Changing Tides Psychiatry

2600 NE Hwy 101 Suite 200 Lincoln City, OR 97367
(541) 921-3584 Fax (541) 614-1291
contact-us@changingtidespsychiatry.org

PATIENT INFORMATION FORM

Name: _____ DOB: _____

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

Phone: (Cell) _____ (Home) _____ SSN: _____

Email: _____

Circle one: MINOR SINGLE MARRIED DIVORCED WIDOWED SEPARATED

Emergency Contact: _____ Phone: _____

Spouse or guardian: _____ Phone: _____

Who referred you? _____

RESPONSIBLE PARTY

Name: _____ Relationship to patient: _____

Address: _____ Phone: _____

Drivers License/ID # _____ DOB: _____ SSN: _____

Employer: _____ Phone: _____

Is this person currently a patient in this office? Yes No

INSURANCE INFORMATION

Insurance Company: _____ ID: _____ Group: _____

Secondary: _____ ID: _____ Group: _____

X _____ Date: _____

Signature of patient (or guardian if minor)

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Office Policies and Procedures

PATIENT INFORMATION AND CONSENT

Practice Information

- Office Hours: Money 9 – 3, Tuesday, Wednesday and Thursday 9-5 and Friday 9-2.
- Emergency Contact: (541) 921-3584
- After-hours Coverage: (541) 921-3584
- Website: https://sites.google.com/view/changingtidespsychiatry/

Appointment Policies

1. Scheduling and Cancellations

- Initial appointments are 60 to 90 minutes in length
- Follow-up appointments are 30 to 60 minutes in length
- 48-hour notice is required for cancellations
- Late cancelations or no-shows will incur a fee of 85.00, except if you carry Medicaid insurance.
- Repeated no-shows may result in termination of care

2. Payment and Insurance

- Self pay is due at the time of service
- Accepted payment methods: Cash, credit card, check
- We accept the following insurance plans: Most plans please ask
- Patients are responsible for knowing their insurance coverage
- Co-pays and deductibles must be paid at the time of visit

3. Medication Management

- Prescription refills require 72-hour notice
- Controlled substances require an appointment for refills at a minimum every three months
- Lost prescriptions will not be replaced without an appointment
- Random drug screening may be required for certain medications

4. Communication Policies

- Emergency situations: Call 911, 988 or go to the nearest emergency room
- Non-urgent matters: Response within 48 business hours
- Portal communication is for refills or questions related to medications or a request to change an appointment.
- Telehealth appointments are available

5. Confidentiality and Records

- All information is confidential except when:
  - Patient authorizes release of information
  - Patient presents immediate danger to self or others
  - Child/elder abuse is suspected
  - Court order requires information release
- Medical records requests require written authorization
- Processing time for records: seven business days

6. Treatment Agreement

I understand and agree to the following:

- Active participation in treatment is required
- Regular attendance at scheduled appointments
- Compliance with recommended treatment plan
- Honest communication about symptoms and medication effects
- Immediate notification of significant changes in condition
- Adherence to payment policies

CONSENT FOR TREATMENT

I, _____ , have read and understand the above policies. I authorize Changing Tides Psychiatry to provide psychiatric evaluation and treatment. I understand that I have the right to revoke this consent in writing at any time except to the extent that action has been taken in reliance upon it.

Signature: _____

Date: _____

PRIVACY PRACTICES ACKNOWLEDGEMENT

I acknowledge that I have received the Notice of Privacy Practices from Changing Tides Psychiatry.

Signature: _____

Date: _____

EMERGENCY CONTACT INFORMATION

Primary Contact: _____

Relationship: _____

Phone: _____

Secondary Contact: _____

Relationship: _____

Phone: _____

CREDIT CARD AUTHORIZATION

I authorize Changing Tides Psychiatry to charge my credit card for services rendered, including missed appointment fees and late cancellation fees.

Card Type: _____

Last 4 Digits: _____

Expiration Date: _____

Signature: _____

Date: _____

Patient Medical History Form

1. Personal Information

Full Name: _____ Date of Birth: ____/____/____

Address: _____ Phone: _____

Emergency Contact: _____ Relationship: _____

2. Current Health Status

Height: _____ Weight: _____ Last physical exam: _____

Primary Care Physician: _____ Phone: _____

3. Medical Conditions

Please check all that apply and provide year of diagnosis:

- ☐ High Blood Pressure (_____)
- ☐ Diabetes (_____)
- ☐ Heart Disease (_____)
- ☐ Cancer (_____)
- ☐ Asthma (_____)
- ☐ Thyroid Issues (_____)
- ☐ Mental Health: _____

4. Current Medications

Please list all medications, including over-the-counter drugs and supplements:

1. _____ Dosage: _____ Frequency: _____
2. _____ Dosage: _____ Frequency: _____
3. _____ Dosage: _____ Frequency: _____

5. Allergies

- ☐ Medications: _____
- ☐ Food: _____
- ☐ Others: _____

6. Surgical History

Procedure	Year
1. _____	_____
2. _____	_____

7. Family History

Please indicate any immediate family members (parents, siblings) with:

- ☐ Heart Disease ☐ Diabetes ☐ Cancer ☐ High Blood Pressure
- ☐ Mental health conditions: _____

8. Social History

Tobacco Use:	☐ Never	☐ Current	☐ Former (Quite Date: _____)
Alcohol Use:	☐ Never	☐ Occasional	☐ Regular
Exercise Level:	☐ None	☐ Moderate	☐ Regular

9. Women Only

Last Menstrual Period: ____/____/____

Pregnant? ☐ Yes ☐ No

Number of Pregnancies: _____ Number of Live Births: _____

I certify that the above information is accurate to the best of my knowledge.

Signature: _____ Date: ____/____/____

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TELEHEALTH/TELEPHONE APPOINTMENT CONSENT FORM

Patient Name: _____

Date of Birth: _____

Provider Name: _____

Date: _____

CONSENT FOR TELEHEALTH/TELEPHONE SERVICES

I hereby consent to receive psychiatric care through telehealth/telephone services. I understand that:

1. Telehealth/telephone services involve the delivery of healthcare services using electronic or telephone communications while the provider and patient are at different locations.

2. The same confidentiality protections that apply to in-person visits apply to telehealth/telephone services.

3. There are potential risks to telehealth/telephone technology, including:
   - Internet or phone service interruptions
   - Technical difficulties
   - Unauthorized access to confidential information
   - Limited ability to perform physical examinations

4. I have the right to withhold or withdraw this consent at any time.

5. All applicable federal and state laws regarding privacy, security, and access to my medical information apply to telehealth/telephone services.

EMERGENCY PROCEDURES

In case of emergency during a telehealth/telephone session:

Emergency Contact Name: _____

Phone: _____

Local Emergency Services Phone: _____

Current Location Address: _____

PATIENT ACKNOWLEDGMENT

- I agree to information my provider of my location at the start of each session.
- I understand that telehealth services may not be appropriate for all medical conditions.
- I agree to ensure privacy at my location during sessions.

INSURANCE INFORMATION

Insurance Provider: _____

Policy Number: _____

By signing below, I acknowledge that I have read, understand, and agree to the terms above:

Patient Signature: _____

Date: _____

Guardian Signature (if applicable): _____

Date: _____

Patient Name: _____

Date: _____

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This notice describes how medical information about you may be used and disclosed and how you can get access to this information.
Please review this notice carefully.

Your health record contains personal information about you and your health. This information about you that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services is referred to as Protected Health Information ("PHI"). This Notice of Privacy Practices describes how we may use and disclose your pHI in accordance with applicable law, including the Health Insurance Portability and Accountability Act ("HIPAA"), regulations promulgated under HIPAA including the HIPAA Privacy and Security Rules, and the *NASW Code of Ethics*. It also describes your rights regarding how you may gain access to and control your PHI.

We are required by law to maintain the privacy of PHI and to provide you with notice of our legal duties and privacy practices with respect to PHI. We are required to abide by the terms of this Notice of Privacy Practices. We reserve the right to change the terms of out Notice of Privacy Practices at any time. Any new Notice of Privacy Practices will be effective for all PHI that we maintain at that time. We will provide you with a copy of the revised Notice of Privacy Practices by posting a copy on our website, sending a copy to you in the mail upon request or providing one to you at your next appointment.

How We May Use and Disclose Health Information About You

For Treatment. Your PHI may be used and disclosed by those who are involved in your care for the purpose of providing, coordinating, or managing your health care treatment and related services. This includes consultation with clinical supervisors or other treatment team members. We may disclose PHI to any other consultant only with your authorization.

For Payment. We may use and disclose PHI so that we can receive payment for the treatment services provided to you. This will only be done with your authorization. Examples of payment-related activities are: making a determination of eligibility or coverage for insurance benefits, processing claims with your insurance company, reviewing services provided to you to determine medical necessity, or undertaking utilization review activities. If it becomes necessary to use collection processes due to lack of payment for services, we will only disclose the minimum amount of PHI necessary for purposes of collection.

For Health Care Operations. We may use or disclose, as needed, your PHI in order to support our business activities including, but not limited to, quality assessment activities, employee review activities, licensing, and conducting or arranging for other business activities. For example, we may share your PHI with third parties that perform various business activities (e.g., billing or typing services) provided we have a written contract with the business that requires it to safeguard the privacy of your PHI. For training or teaching purposes PHI will be disclosed only with your authorization.

Required by Law. Under the law, we must disclose your PHI to you upon your request. In addition, we must make disclosures to the Secretary of the Department of Health and Human Services for the purpose of investigating or determining our compliance with the requirements of the Privacy Rule.

Without Authorization. Following is a list of the categories of uses and disclosures permitted by HIPAA without an authorization. Applicable law and ethical standards permit us to disclose information about you without your authorization only in a limited number of situations.

Child Abuse or Neglect. We may disclose your PHI to a state or local agency that is authorized by law to receive reports of child abuse or neglect.

Judicial and Administrative Proceedings. We may disclose your PHI pursuant to a subpoena (with your written consent), court order, administrative order or similar processes.

Deceased Patients. We may disclose PHI regarding deceased patients as mandated by state law, or to a family member or friend that was involved in your care or payment for care prior to death, based on your prior consent. A release of information regarding deceased patients may be limited to an executor or administrator of a deceased person's estate or the person identified as next-of-kin. PHI of persons that have been deceased for more than fifty (50) years is not protected under HIPAA.

Medical Emergencies. We may use or disclose your PHI in a medical emergency situation to medical personnel only in order to prevent serious harm. Our staff will try to provide you a copy of this. Notice as soon as reasonably practicable after the resolution of the emergency.

Family Involvement in Care. We may disclose information to close family members or friends directly involved in your treatment based on your consent or as necessary to prevent serious harm.

Health Oversight. If required, we may disclose PHI to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies and organizations that provide financial assistance to the program (such as third-party payors based on your prior consent) and peer review organizations performing utilization and quality control.

Law Enforcement. We may disclose PHI to a law enforcement official as required by law, in compliance with a subpoena (with your written consent), court order, administrative order or similar document, for the purpose of identifying a suspect, material witness or missing person, in connection with the victim of a crime, in connection with a deceased person, in connection with the reporting of a crime in an emergency, or in connection with a crime on the premises.

Specialized Government Functions. We may review requests from U.S. military command authorities if you have served as a member of the armed forces, authorized officials for national security and intelligence reasons and to the Department of State for medical suitability determinations, and disclose your PHI based on your written consent, mandatory disclosure laws and the need to prevent serious harm.

Public Health. If required, we may use or disclose your PHI for mandatory public health activities to a public health authority authorized by law to collect or receive such information for the purpose of preventing or controlling disease, injury, or disability, or if directed by a public health authority, to a government agency that is collaborating with that public health authority.

Public Safety. We may disclose your PHI if necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. If information is disclosed to prevent or lessen a serious threat it will be disclosed to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat.

Research. PHI may only be disclosed after a special approval process or with your authorization.

Fundraising. We may send you fundraising communications at one time or another. You have the right to opt out of such fundraising communications with each solicitation you receive.

Verbal Permission. We may also use or disclose your information to family members that are directly involved in your treatment with your verbal permission.

With Authorization. Uses and disclosures not specifically permitted by applicable law will be made only with your written authorization, which may be revoked at any time, except to the extent that we have already made a use or disclosure based upon your authorization. The following uses and disclosures will be made only with your written authorization: (i) most uses and disclosures of psychotherapy notes which are separated from the rest of your medical records; (ii) most uses and disclosures of PHI for marketing purposes, including subsidized treatment communications; (iii) disclosures that constitute a sale of PHI; and (iv) other uses and disclosures not described in this Notice of Privacy Practices.

Your Rights Regarding Your PHI

You have the following rights regarding PHI we maintain about you. To exercise any of these rights, please submit your request in writing to our Privacy Officer at Secretary of the Department of Health and Human Services: 200 Independence Avenue S.W., Washington D.C. 20201.

- **Right of Access to Inspect and Copy.** You have the right, which may be restricted only in exceptional circumstances, to inspect and copy PHI that is maintained in a "designated record set". A designated record set contains mental health/medical and billing records and any other records that are used to make decisions about your care. Your right to inspect and copy PHI will be restricted only in those situations where there is compelling evidence that access would cause serious harm to you or if the information is contained in separately maintained psychotherapy notes. We may charge a reasonable, cost-based fee for copies. If your records are maintained electronically, you may also request an electronic copy of your PHI. You may also request that a copy of your PHI be provided to another person.

- **Right to Amend.** If you feel that the PHI we have about you is incorrect or incomplete, you may ask us to amend the information although we are not required to agree to the amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement and will provide you with a copy. Please contact the Privacy Officer if you have any questions.

- **Right to an Accounting of Disclosures.** You have the right to request an accounting of certain of the disclosures that we make of your PHI. We may charge you a reasonable fee if you request more than one accounting in any 12-month period.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the user or disclosure of your PHI for treatment, payment, or health care operations. We are not required to agree to your request unless the request is to restrict disclosure of PHI to a health plan for purposes of carrying out payment or health care operations, and the PHI pertains to a health care item or service that you paid for out of pocket. In that case, we are required to honor your request for a restriction.

- **Right to Request Confidential Communication.** You have the right to request that we communicate with you about health matters in a certain way or at a certain location. We will accommodate reasonable requests. We may require information regarding how payment will be handled or specification of an alternative address or other method of contact as a condition for accommodating your request. We will not ask you for an explanation of why you are making the request.

- **Breach Notification.** If there is a breach of unsecured PHI concerning you, we may be required to notify you of this breach, including what happened and what you can do to protect yourself.

- **Right to a copy of this Notice.** You have the right to a copy of this notice.

COMPLAINTS

If you believe we have violated your privacy rights, you have the right to file a complaint in writing with our Privacy Officer at: Secretary of Health and Human Services at 200 Independence Avenue, S.W. Washington, D.C. 20201 or by calling (202) 619-0257. **We will not retaliate against you for filing a complaint.**

_____ _____

Signature of Patient *Date*

_____

Printed Name

The effective date of this Notice is January 8, 2025

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RANDOM DRUG TESTING CONSENT FORM

Patient Name: _____ DOB: _____

- ☐ I hereby agree to submit to a random drug test by furnishing a sample of my: urine for analysis to Changing Tides Psychiatry when requested.
- ☐ I have been fully informed of the reason for this test and I understand what I am being tested for and the procedure involved.
- ☐ I am fully aware that the results of this test may be included in my patient chart and become part of my health care record.
- ☐ I understand that if at any time I refuse to submit to a drug test or if I otherwise fail to cooperate with the testing procedures, my continued care/treatment at Changing Tides Psychiatry may be immediately withdrawn from consideration or I may be subject to immediate termination of treatment/counseling.

Reason for consent: Prescribed a controlled substance as part of my ongoing treatment/counseling at Changing Tides Psychiatry.

X _____ Date: _____
Patient/Guardian Signature

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

I authorize my physician and/or administrative and clinical staff to use or disclose the following protected health information:

_____

_____

Name of entity/class of persons to receive/send information:

_____

_____

Description of protected information to be used or disclosed:

_____ Initial Assessment
_____ Discharge Summary
_____ Progress Notes
_____ Date of Service: _____
_____ Other(specify) _____
_____ Exchange of information/release of clinical information for coordination of care between above named individuals (telephone and/or written communications).

_____ Radiology Reports
_____ Consultation Reports
_____ Lab Reports

Purpose for use or disclosures: (Circle all that apply)

Insurance/Billing School Disability Continuing Care
Legal Personal Other: _____

I understand the contents to be released, the need for the information and that there are statutes and regulations protecting confidentiality of authorized information. I also understand that the contents may be subject to facsimile transmission. I acknowledge that the information may contain sensitive material, such as, but not limited to my condition relating to HIV status, drug use or alcohol abuse or psychiatric or psychological information.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the practice's privacy officer. I understand that this authorization will expire **one year** from the date of its being signed by me. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information or if any authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand the information used or disclosed, pursuant to this authorization may be disclosed by the recipient and may no longer be covered by federal or state law.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if any treatment is related to research or, (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

The use or disclosure requested under this authorization may result in direct or indirect remuneration to my physician from a third party (if applicable).

X _____ X _____
Patients Name - please print Date of birth

X _____ X _____
Signature Patient or personal representative-relationship Date

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Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date:_____ Patient Name:_____ Date of Birth:_____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answer

PHQ-9	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 hurting yourself in some way.	☐ 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? (Circle one)

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers

GAD-7	Not at all	Several days	More than 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? (Circle one)

Not difficult at all **Somewhat difficult** **Very difficult** **Extremely difficult**