Alex Wills, MD
Board Certified Psychiatrist
Psychiatric PA-C

Zana Delic

PATIENT INFORMATION (Please print)	
Last Name	**First Name, M.I.**
SSN	**Sex: (M/F)**
DOB/Age	**Marital Status**
Home Address	**City, State ZIP**
Phone	
Employer	
Primary Care Physician	

PERSON RESPONSIBLE FOR BILL	
Last Name	**First Name, M.I.**
Mailing Address	**City, State ZIP**
Phone	

MEDICAL INSURANCE (REQUIRED)	
PRIMARY PLAN	**MEMBER #**
SUBSCRIBER INFORMATION (If other than patient)	**Group #**
Last Name	**First Name, M.I.**
SSN	**Sex (M/F)**
DOB	**Employer**
Effective Date:	**To:**
SECONDARY PLAN	**MEMBER #**
SUBSCRIBER INFORMATION (If other than patient)	**Group #**
Last Name	**First Name, M.I.**
SSN	**Sex (M/F)**
DOB	**Employer**
Effective Date:	**To:**

Adult Background Information and Psychosocial Intake Summary

P.E.R.M.A. Mental Health

950 W Bannock St. Suite 1100 Boise, ID 83702 | P: (208) 319-3513 | F: (208) 350-6674

www.permamentalhealth.net

CONFIDENTIALITY STATEMENT

(MUST BE READ & SIGNED PRIOR TO APPOINTMENT)

Information gathered in the course of Perma Mental Health's (PMH) work with me will remain confidential. However, there are exceptions to this confidentiality as mandated by law.

1. **If information is shared with PMH that leads the staff to believe that I/my minor child will cause injury to another person, PMH is obligated to either contact that person and/or the police in order to warn of a potential threat.**

2. **In cases where child abuse (where a child is in threat of harm, imminent danger, or has been harmed) is related to the staff, PMH is mandated to contact Child Protective Services (CPS).**

3. **If it were felt that I/my minor child am/is actively suicidal, PMH will attempt to take reasonable precautions to protect me/my minor child from harm.**

4. **Additionally, I understand that PMH does comply with all court ordered subpoenas for medical records.**

In all cases where there is a need to report, the situation will be discussed with me in order to help me understand the need to report and in the hope of securing my consent.

I UNDERSTAND THE EXCEPTIONS TO CONFIDENTIALITY AS DESCRIBED ABOVE.

Patient's Name	Patient's Signature (18 years or older)	Date

CONSENT TO PSYCHOTROPIC MEDICATIONS

(MUST BE READ & SIGNED PRIOR TO APPOINTMENT)

Patient Name:_____ Date of birth:_____ Date: _____

Type(s) of medications that may be prescribed when being seen by the psychiatrist include psychoactive medications including but not limited to antidepressants, antipsychotics, anxiolytics, stimulants and various others to treat certain psychiatric conditions.

Your doctor will always discuss the risks and benefits of the medications prescribed and also provide written information or other resources as desired and as available in addition to the information provided at the pharmacy. It is your right and we request your diligence in requesting and receiving information about any of the prescribed medications. If you do not feel your concerns have been addressed, it is your responsibility to make your concerns and questions known to the clinic in a timely manner. We will work hard to answer your questions and provide any informational resources as soon as possible.

I agree that I will discuss with my provider the name, type, class risks and benefits of any medication prescribed and if I have any concerns or further questions I will make them known. I hereby give my consent to receive prescriptions for medications from my provider (or for my child/dependent as applicable).

Patient Signature: _____ Date: _____

Authorization for Use and Disclosure of Protected Health Information

(MUST BE READ & SIGNED PRIOR TO APPOINTMENT)

I authorize Perma Mental Health, PLLC *to release/obtain the protected health information of:*

*Patient Name: _____ Birth date: _____

Address (City, State, Zip): _____Phone #: _____

To/From* Institution: Including Name_____
Address (City, State, Zip): _____

To/From* Institution: Including Name:_____
Address (City, State, Zip): _____

*Information to be disclosed: Date(s) of Service: _____ □ Discharge Summary □ ER report □ History & Physical □ Lab Results □ Consults □ X-Ray/Imaging Reports □ Operative Reports □ Entire Record □ Other please specify: _____	*Purposes for Use and/or Disclosure: □ At the request of the individual □ Legal Purposes □ Physician follow-up

I agree to the release of the following information even if it should contain in my medical record: Acquired Immune Deficiency Syndrome (AIDS) or HIV, Alcohol and/or drug abuse treatment, or behavioral or mental health services.

*Unless otherwise revoked, this authorization will expire on the following date or event: _____.If a date or event is not specified, this authorization will expire one year from my date of signature below.

This authorization is voluntary. I understand that I can refuse to sign this authorization and Perma Mental Health, PLLC will not condition my treatment, payment, enrollment or eligibility for benefits on the signing of this authorization except as allowed under federal privacy laws for: (i) research-related treatment; or (ii) health care provided solely for disclosure to a third party or (iii) health plan initial enrollment/eligibility determinations, underwriting or risk rating determinations.

I understand that I may revoke this authorization at any time by notifying Perma Mental Health Clinic, in writing, of my revocation. I understand that the revocation will not apply to any information that already was released in reliance on this authorization.

I understand that the health information released under this authorization may be re-disclosed by the recipient and may no longer be protected under federal privacy regulations.

I hereby release Perma Mental Health, PLLC from all liability and all claims of any nature whatsoever pertaining to the disclosure of information, or of any professional opinions, findings, or recommendations as contained in the records released to or by Perma Mental Health, PLLC

*Signature: _____ Date:_____

*Items that MUST be completed for authorization to be valid.

(MUST BE READ & SIGNED PRIOR TO APPOINTMENT)

PERMA MENTAL HEALTH, PLLC

TERMS AND CONDITIONS OF SERVICE

PATIENT NAME / Information

1. ***Consent for Treatment***

   I or my minor child/ward wish to receive mental health/psychiatric/ psychology and treatment at Perma Mental Health, PLLC (PMH). Accordingly, I give consent for any and all mental health services rendered to me or my minor child/ward under the general and specific instructions of the attending psychiatrist/psychologist as may be determined to be appropriate by their professional judgment.

   I am aware that the practice of medicine/psychiatry, psychology is not an exact science. I acknowledge that this facility has not made any guarantees to me or my minor child/ward as to the results of treatments or examinations. I am also aware that I should ask the therapist/nutritionist any questions that I may have about my or my minor child's/ward's diagnosis, treatment, risks or complications, alternative forms of treatment, and/or anticipated results of treatment.

2. ***Disclosure of Information for Payment Purposes***

   I understand my or my minor child's/ward's health medical information will be sent to my insurance carrier for billing purposes for any treatment or counseling I may or my minor child/ward may receive at this medical facility. As such, I understand that this health information may contain entries or information relating to sexually transmitted diseases, including Human Immunodeficiency Virus (HIV) and/or Acquired Immune Deficiency Syndrome (AIDS), mental health diagnoses, psychiatric impairment and/or drug, alcohol or other substance abuse and other personal information. I understand that according to Idaho law, I may choose to pay for services pertaining to HIV or AIDS treatment if I do not want my or my child's/ward's health information to be provided to my insurance company. I agree to notify PMH of my wishes regarding payment before these services are provided. I also understand that if I fail to pay for the services, the information will be sent to my insurance company.

3. ***Information to other providers***

   I understand that in the course of my treatment and/or making arrangements for my care, my information may be shared with other providers. If I prefer that PMH not use or share my information for this purpose, I may submit a written request for consideration per this facility's Notice of Privacy Practices.

4. ***Non-Discrimination Policy***

   This medical facility will admit and treat patients within its capabilities regardless of race, color, national origin, religious beliefs, sex, sexual orientation, marital status, veteran's status, age, political beliefs, or disability.

5. ***Financial Agreement***

   I understand that I will receive a bill from this medical facility for these services. I understand and agree to pay all charges for services rendered and that I am obligated to pay for services in accordance with the regular rates and terms of this medical facility. This medical facility reserves the right to charge a Late Payment Fee and/or a Returned Check fee.

   If I choose to pay all charges myself, I will notify this medical facility prior to receiving service.

   Should the account be referred to an attorney or collection agency for collections, I agree to pay any reasonable attorney's fees, collection expenses and interest at the statutory rate on all delinquent accounts, whether or not the account is referred to a collection agency.

   Missed Appointments: I also agree to pay the full cost for all visits missed or canceled late unless I notify PMH of the cancellation at least 24 hours in advance of the scheduled appointment. I recognize that missed appointments and late cancellations will be charged directly to me unless prohibited by my insurance plan. These fees will not be billed to my insurance.

   Notify your provider no less than 24 hours in advance of any cancellations. Appointments are the responsibility of the client and/ or parents and reminders from the provider should not be expected. You may miss one appointment without penalty. If you miss a second appointment without proper notice, you will be charged a $50 no-show fee and will not be allowed to reschedule until that

fee is paid. If three (3) appointments are missed, you will be discharged from treatment and given a referral to other treatment providers.

Prescription Refills: I understand that controlled substance prescriptions expire 72 hours after being written by the doctor. If I fail to get the prescription filled within the 72 hours I will be charged fee for my doctor to rewrite the prescription. This fee will not be billed to my insurance.

6. ***Medicare Coverage (if applicable)***

I certify that the information I have given in applying for payment under Medicare is correct. 1 authorize the Social Security Administration to release information about my Medicare effective dates and Medicare claim number to this medical facility. I authorize any holder of medical or related information about me to release any information needed to process this or a related Medicare claim to the Social Security Administration or its intermediaries. I request that payment of benefits be made on my behalf to this medical facility for any services provided to me by this medical facility.

7. ***Assignment of Benefits***

I hereby authorize assignment of my medical insurance benefits I am due to this medical facility for application to my bill for medical services I received. I further authorize this medical facility to receive direct payment from all such benefit payments. I agree to remain responsible and liable for payments of all amounts due this medical facility and not received from my insurance carrier(s). I understand this medical facility is submitting claims on my behalf as a courtesy. I WILL NOT REVOKE THIS ASSIGNMENT FOR ANY REASON.

8. ***Patient's Rights and Responsibilities***

My signature below confirms that I agree to these terms and conditions and that I have received the information on my Rights and Responsibilities as a patient.

ACKNOWLEDGEMENT OF RECEIPT OF THIS MEDICAL FACILITY'S NOTICE OF PRIVACY PRACTICES

_____ I HAVE RECEIVED A COPY OF THIS FACILITY'S NOTICE OF PRIVACY PRACTICES

_____ THE PATIENT OR THEIR DULY AUTHORIZED REPRESENTATIVE IS UNABLE TO MAKE THIS ACKNOWLEDGEMENT.

MINORS OR INCAPACITATED PERSONS - THE PATIENT IS:

A MINOR _____ YEARS OF AGE

INCAPACITATED AND UNABLE TO SIGN FOR THE FOLLOWING REASON(S):

I HAVE READ THIS CONSENT AND I AM THE PATIENT, OR THE PATIENT'S DULY AUTHORIZED REPRESENTATIVE. ON MY OWN BEHALF (OR ON BEHALF OF THE PATIENT), I ACCEPT AND AGREE TO BE BOUND BY ALL OF THESE TERMS AND CONDITIONS OF SERVICE.

_____ _____ _____

PATIENT OR REPRESENTATIVE'S SIGNATURE DATE TIME

_____

PRINT NAME

_____

RELATIONSHIP TO PATIENT

REPRESENTATIVE: PLEASE DESCRIBE YOUR AUTHORITY TO ACT ON BEHALF OF THE PATIENT:_____

WITNESS SIGNATURE: _____ _____ _____ _____

DATE TIME PLACE ITEM # 26122 (11/04) SR

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Today's Date: _____

Name: _____ Age: _____ Birthdate: _____ Gender: _____

Marital Status: ☐ Single ☐ Married ☐ Separated ☐ Divorced ☐ Widowed

Employer & Position: _____ Education: _____

Ethnicity: _____ Religion: _____

Primary reason(s) for seeking services:

❒Alcohol/drugs ❒Anger management ❒Anxiety ❒ Behavior problems

❒Coping with medical illness ❒Depression ❒Eating disorder

❒Family concerns ❒Fears/phobias ❒Sexual concerns

❒Sleeping problems ❒Suicidal feelings ❒Marital/relationship problems

❒Psychological/psychiatric evaluation ❒Recent loss/death ❒Other concerns (specify):

_____

HISTORY OF PRESENTING PROBLEM:

When did the problem(s) begin?

_____

How often do the problem(s) occur?

_____

What causes the problem(s)?

_____

How have the problem(s) affected your family, school and/or work?

_____

_____

What has already been done to address the problem(s)?

_____

Circle or check any of the following that apply to you:

Depressed	Anxiety	Fear of losing control
No interest in usual activities	Panic attacks	Unable to go out alone
Weight change	Excessive worry	Distractibility
Sleep disturbance	Heart palpitations	Hyperactivity
Poor appetite	Excessive sweating	Problems at work
Fatigue/low energy	Trembling/Shaking	Unusual thoughts
Feel worthless/guilty	Chest pain	Strange experiences
Difficulty concentrating	Nausea/Stomach trouble	Drink too much
Indecisiveness	Numbness/Tingling	Drug use
Irritability	Shortness of breath	Memory problems
Hopelessness	Chills/Hot flushes	Fear of becoming fat
Sexual problems	Fear of dying	Eating problems
Crying spells	Dizziness	Family conflict
Low self-esteem	Phobias	Anger
Head Injury	Nightmares	Domestic violence
Thoughts of suicide	Fear of going crazy	Thoughts of harming others

Describe any other concern(s) and/or stressors:

_____

Are you currently on probation, parole, or have any legal charges pending?

❒Yes ❒No

If yes, please explain: _____

Are you currently involved in any legal proceedings (e.g., a civil suit, divorce, custody case, bankruptcy, etc)? ❒Yes ❒No

If yes, please explain:_____

If any of the following information does not apply or has been filled out in other sections, please feel free to omit. However, you are responsible for providing a complete and accurate history.

PAST PSYCHIATRIC HISTORY:

Are you currently in counseling or receiving mental health or substance abuse services from any other provider? ❒Yes ❒No

If yes, with whom, and when? _____

Have you ever had psychological testing? ❒Yes ❒No

If so, approximately when and where? _____

Have you ever received counseling, mental health or substance abuse services, and/or psychiatric hospitalizations? ❒Yes ❒No If so, please list below:

Have you ever tried to hurt or kill yourself? If so, when? _____

Are you on any PSYCHIATRIC medications **at this time**?* ❒Yes ❒No If so, please list below:

Name of Medication	*Approximate Dates*	*Dosage (in mg)*

Were you on any PSYCHIATRIC medications **in the past**?* ❒Yes ❒No If so, please list below:

Name of Medication	*Approximate Dates*	*Dosage (in mg)*

MEDICAL HISTORY:

List any current medical problems, illnesses, or concerns:

_____

When was your last physical examination?

_____

Who is your primary care physician?_____

List any surgeries, and your age at the time: _____

List any past serious illnesses, injuries, hospitalizations, accidents, and/or loss of consciousness, and age at the time: _____

Current height: _____ Current weight: _____

Highest adult weight and when: _____ Lowest adult weight and when: _____

Exercise (type, amount, frequency): _____

Allergies or other problems with any medications: _____

REPRODUCTIVE AND SEXUAL HISTORY:

Are you sexually active? _____ Sexual preference: ☐ Men ☐ Women ☐ Both

List any concerns about your sex life and/or sexual functioning:_____

Have you ever had an extra-marital affair? _____

Have you had a sexually transmitted disease? _____

Have you been tested for HIV/AIDS? Result?_____

For females ONLY: Age of first period? _____ Date of last period? _____

List any concerns about menstruation (e.g., cramps, pain, irregularity, mood changes):

_____

If menopausal, at what age did it start? ____ Symptoms: _____

Have you had any miscarriages (when and why)?_____

Have you had any abortions (when and why)? _____

SUBSTANCE USE HISTORY:

Describe alcohol and/or other substance use, including tobacco:

Alcohol &/or Substance	*Amount*	*Frequency*	*Date of first use*	*Date of last use*

Do you think you have a problem with alcohol or other substance use? _____

Has your alcohol or other substance use caused any problems with your family, social, educational/occupational functioning, health and/or the law? _____

Have you ever sought help or treatment for alcohol/substance use? If so, where and when?

_____

FAMILY PSYCHIATRIC HISTORY:

List any relatives who have (or had) emotional difficulties or psychiatric illnesses, including alcohol/substance abuse or criminal offenses:

Relative	*Problem*	*Treatment*	*When*	*Where*

FAMILY MEDICAL HISTORY:

List any major medical problems that run in either side of your family (e.g., cancer, heart problems, diabetes, stroke, tuberculosis, epilepsy, neurological disorders, etc.):

Relative	*Medical Problem*

Parents' marital status to each other ? _____ How long together? _____

Describe your mother: _____

Describe your father: _____

If parents divorced, how old were you at that time? _____

List any problems in childhood, including delays in walking, talking, toilet training, fears, hyperactivity, learning problems, and traumatic events witnessed or experienced:

_____

When did you leave home and why? _____

SOCIAL HISTORY:

Where were you born and raised? _____How long in the USA?_____

When and how did you meet your partner? _____

How long have you been together? _____ How long married? _____

Describe your partner:_____

Do any of your children present special problems? _____

Have you ever put a child up for adoption (when and why)? _____

LEGAL HISTORY:

Have you ever been in trouble with the law, including arrests, charges, jail time and/or other sentencing for any crime (please give brief details)? _____

Name of probation or parole officer:_____ Phone #_____

List any lawsuits you are currently involved in or anticipating:

_____

Name of attorney:_____ Phone #_____

FOR ANY EMERGENCIES, PLEASE CALL 911 OR GO TO YOUR NEAREST EMERGENCY ROOM

Useful numbers:

National Suicide Prevention Lifeline
Need to talk to someone right away?
Need help? In the U.S., call 1-800-273-8255

IDAHO - STATEWIDE
Suicide Prevention & Hotline
24 hours / 7 days, call 1-800-564-2120

IDAHO Careline:
Information and Referral:
M-F, 8-6pm MST
211 or **1-800-926-2588**

Serving Ada, Boise, Valley & Elmore Counties
Regional Mental Health Services-Boise
24-Hour Crisis Line
(208) 334-0808
1-800-600-6474

Idaho Department of Health & Welfare
www.healthandwelfare.idaho.gov/