationship:**_____ **Phone:** _____

### INSURANCE INFORMATION

**Insurance:**_____ **ID#:**_____ **Group #:**_____

**Policyholder Name (if not client):**_____ **Relationship:**_____**Phone:**_____

**Secondary Insurance:**_____ **ID#:** _____ **Group #:**_____

**Policyholder Name (if not client):**_____ **Relationship:**_____**Phone:**_____

### CLIENT REPORT OF PROBLEM

**Briefly describe your reason(s) for seeking help:**_____

_____

**How long have you had the issue?**_____

**What other ways have you tried to deal with this problem?**_____

_____

**Is there anything else you'd like me to know prior to our first appointment:**_____

_____

_____

# MENTAL HEALTH MEDICAL HISTORY

## PRIOR OUTPATIENT COUNSELING/PSYCHIATRY

Therapist Name:_____ Dates Seen: _____ ☐ Helpful ☐ Unhelpful
Therapist Name:_____ Dates Seen: _____ ☐ Helpful ☐ Unhelpful
Therapist Name:_____ Dates Seen: _____ ☐ Helpful ☐ Unhelpful

Psychiatrist/Psychiatric Nurse NP:_____ Dates Seen:_____ ☐ Helpful ☐ Unhelpful
Psychiatrist/Psychiatric Nurse NP:_____ Dates Seen:_____ ☐ Helpful ☐ Unhelpful
Psychiatrist/Psychiatric Nurse NP:_____ Dates Seen:_____ ☐ Helpful ☐ Unhelpful

## PRIOR INPATIENT TREATMENT

Facility Name:_____ Dates Seen:_____ ☐ Helpful ☐ Unhelpful
Facility Name:_____ Dates Seen:_____ ☐ Helpful ☐ Unhelpful
Facility Name:_____ Dates Seen:_____ ☐ Helpful ☐ Unhelpful

## FAMILY MENTAL HEALTH HISTORY

Relationship:_____ Mental/Emotional Problem(s):_____
Relationship:_____ Mental/Emotional Problem(s):_____
Relationship:_____ Mental/Emotional Problem(s):_____

## PRIOR PSYCHIATRIC MEDICATION USE

Medication Name:_____ Was it helpful? ☐ Yes ☐ No ☐ Not sure Year(s) taken:_____
Diagnosis:_____ If you had a negative reaction, please explain:_____
_____

Medication Name:_____ Was it helpful? ☐ Yes ☐ No ☐ Not sure Year(s) taken:_____
Diagnosis:_____ If you had a negative reaction, please explain:_____
_____

Medication Name:_____ Was it helpful? ☐ Yes ☐ No ☐ Not sure Year(s) taken:_____
Diagnosis:_____ If you had a negative reaction, please explain:_____
_____

SR STEVEN RAINS
PMHNP-BC

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# CURRENT MEDICATION AND SUBSTANCE USE

## CURRENT MARIJUANA/ALCOHOL USE

**Are you currently using any form of marijuana? (<u>any</u> product containing THC, ie: lotion):** ☐ Yes ☐ No
**In what way are you ingesting?** ☐ Smoking (including vape) ☐ Oils ☐ Edibles ☐ Pills or Liquid ☐ Other
**Frequency of use:** ☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally
**Reason you started using:** ☐ Physical Pain ☐ Anxiety/Depression ☐ Recreational ☐ Other
**How long have you used marijuana:** _____

**Are you currently drinking alcohol?** ☐ Yes ☐ No | Have you ever abused alcohol? ☐ Yes ☐ No ☐ Unsure
**Frequency of use:** ☐ 1-2 Drinks Daily ☐ 1-2 Drinks Weekly ☐ A few drinks a Month ☐ On Occasion
**Is there a specific reason you drink:** ☐ Pain/Numbing ☐ Anxiety/Depression ☐ Socially ☐ Other
**Are you aware of any alcohol dependency in your family?** ☐ Yes ☐ No ☐ Maybe/Unsure

## CURRENT MEDICATION USE

**Medication Name:**_____ **Dosage:**_____
**Medication Name:**_____ **Dosage:**_____
**Medication Name:**_____ **Dosage:**_____
**Medication Name:**_____ **Dosage:**_____
**Medication Name:**_____ **Dosage:**_____
**Medication Name:**_____ **Dosage:**_____
**Medication Name:**_____ **Dosage:**_____

## ALLERGIES TO MEDICATIONS

**Medication Name:**_____ **Reaction:**_____
**Medication Name:**_____ **Reaction:**_____
**Medication Name:**_____ **Reaction:**_____

## OTHER MEDICAL CONDITIONS

**Diagnosis:**_____ **Year:**_____
**Diagnosis:**_____ **Year:**_____
**Diagnosis:**_____ **Year:**_____



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**Welcome to Steven Rains NP LLC. Please read this document which contains important information about my professional services and business policies.** A Notice of Privacy Practices for use and disclosure of Protected Health Information (PHI), is also posted in the reception area.

The law requires that I obtain your signature acknowledging that I have provided you with this information and that you have agreed to its terms. When you sign this document, it will represent a contract between us. You may revoke this contract in writing at any time. That revocation will be binding on me unless I have already taken action in reliance on it; if there are obligations imposed on me by your health insurer in order to process or substantiate claims made under your policy; or monies owed in connection with treatment.

All first appointments will be in person at my office unless there are extenuating circumstances. Future visits may be completed via telehealth using Spruce Communications based on need and insurance approval.

## PAYMENT OF SERVICE

Payment is required at the time of each visit and accepted payment options include cash, check, credit, debit, FSA and HSA cards as forms of payment. There will be a $25 charge for any returned check. You will be responsible for the fees that are charged in connection with your treatment. My fee is $250.00 for the initial visit and $150.00 for any visit following. I will submit claims directly to insurance companies for which I am a contracted provider.

I cannot guarantee payment by your insurance company. If your claim is not paid, it will be your responsibility. If your account has not been paid for more than 60 days and arrangements for payment have not been agreed upon in advance, I have the option of using legal means to secure the payment. This may involve employing the services of a lawyer or agency for collection purposes. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of the services and the amount due or other PHI allowed by HIPAA (Health Insurance Portability and Accountability Act).

## I AGREE TO THE FOLLOWING BILLING PROCEDURES

_____ (initial) My copay will be billed the day before or day of my appointment, if my payment does not clear, I will be contacted for another form of payment. If I have not met my deductible, I understand the entire visit fee will be charged instead. This fee is based on individual contracted rates with your individual insurance. Should we cancel your appointment for any unforeseen reason, your payment on file will be reimbursed.

_____ (initial) If I would like to change the card on file, this must be done so 24 hours prior to my upcoming appointment, or the card on file will be charged.

_____ (initial) I understand that payment arrangements can not be made after the transaction has been processed. Reimbursements will not be made unless due to a clerical error.

_____ (initial) I understand that remaining balances can not be carried over from appointments. My appointment must be paid in full prior to my next appointment.



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_____ (initial) Failure to cancel an appointment 24 business hours Monday thru Friday prior to the scheduled time will result in a $75 fee. You may notify us via text to the main practice phone line at 913-382-8597. Communications are timed and date stamped.

_____ (initial) Every effort is made to communicate in a timely fashion; however, I understand provider contact is not available outside of the clinic hours. Normal business hours are Monday thru Friday 8 am to 5 pm. Most calls received prior to 12:00 noon are returned the same day, however, calls made after that time may be returned the following business day. Most non-urgent questions should be reserved to the following scheduled appointment. In the event of an emergency, I understand I should call 911 or go to the nearest Emergency Room for assistance.

## I AGREE TO THE FOLLOWING PRACTICE POLICIES

_____ (initial) The first appointment will be in person at my office unless there are extenuating circumstances. Future visits may be completed using Spruce based on need and insurance approval.

_____ (initial) In the event I miss my appointment, I will be unable to receive a refill on my prescription until seen by my provider.

_____ (initial) Before contacting the office for a refill, I will double check with my pharmacy to see if there is already one on file.

_____ (initial) In the event I need an unforeseen refill prior to my next appointment, I understand I must call the office 24-48 hours before the refill is needed. Under no circumstance can refills be fulfilled the day of.

_____ (initial) I understand that under the discretion of my provider, Steven Rains PMHNP-BC, care may be terminated at any time by issuance of a 30 day notice. This is rare but will happen in the event treatment plans are not consistently followed or due to the dissolution of the therapeutic relationship.

## FEES FOR ADDITIONAL SERVICES:

Your insurance company does not typically reimburse for activities that are not a part of direct patient care. The following is a list of some activities where an additional fee is required to be paid in advance.

1. Copying your clinical record (rate based on prevailing community standard)
2. Any forms to be filled by the provider including but not limited to FMLA, work accommodations, emotional support letter, or other paperwork must be completed by appointment. We are unable to accommodate last minute appointments to fulfill these requests, please message through spruce to schedule your appointment.
3. Time spent away from the office to testify in court ($175 an hour).
4. Consultation with other entities including but not limited to attorney, school, disability insurers, workmen's compensation ($175 an hour).

_____ (initial) I understand the above costs required for any additional services by Steven Rains PMHNP-BC.



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## CONFIDENTIALITY

The law protects the privacy of all communications between the patient and the provider, social worker, or other medical provider. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements by HIPAA. Your signature on this agreement provides consent for release of information consistent with HIPAA and state law.

A summary of the circumstances in which I may disclose private health information (PHI) without your consent is as follows:

1. If there is a situation that is potentially life threatening.
2. When child abuse is known or suspected. (Reporting required by state law)
3. When the abuse of an elderly or dependent person is known or suspected. (Reporting required by state law)
4. If you commit a crime against a staff member or another person on the premises
5. If you bring charges against, or sue, your provider.
6. When ordered by the court.
7. In some cases, details of your treatment may be discussed with another clinician for the purpose of consultation. When this is done, no identifying information will be included (ie, the patient is anonymous).
8. In some cases, records may be audited by the quality improvement activity of your insurance company.
9. If it becomes necessary to refer your account to a collection service. Only information to pursue collection will be released.

_____(initial) I understand the above circumstances in which Steven Rains PMHNP-BC does not need my permission to disclose private health information.

## TELEHEALTH AGREEMENT

Under certain circumstances and at the discretion of the provider, Telehealth may be used for an appointment via the HIPAA protected Spruce Communications App. Please review the following statements and initial:

1. I understand that I am required to use the Spruce Communication desktop, IOS or Google app for my telecommunication between my provider and myself for evaluating, testing, and diagnosing my medical conditions.
2. I understand that in the event technical difficulties occur during my telehealth session, my appointment may not be started or ended as originally intended.
3. I accept that my provider can contact interactive sessions via video call; however, I am informed that the sessions can be conducted via regular voice communication (phone call) if the technical requirements such as internet speed are unable to be met.
4. I understand that my current insurance may not cover the additional fees of the telehealth practices, in this circumstance I may be responsible for any fee that my insurance company does not cover.


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5. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in any of these, my information will follow the office confidentiality policies as stated in this form.

_____(initial) I agree to the above terms and conditions that require my compliance to be serviced via Telehealth.

## PARENTS OF MINORS ONLY

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Parents will need to sign a permission to treat form for services provided to a minor. In divorced families, patients under 18 need the consent of the custodial parent(s). A copy of the divorce decree may be requested prior to initiating evaluation and treatment.

I verify that I do have legal custody of this child_____(initial).

## APPROVAL FOR DISCLOSURE

Patient Consent to Exchange Information with My Primary Care Physician, Therapist or other Specialist.

HIPAA policy allows collaboration between healthcare providers regarding your care. By my initials below, I authorize exchange of information with my/my child's Primary Care Physician, Therapist, or other healthcare provider. I place no limits on dates, history of illness, diagnostic and therapeutic information, including treatment for alcohol and/or drug abuse.

Please list providers/individuals that you would like permission to collaborate or release information regarding your care:

**Physician/Therapist name:**_____

**Phone:**_____**Fax:**_____

**Physician/Therapist name:** _____

**Phone:**_____**Fax:**_____

**Physician/Therapist name:**_____

**Phone:**_____**Fax:**_____

_____ (initial) I hereby authorize the offices of Steven Rains NP, LLC to disclose my medical records, genetic results, and labs to the above parties. In the event I want to change the name of a physician or family member that has permissible disclosure, it is my responsibility to contact the office of Steven Rains NP LLC, and or submit a new form. I have completed in full the information above to the best of my knowledge and ability.

## CLARIFICATION

If any of these policies or procedures cause problems or seem confusing, please speak with me, so that I may clarify them for you. I make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. I have no control over what they do with the information. In some cases, they may share the information with a national medical database. By signing this Agreement, you agree that I can provide the necessary information to your insurance carrier or other designated third-party payers such as Medicare to process claims and for quality assurance activities.

By signing the agreement below I am acknowledging that I have reviewed the entirety of this Patient Treatment Agreement and Consent to Treat document. I have read these policy statements and having been informed to my satisfaction, I give consent to treatment and/or evaluation by Steven Rains PMHNP-BC.

I understand that by signing this agreement I am acknowledging that I understand the content on this form and agree to comply with all aspects of it.

Patient Signature Date

If Patient is a Minor (Guardian Signature) Date

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## CONTROLLED SUBSTANCE AGREEMENT

The following agreement is required for all clients who will be prescribed controlled substances by Steven Rains PMHNP-BC. Since it has yet to be determined whether or not controlled substances will be a part of your care, please still fill out this form so that our office can have it on file for future use.

I,_____, understand that if my healthcare provider, Steven Rains PMHNP-BC, has prescribed me controlled substances for the treatment of my medical condition, this treatment may carry risks and benefits, and that the effectiveness of the treatment may depend on how strictly I adhere to the prescribed regimen.

**As a part of my treatment plan, I understand and agree to the following guidelines:**

_____ (initial) I will only use the prescribed medication as directed by Steven Rains PMHNP-BC. I will not alter the dose, frequency or route of administration without first consulting my healthcare provider.

_____ (initial) I will not share my medication with anyone else, nor will I obtain medication from any non-prescribed sources.

_____ (initial) I will report any side effects or adverse reactions to my healthcare provider immediately.

_____ (initial) I understand that long-term use of controlled substances can lead to physical and psychological dependence, and I will notify the office of Steven Rains NP LLC if I feel like I am becoming dependent on the medication.

_____ (initial) I agree to submit to random drug screening as required by my provider, and understand that refusal to submit to a drug screen may result in discontinuation of my medication.

_____ (initial) I understand that my healthcare provider, Steven Rains PMHNP-BC, may need to consult with other healthcare providers and utilize prescription drug monitoring programs to ensure safe and responsible prescribing.

_____ (initial) I will keep my medication in a secure location and out of reach of children or pets.

_____ (initial) I agree that I am responsible for my medicine. I will not share, sell, or trade my prescription and I will not take anyone else's prescriptions. I understand doing so is a felony.

_____ (initial) I understand that if my medicine is lost, stolen or used sooner than prescribed, it will not be replaced.

_____ (initial) I agree to keep all appointments set up by the office of Steven Rains NP LLC..

_____ (initial) I understand that if I need to stop this medicine, I must do so slowly or I may become very sick. If you become pregnant please contact the office immediately.

_____ (initial) I understand that I may be asked to comply with additional guidelines as deemed necessary by Steven Rains PMHNP-BC, given my specific treatment plan.



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## TERMINATION OF CONTROLLED SUBSTANCE AGREEMENT

If I break any of the rules, or if my provider, Steven Rains PMHNP-BC, decides that this medicine is hurting me more than helping me, this medicine may be stopped by him in a safe way.

## PROVIDER RESPONSIBILITIES

As your provider, Steven Rains PMHNP-BC, I agree to perform regular checks to see how well the medicine is working.

I agree to provide psychiatric care for you even if you are no longer getting controlled substances from me except in the event I am required to terminate care.

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# AUTHORIZATION TO RELEASE MEDICAL INFORMATION

**Patient First Name:**_____ **Last Name:**_____ **DOB:** _____
**Address:**_____ **City:**_____ **State:**_____ **Zip:**_____
**Phone:**_____ **Email:**_____
**Parent/Guardian Name (if patient is a minor):**_____
**Relationship:**_____ **Phone:**_____

I hereby authorize the following health care professional, family member, employer, medical facility, mental health facility, or labratory to release all health information about me including my entire medical record, treatment record, diagnostic record, record of labs, genetic testing results, and record of drug and/or alcohol consumption.

**Person/Organization Name to Release Information:**_____
**Address:**_____ **City:**_____ **State:**_____ **Zip:**_____
**Phone Number:**_____ **Fax Number:**_____
**Relationship:**_____ **Phone:** _____

The following person/organization is hereby authorized to receive my entire medical record, treatment record, diagnostic record, release of labs, genetic testing results, and drug and/or alcohol consumption record to the following person or organization:

**Person/Organization Name to Release Information:**_____
**Address:**_____ **City:**_____ **State:**_____ **Zip:**_____
**Phone Number:**_____ **Fax Number:**_____
**Relationship:**_____ **Phone:** _____

Please sign below to acknowledge that you understand fully the release of medical records and have completed the contents of form to the best of your knowledge and ability.

_____

Patient Signature Date

_____

If Patient is a Minor (Guardian Signature) Date

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## CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until canceled. Your card will be charged the day of your visits. If you would like to organize a payment plan you must do so prior to your appointment. Charges can not be refunded after they have been processed, unless due to clerical error.

| Primary Card Information |
| --- |
| Card Type: □ MasterCard □ VISA □ Discover □ AMEX □ Other:_____ |
| Cardholder Name (as shown on card): |
| Card Number: |
| Expiration Date (MM/YY): |
| Security Code (3-digit): |
| Cardholder ZIP Code (from credit card billing address): |

I _____, authorize the Office of Steven Rains NP, LLC to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account. For further questions regarding billing refer to

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