Laura Wagner, ARNP dba
Sound Psychiatric Solutions, LLC
(360) 515-0342

1700 Cooper Point Rd. SW, Bld. C4
Olympia, Washington 98502

Intake Information: Adult

Today's date: _____

Name _____ DOB _____Gender_____ Age_____ Race/Ethnicity_____

Address_____City_____State_____Zip_____

Telephone home _____ work_____ cell_____

May I leave a message for you at home? ☐Yes ☐No at work? ☐Yes ☐No on cell? ☐Yes ☐No

Emergency Contact _____ Relationship _____ Phone _____

May I email you? If so, email: _____ How did you hear about me?_____

Marital Status ☐single ☐ married ☐partnered ☐divorced ☐separated ☐widowed ☐other:_____

Names of those that you live with and their relationship to you:

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Name _____ Relationship _____

Occupation _____ Employer_____Years of Education_____

Sexual ID: Heterosexual____ Bisexual____ Lesbian____ Gay Male____ Transgendered____ Comment_____

Briefly describe the problem that brought you here:

Please check all of the behaviors and symptoms that you currently consider problematic:

☐Distractibility	☐Change in appetite	☐Suspicion/paranoia
☐Hyperactivity	☐Lack of motivation	☐Racing thoughts
☐Impulsivity	☐Withdrawal from people	☐Excessive energy
☐Boredom	☐Anxiety/worry	☐Wide mood swings
☐Poor memory/confusion	☐Panic attacks	☐Sleep problems
☐Seasonal mood changes	☐Fear away from home	☐Nightmares
☐Sadness/depression	☐Social discomfort	☐Eating problems
☐Loss of pleasure/interest	☐Obsessive thoughts	☐Gambling problems
☐Hopelessness	☐Compulsive behavior	☐Computer addiction
☐Thoughts of death	☐Problems with pornography	☐Aggression/fights
☐Self-harm behaviors	☐Frequent arguments	☐Parenting problems
☐Crying spells	☐Irritability/anger	☐Sexual problems
☐Loneliness	☐Thoughts of hurting others	☐Relationship problems
☐Low self-worth	☐Flashbacks	☐Work/school problems
☐Guilt/shame	☐Hearing voices	☐Alcohol/drug use
☐Fatigue	☐Seeing things	☐Phobias
☐Anorexia	☐Shortness of breath	☐Overspending
☐Bulimia	☐Sweating	☐Chronic pain
☐Weight changes	☐Heart racing	☐Problems focusing

☐Other _____

Are your problems affecting any of the following?

☐Handling everyday tasks	☐Self-esteem	☐Relationships	☐Hygiene
☐Work/School Housing	☐Legal matters	☐Finances	☐Health
☐Recreational activities	☐Sexual activity	☐Other _____	

Laura Wagner, ARNP dba
Sound Psychiatric
Solutions, LLC
(360) 515-0342

1700 Cooper Point Rd. SW, Bld. C4
Olympia, Washington 98502

History of past mental health problems/diagnosis? ☐Yes ☐No

Diagnosis	Dates treated or age	By whom	Comments
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Experience with a Therapist? ☐Yes ☐No Helpful? ☐Yes ☐No Comment _____

Experience with a PMHNP? ☐Yes ☐No Helpful? ☐Yes ☐No Comment _____

Experience with a Psychiatrist? ☐Yes ☐No Helpful? ☐Yes ☐No Comment _____

Medications previously taken for mental health issues:

Name	Length of use	Dosage	Usefulness/Side Effects/Concerns?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Previous hospitalization for mental health problems? ☐Yes ☐No Please explain circumstance: _____

_____

Please note presence of family history of mental health problems:

Issue	Relationship to you	Age of Diagnosis?	Treatment?
☐Depression			
☐Anxiety			
☐ADHD/ADD			
☐Bipolar (manic/depressive)			
☐Post-traumatic stress disorder			
☐Schizophrenia			
☐Alcohol abuse			
☐Other substance abuse			
☐Suicide/or attempted			
☐Other			

Date of Last physical ___/___/_____ List medical concerns: _____

Name of Primary Care Provider _____ Phone_____

Address_____Fax _____

Laura Wagner, ARNP
(360) 515-0342

1700 Cooper Point Rd. SW, Bld. C4
Olympia, Washington 98502

Allergies? ☐Yes ☐No If Yes, list: _____

Suicide Attempt or Thoughts? ☐Yes ☐No If Yes, when _____ where _____ **got help?** ☐Yes ☐No

History of Abuse (physical____, sexual____, emotional____)? Comment _____

Current prescription medication/ Over the counter meds/ Herbal remedies / Nutritional Supplements:

Name	Dosage/Frequency	Purpose	Provider's Name

Presence of personal or family medical problems (Check if Yes):

	Personal History	Current You	Family History	Relationship to you?	Comment
Thyroid Disease					
Anemia					
Liver Disease					
Kidney Disease					
Heart Disease					
Diabetes					
Asthma					
Stomach Intestinal					
Problems					
Cancer					
Epilepsy					
Pain					
High Cholesterol					
High Blood Pressure					
Head trauma					
Alcohol					
Drugs					
Cigarette					
Caffeine					
Other:					

Laura Wagner, ARNP
(360) 515-0342

1700 Cooper Point Rd. SW, Bld. C4
Olympia, Washington 98502

Height: _____ **Weight:_____** Weight Range in past 3 years: _____ to _____ Ideal Weight: _____

Sleep: Ave # of hrs/night _____ Go to bed @_____ Get up @_____ # of wakings _____

Sleep aides/meds _____

Nightmares ☐ Yes ☐ No Comment _____

_____

More details about what brought you in today:

_____

_____

_____

What are your goals for treatment?

_____

_____

_____

Other Questions or Comments?

_____

_____

_____

_____ _____

Client Signature **Date**

Laura Wagner, ARNP
(360) 515-0342

1700 Cooper Point Rd. SW, Bld. C4
Olympia, Washington 98502

Notice of Privacy Practices and Professional Disclosure Statement
Receipt and Acknowledgment of Notice

Client Name: _____

I hereby acknowledge that I have received and have been given an opportunity to read a copy of Laura Wagner, ARNP dba Sound Psychiatric Solutions, LLC's Notice of Privacy Practices and Professional Disclosure Statement. I understand that if I have any questions regarding the Notice or my privacy rights I can contact Laura Wagner, ARNP.

_____

Signature of Client **Date**

If this acknowledgment is signed by a personal representative on behalf of the client, complete the following:

Personal Representative's Name: _____ Relationship to Client: _____

This form will be retained in your medical record

Laura Wagner, ARNP
(360) 515-0342

1700 Cooper Point Rd. SW, Bld. C4
Olympia, Washington 98502

POLICY STATEMENT

Confidentiality

Communication between client and provider/therapist is confidential. You will be informed in the event that any information is released without your express consent. Information may be released without written permission only: 1) if a court order is received, 2) when there is reasonable cause to believe that child/elder abuse or neglect has occurred, 3) when there is reasonable cause to believe that there is clear and imminent danger to self and/or others, 4) when a medical emergency exists, and 5) when required for insurance billing. **A release of information must be signed before any information can be provided to or requested from other individuals or agencies.**

Client Responsibilities

- Become actively involved in the treatment goals and share periodic reviews with your provider to be sure that we are working toward desired outcomes.
- Assume control of all payments to the provider at the time of the appointment
- Notify the provider no less than 48 hours in advance of any cancellations.
- Failure to comply with the cancellation policy will result in a missed appointment fee. Insurance companies do not typically reimburse patients for these costs and the client will be directly held responsible for these costs.

Telephone Messages and Emergency Coverage

You may reach me or leave a voicemail at (360) 515-0342. I work part time and only return calls on days I am in my office. If I am away for an extended time period, the message will direct you as to who is providing coverage for my patients. In the event of an emergency, call 911 or go to the nearest emergency department. I do not carry a 24 hour pager. Sound Psychiatric Solutions, LLC does not offer crisis services. In the event of a crisis, you may contact:

- Emergency (police, fire, ambulance) 911
- Thurston/Mason County Crisis Line (360) 586-2800; Toll-Free: (800) 627-2211, 273-TALK or 273-8225
- King County Crisis Line: (866) 4CRISIS or (866) 427-4747
- Pierce County Crisis (253) 798-4333; Toll Free: (800) 576-7764; TDD: (253) 798-4349
- BHR Crisis Resolution Services (360)754-1338 or (800)270-0041
- Crisis Clinic - Grays Harbor (360)592-HELP(4357) (for Hoquiam area) or (800)685-6556
- Washington Information Network 2-1-1 Dial 211
- Providence St. Peter Hospital Outpatient Psychiatric Services (360) 493-7060
- Washington Recovery Help Line for Substance Abuse, Problem Gambling & Mental Health 866-789-1511

Prescription Refills

- Refills of medication usually are written at the time of your scheduled appointment.

- Prescription refills are not emergencies, and must therefore be handled during regular business hours.
- Please contact your pharmacy and have them fax a refill request at (360) 338-0502 allowing 72 hours for refills to be completed on business days.

Payment Agreement

1. It is your responsibility to know if your insurance covers services. Charges not covered by your insurance are your responsibility. It is also your responsibility to notify of any changes in insurance coverage.
2. It is customary to pay for professional services when rendered. Payments must be made or services may be discontinued.
3. If you have a balance on your account, you will receive a statement. All accounts are due and payable within thirty days of notification. If payment is not received within 60 days, a late fee will be applied. If a client fails to be responsible for the account, and it is necessary to place a delinquent account into the hands of a collection agency/attorney, the client agrees to pay all court costs affixed by the court.
4. If you have a question regarding the payment of fees, please discuss this with me.
5. If you cancel with less than 48 hour notice or miss an appointment, you will be charged the total appointment fee. Insurance companies typically do not pay these fees and it will be your responsibility to pay these costs. Additionally, insurance companies do not typically pay charges for phone sessions or written documentation. You will be asked to pay for these charges directly.
6. There is a $40 service charge for NSF/Returned checks.

Length of Treatment

Medication management sessions are more frequent in the beginning. Duration of treatment varies depending on the nature of the treatment and individual client needs. When medications are used in psychiatry, please be advised that they are frequently used “off-label” meaning that they are used to control symptoms other than what the FDA originally approved the medication to treat.
Patients must be seen at minimum every 90 days to be considered active patients with Laura Wagner, ARNP dba Sound Psychiatric Solutions, LLC.

Should you not schedule an appointment for a period of 90 days and make no arrangement in writing with this provider for said time, you will no longer be considered an active client of Laura Wagner, ARNP and therefore have terminated treatment. Also, if you "miss" or "no show" three times or “no show”/ “late cancel” for two consecutive appointments or “no show”/ “late cancel” for one appointment and do not reschedule within thirty days, you will be considered to have terminated treatment with Laura Wagner, ARNP dba Sound Psychiatric Solutions, LLC.

Laura Wagner, ARNP
(360) 515-0342

1700 Cooper Point Rd. SW, Bld. C4
Olympia, Washington 98502

Client Endorsement

After reading these, policies please sign below. By signing you express that you understand these policies. You can request a signed copy for your records. I have read this policy statement and understand its provision.

PRINTED CLIENT: _____

SIGNED: _____

DATE: _____

PRINTED NAME of PARENT / GUARDIAN: _____

SIGNED: _____

DATE: _____

INFORMED CONSENT FOR EVALUATION AND TREATMENT

1. You have the RIGHT TO BE INFORMED REGARDING The terms UNDER WHICH TREATMENT OR EVALUATION WILL BE PROVIDED. Policies related to charged; billing third party payers, appointments, emergencies, and coverage for when your provider is unavailable, and other matters will be explained or provided to you. It is your responsibility as a client to stay informed.
2. You have the RIGHT TO CHOOSE THE BEST TREATMENT AND PROVIDER. There are a variety of professionals offering counseling, psychotherapy, psychiatric evaluation. There are also a number of different approaches to working with mental health issues. It is your right and responsibility to choose the treatment and provider that best matches your needs. You also have a right to a detailed explanation or any treatment or procedure your provider may choose to use including the risks involved and the side effects if any. If you believe you are not receiving the treatment you require, then raise this concern with your provider and she will work with you to revise your treatment plan or to refer you to other professionals who may be able to meet your needs.
3. You have the RIGHT TO KNOW THE QUALIFICATIONS AND TRAINING of your provider. You may request a provider information sheet from your provider.
4. You have the RIGHT TO REFUSE TREATMENT OR TO STOP TREATMENT at any time and for any reason. You also have the right to refuse or stop evaluations. Your provider also has the right to refuse or terminate treatment, in which case you will be provided with alternatives. If you have concerns regarding your treatment or wish to discontinue, you are encouraged to discuss this with your provider.

5. You have the RIGHT TO CONFIDENTIALITY. This means that what you tell your provider and what is contained in your clinical file will not be repeated or released by the provider to anyone else without your expressed permission (i.e. by a signed release of information). You have the right to see and have access to the contents of your file. You have the right to discuss your own therapy or evaluation with anyone you choose, including another provider.

There are, however, some limits and exceptions to complete confidentiality:

CHILD OR ELDER ABUSE: Generally, providers are required by law to report any known or

a. suspected cases of child or elder abuse to the Children's Services Division or other appropriate state agency.

b. VIOLENCE: If a provider learns that someone is about to kill or to do harm to someone else, she will

do her best to warn the intended victim.

c. SUICIDE: If a provider learns that a client intends to harm her/himself, the provider will breach confidentiality to the extent necessary for the client's protection.

d. SUPERVISION: Your provider may present your case in clinical staffing and also periodically review and discuss your treatment.

CONSULTATION: Occasionally, it is in your best interest for your provider to consult other providers regarding your treatment (e.g. medication issues, family issues, obtaining another's expert opinion, covering emergency phone calls, etc.). This will be carried out with the utmost consideration for your privacy.
INSURANCE: Insurance companies or their designated management company may require information about your diagnosis, treatment history, prognosis, treatment, or other relevant information in order to authorize services or process claims. A release of information will be obtained for this if you are utilizing an insurance company.

I have read and understand my rights and responsibilities as outlined in the informed consent for services to be provided by Laura Wagner, ARNP dba Sound Psychiatric Solutions, LLC.

PRINTED NAME: _____ DATE:_____

SIGNED: _____

PRINTED NAME of GUARDIAN: _____

RELATIONSHIP TO CLIENT: _____

SIGNED: _____ DATE: _____

1700 Cooper Point Rd. SW, Bld. C4
Olympia, Washington 98502

phone (360)515-0342
Fax: (360) 338-0502

Laura Wagner, ARNP **Psychiatric Mental Health Nurse Practitioner**

Authorization to Use and Disclose Protected Health Information (PHI) to Insurance

Client Name_____ DOB____/_____/_____
Street Address: _____
City, State, Zip Code: _____
Telephone Number: _____ Social Security Number:_____

I , the under signed, hereby authorize Laura Wagner, ARNP to send information to billing representatives. I , the undersigned, hereby authorize Laura Wagner, ARNP and her billing representatives to send information to:
Insurance Company: _____ Subscriber: _____
ID Number: _____ Group/Policy #: _____

Secondary Insurance : No Yes:
Insurance Company: _____ Subscriber:_____
ID Number : _____ Group/Policy #: _____

I, the undersigned, certify that I have Neither Medicare or Medicaid.

Purpose of Disclosure (please initial):
___ Authorization to bill the insurance companies named above and to allow Laura Wagner, ARNP dba Sound Psychiatric Solutions, LLC and her billing representatives to coordinate all billing procedures with the same.

Information to be released is (**please initial**):

_____ Diagnosis
_____ Psychosocial History
_____ Treatment plan or summary
_____ Psychological Evaluation/Reports
_____ Psychotherapy Notes
_____ Chemical Dependency
_____ HIV or AIDS information
____ Other

Required Statements:
I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under Federal law. However, I also understand that federal or state law may restrict re-disclosure of HIV/AIDS, mental health information, genetic testing information, and drug/alcohol diagnosis, treatment, or referral information.

I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment from Laura Wagner, ARNP, unless the health care services are solely for the purpose of providing health information to someone else and the authorization is needed to make the disclosure. If I do not sign this authorization, I understand that Laura Wagner, ARNP, will not be able to bill my insurance. I will be required to pay "Cash Pay" based on the fair and customary rate for all mental health treatment by Laura Wagner, ARNP dba Sound Psychiatric Solutions, LLC.

I may revoke this authorization in writing at any time. If I do so, the information described may no longer be used or disclosed for the purposes described in this written authorization. Any use or disclosure already made cannot be undone. If I revoke this authorization, I understand I will enter into the "Cash Pay" arrangement described above as Laura Wagner, ARNP will not be able to bill my insurance.

This written authorization is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon. If not earlier revoked, or by other agreement specified below, this authorization shall expire twelve months from the date signed. Other (specified): _____

I have read this authorization and understand it.

_____
Signature of Client Date

_____ _____ _____
Subscriber Signature *Relationship to Client* *Date* *DOB of Client*

_____

1700 Cooper Point Rd. SW, Bld. C4 (360)515-0342
Olympia, Washington 98502 Fax: (360) 338-0502

Laura Wagner, ARNP **Psychiatric Mental Health Nurse Practitioner**

1700 Cooper Point Rd. SW, Bld. C4, Olympia, Washington 98502 • Telephone: (360) 515-0342 • Fax (360)338-0502

CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION TO THE PRIMARY CARE PROVIDER

I,_____, hereby authorize Laura Wagner, ARNP to receive information from and/or send information to the clinician indicated below. This release pertains to the following types of information: medical history, mental or physical conditions or treatment, including information relating to my mental health diagnosis and/or substance abuse diagnosis and treatment to my primary care provider.

Clinician Name: _____

Clinician Address (Street, City, and Zip): _____

Clinician Phone Number and/or Fax Number: _____

This authorization for release extends to the care and treatment the client received during:

□ All dates of service or

□ Service between_____and _____

This information may be used for the following purpose(s):

□ Evaluation, assessment and/or treatment and/or □ Ongoing coordination of treatment and/or

□ Other: _____

The information to be released is:

□ Diagnoses □ Psychological Evaluations/Reports □ Medical Evaluations

□ Treatment Plan or summary □ Chemical Dependency Information □ Other: _____

This written consent is subject to revocation by the undersigned at any time, except to the extent that action has been taken in reliance hereon. If not earlier revoked, or by other agreement specified below, this consent shall expire:

One year from date signed or □ Upon termination of treatment or □ Other:_____

_____ _____

Signature of client, parent, or legal guardian Date signed

_____ _____

Witness Date signed

_____ _____

Laura Wagner, ARNP **Date**

Laura Wagner, ARNP **Psychiatric Mental Health Nurse Practitioner**

1700 Cooper Point Rd. SW, Bld. C4, Olympia, Washington 98502 • Phone: (360) 515-0342 • Fax (360) 338-0502

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Client Name _____DOB _____/_____/_____
Street Address: _____
City, State, Zip Code: _____/_____/_____
Telephone Number: _____

I authorize Laura Wagner, ARNP dba Sound Psychiatric Solutions, LLC

Check appropriate spaces and initial and give complete name and address:

___To give health records to: Name: _____
___To receive health records from: Street Address: _____
___To verbally exchange health information with: City, State, and Zip Code: _____
Telephone: _____
Fax Number: _____

For the purpose of continuing care or: _____
___ All information in chart
___Specific information to be released:_____,
if such information exists:

____Mental health related information ___HIV/AIDS related records
____Drug/alcohol diagnosis, treatment or referral information ___Genetic testing information

As indicated below, the authorization for release extends to the care and treatment the client received during:

_____ All dates of service _____Service between _____ and _____

Required Statements:
This authorization will expire in one (1) year or upon (insert date or event) _____

I may revoke this authorization in writing by presenting my written revocation to Sound Psychiatric Solutions, LLC.

The revocation will not apply to information that has already been released in response to this authorization. I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used and/or disclosed under this authorization. Laura Wagner, ARNP dba Sound Psychiatric Solutions LLC is not responsible for the cost of copies.

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing information under federal or state law.

Signature of Client_____Date_____

Signature of Personal Representative_____Date_____

Relationship to Client_____

*