CONSENT TO TREAT

I hereby voluntarily apply for treatment from Ruth Flucker, MS, PMHNP-BC, CNE.

I hereby authorize the release of medical information necessary to process billing claims. I also authorize payment of medical benefits to Peaceful Minds for all services rendered.

I understand that I am financially responsible for all charges whether or not they are paid by my insurance company.

I also understand that appointments must be cancelled at least 24 hours in advance to avoid late cancellation or no-show fees.

Peaceful Minds and its affiliates participate in programs for training health care personnel. Students, interns, residents, and Licensed Associate Counselors (LAC) may participate in your treatment recommendations, conduct assessments, provide counseling, or be present at various times during your sessions. You can decline student services at any time.

If you have any concerns or questions regarding medical students, medical interns, or medical residents you may contact Dr. Patino at (480) 464-4431.

_____ _____

Patient Name Date

_____ _____

Patient/Guardian Signature Date

_____ _____

Office Witness Date

RUTH FLUCKER, MS, PMHNP-BC, CNE
Family Psychiatric Mental Health Nurse Practitioner
70 N. McClintock Dr. Suite #4
Chandler, AZ 85226
480.464.4431—phone
480.464.2338—fax

Peaceful Minds Personal History Questionnaire

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name:	☐ M ☐ F	**DOB:**
Marital status: ☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
PCP or referring doctor:		**Date of last physical exam:**

PERSONAL HEALTH HISTORY

Reason for Visit: ☐ Depression ☐ Bipolar Disorder ☐ Anxiety ☐ ADHD/ADD ☐ PTSD ☐ Behavioral Issues
☐ Dementia ☐ Schizophrenia ☐OCD ☐ Poor Sleep ☐ Other: _____

Recent hospitalizations (psychiatric or otherwise):

Reason	Hospital

List all your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers

Name & Dose	Frequency Taken	When was this medication started?

Allergic to medications? **Yes** ☐ **No** ☐ **If yes, Please list:**

List all previous tried **psychiatric medications,** when they were tried (approximately), and why they were discontinued:

Do you have a history of past psychiatric treatment? ☐ Yes ☐ No Is yes, who was your provider? _____			
Are you currently being treated for any of the following chronic disorders?	☐ HIV	☐ Sleep Apnea	☐ MultipleSclerosis
	☐ Lupus	☐ TBI/Head Injury	☐ Cancer
	☐ Arthritis	☐ CHF	☐ COPD ☐ Other:

If you checked any above, please comment here on length of diagnosis and current treatment:

_____

_____

OVERVIEW OF MEDICAL HISTORY

Check and describe briefly if you currently have, or have had, any symptoms or problem in any of following areas to a significant degree and briefly explain.

☐ Skin	☐ Reproductive Health	*Recent changes in:*
☐ Head/Brain injury/Neck	☐ Back	☐ Weight
☐ Ears/Nose/Throat	☐ Intestinal	☐ Energy level
☐ Lungs/Respiratory	☐ Bladder	☐ Ability to sleep
☐ Chest/Heart	☐ Bowel	☐ Other pain/discomfort:
☐ Kidneys	☐ Recent Surgeries	

Please describe briefly:

_____

_____

_____

HEALTH HABITS

Do you drink Alcohol? If yes, How much alcohol? _____/day /week/month	☐ Yes	☐ No
Do you smoke cigarettes? If yes, How much and how often? _____/day and how long have you smoked? _____years	☐ Yes	☐ No
Do you have a history of any substance abuse?	☐ Yes	☐ No
Are you addicted to or abuse legal or illegal drugs?	☐ Yes	☐ No
Do you drink coffee or caffeinated beverages? If yes, how much and how often? _____/day	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you exercise regularly?	☐ Yes	☐ No
Do you feel comfortable with your weight?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No
Have you ever had a sleep study? If yes, when? _____	☐ Yes	☐ No
Have you ever had a seizure? If so, when was your most recent seizure? _____	☐ Yes	☐ No
Do you have any history of head injuries or concussions? If yes, when? _____	☐ Yes	☐ No
Have you ever been to a counselor? If yes, who? _____	☐ Yes	☐ No

_____ _____

Patient/Guardian Signature Date

Patient Name: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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 fidgety 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 in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

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
☐	☐	☐	☐

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.

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?	○	○

PERMISSION TO COMMUNICATE WITH FAMILY & FRIENDS

☐ I choose to allow the people listed below to receive information regarding my appointment dates and times and billing issues. I understand this authorization may be revoked at any time. No aspects of care nor medical records will be released to them without a HIPAA compliant release of information being signed.

☐ I choose to **not allow** anyone participate in my care and am aware that only I will be able to receive information regarding my appointment dates and times, billing issues, or any aspects of my care unless it is a life-threatening emergency.

Parents: If your child is **over 18 years of age** and you are not their legal guardian, this form MUST include you for us to be able to discuss your child's appointment dates and times and billing issues.

NAME	PHONE NUMBER	RELATIONSHIP TO PATIENT
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

☐ I choose to allow the stepparent/s _____, _____ to bring minor to appointment, make appointments and receive information.

☐ I do not choose to allow the stepparent/s _____, _____ to bring minor to appointment, make appointments and receive information.

_____ _____
Patient Name Date

_____ _____
Patient Signature Date

_____ _____
Office Witness Date

PEACEFUL MINDS
RUTH FLUCKER, MS, PMHNP-BC, CNE

CLINICAL CONDITIONS OF EVALUATION AND TREATMENT

The undersigned _____ acknowledges having scheduled a voluntary Psychiatric evaluation for diagnostic and treatment purposes with Ruth Flucker, MS, PMHNP-BC, CNE, is a licensed family psychiatric/mental health nurse practitioner.

I acknowledge that I was provided with instructions about the evaluation process, and that the evaluation may include the completion of multiple forms for the collection of clinical information, as well as an interview with Ruth Flucker, MS, PMHNP-BC, CNE.

After completion of the initial evaluation, I may be provided with the available Diagnostic findings and I am in agreement that at this point a decision can be made by either party to establish, or not, a provider-patient relationship. In the event of either myself refusing to continue with services or Ruth Flucker, MS, PMHNP-BC, CNE deciding to not be my provider, I will be provided with the name of at least 3 local psychiatric physicians capable of providing me with a second opinion.

I acknowledge that Ruth Flucker, MS, PMHNP-BC, CNE will not provide me or my family with formal Psychotherapy services beyond supportive therapy in the context of medication management and psychiatric assessment. If Ruth Flucker, MS, PMHNP-BC, CNE recommends formal Psychotherapy services it is my sole responsibility to procure and secure those services.

I acknowledge that the completion of disability, school, and other employment forms is not considered part of the evaluation or medication management reimbursement fee, therefore a fee will be charged based on the time and complexity of the form.

Please initial:

I understand that my medication management visits are scheduled for 30 minutes. If I arrive 10 minutes late to my appointment based on our clock, I will be considered as having missed my appointment, and will be rescheduled for next available appointment, and a medication refill will be provided. I also recognize that if I don't cancel my appointment at least 24 hours in advance a fee of $50.00 will be charged to my account. I understand that occasionally, Ruth Flucker, MS, PMHNP-BC, CNE will run late on her schedule due to unexpected patient situations.

I acknowledge that Peaceful Minds **DOES NOT** provide Emergency Psychiatric or Continuous Crisis Management Services, and agree to call 911 or visit my closest Emergency Room or Psychiatric Urgent Care Center/Hospital in the event of a Psychiatric Emergency. I understand that Ruth Flucker, MS, PMHNP-BC, CNE's schedule is filled in advance and does not allow for a patient to be seen on an urgent basis unless there is a cancellation, and that any questions regarding medications or treatment should be directed to Ruth Flucker, MS, PMHNP-BC, CNE at 480-464-4431, option 3 or 5 or via email at nurse@metropsych.com.

I acknowledge as part of my treatment, my provider will require me to obtain blood work and/or a urine drug screen. This may be new blood work and/or urine drug screen testing if the provider deems it a clinical necessity. If lab work was done recently through a coordinating physician, new lab work may not be necessary. Blood work and/or urine drug screens may be required on an ongoing basis throughout my treatment and my provider will discuss this with me.

I also acknowledge that Ruth Flucker, MS, PMHNP-BC, CNE does not provide Emergency Medication refills, that it is my responsibility to assure that an adequate supply of medications is always maintained, that medication refills be requested at least 4-5 days before running out of the most recent medication supply, that medication refills will be completed within 3 business day, and that medication prior authorizations will be completed within 7-10 business days from receipt of the request, depending on insurance company.

I am aware and agree that Ruth Flucker, MS, PMHNP-BC, CNE will terminate my clinical services upon my verbal or written request.

I am aware and agree that Ruth Flucker, MS, PMHNP-BC, CNE may terminate my clinical services under the following:

- My failure to maintain compliance with at least 2 consecutive schedule appointments without prior notification
- Any abuse or misuse of prescribed medication
- Any dangerous behavior toward staff or providers
- My unwillingness to comply with recommended treatment recommendations, if in the opinion of Ruth Flucker, MS, PMHNP-BC, CNE my lack of compliance places me or other people in danger.
- The initiation of involuntary Commitment Proceedings.

AS A REMINDER:

-I understand that my medication management visits are scheduled for 30 minutes; if I arrive **10 minutes late** to my appointment based on our clock, I will be considered as having missed my appointment, and will be rescheduled for the next available appointment, and a medication refill will be provided at no charge.

- I also recognize that if I do not cancel my appointments at least 24 hours in advance a fee of $50.00 will be placed on my account. I understand that Ruth Flucker, MS, PMHNP-BC, CNE will run late on her schedule due to unexpected patient situations.

By initialing this box, you acknowledge that you have read and understand this reminder:

- Medication refills **must be requested at least 3-5 business days prior to running out of medication supply.** This can be done by contacting your local pharmacy directly prior to running out of medications so that if authorization is needed our Nurses or Medical Assistant can address your requests in a timely manner. If you have a question about refills, please email or call the nurse/medical assistant directly: 480-464-4431 or nurse@metropsych.com.

-If you need a refill, **please always contact your pharmacy first**, even if your medication bottle says no refills remaining. As long as you have a follow-up appointment scheduled with our office, refills can and will be authorized through our office. Your pharmacy will fax us a request.

- I acknowledge as part of my treatment, my provider will require me to obtain blood work. This may be new blood work if the provider deems it necessary or from a coordinating physician if the lab work is recent. This will be necessary on an ongoing basis throughout my treatment and my provider will discuss this with me.

I understand that in the event of service being terminated (except in cases of involuntary commitment) I may be provided with a 30 day supply of medications and the name of 3 local Psychiatrists that may be available to provide me with Clinical Psychiatric Services. I also understand I may request a copy of this agreement at any time.

Patient Name :_____

Patient or Parent Signature:_____

Today's Date:_____

Witness Name & Initials:_____

ACKNOWLEDGEMENT OF RECEIPT OF PEACEFUL MIND'S NOTICE OF PRIVACY PRACTICES

Patient Name_____ Date of Birth_____

I have been allowed to review and/or have received Peaceful Mind's Notice of Privacy Practices.

_____ Today's Date:_____

Patient's Signature or legally authorized individual

You May Refuse to Sign This Acknowledgement

****

For Office Use Only

Peaceful Minds could not obtain a written acknowledgement of receipt of our Notice of Privacy Practice due to the fact:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited it
- ☐ An emergency situation prevented us
- ☐ Other (please specify)

Employee Signature _____ Date _____

****