Ashland Integrative Care PC

1745 Ashland St
Ashland, Oregon 97520
Ph: 541.201.3173 Fax: 541.371.5551

PATIENT INFORMATION FORM

(Please Print)

PATIENT INFORMATION				
Patient's Last Name: First: Middle:			Birthdate:	Sex: ❑ M ❑ F ❑ Other
Phone (H): Phone (Cell):	Patient's Email:	Preferred Communication? (circle one) Phone / Email		Marital Status (circle one) S M D Other
Street Address:				P.O. Box:
City:	State:	ZIP Code:		Social secuirity #
Primary Care Physician:				PCP Phone:
Referred by (please check one box): ❑ Family ❑ Friend ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Website ❑ Therapist ❑ Other				
Next of Kin:		Other family members seen here:		

INSURANCE INFORMATION			
(Please give your insurance card to the receptionist.)			
Insurance Name:	Address:		City, State, Zip:
ID/Policy #:	Group #:		Insurance Phone (MH/SA):
Subscriber's Name:	Subscriber's Soc. Sec. #:	Birth date:	Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other:
Subscriber's Address:			Same address as patient? ❑ Yes ❑ No
Name of Secondary Insurance (if applicable):	Subscriber's name:	ID/Policy #:	Group #:
Patient's relationship to subscriber: ❑ Self ❑ Spouse ❑ Child ❑ Other			

IN CASE OF EMERGENCY			
Emergency Contact:	Relationship to Patient:	Home Phone:	Work Phone.:

DEMOGRAPHIC INFORMATION			
Highest Grade Completed:	Currently In School? ❑ Yes ❑ No	Veteran? ❑ Yes ❑ No	Tribal Affiliation:
Race: ❑ Alaska Native ❑ American Indian ❑ White ❑ Asian ❑ Black/African/American ❑ Native Hawaiian/Pacific Islander ❑ Other Single Race ❑ 2 or More Unspecified Races			
Employment: ❑ Full-Time ❑ Part-Time Occupation: _____ Employer: _____ ❑ Unemployed ❑ Homemaker ❑ Student ❑ Retired ❑ Disabled (unable to work) ❑ Other			
Living Arrangement: ❑ Private Residence ❑ Foster Home ❑ Homeless ❑ Residential Facility ❑ Support Housing ❑ Alcohol/Drug Free Housing ❑ Other			

The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.

Patient/Guardian signature *Date*

Patient/Guardian name (Please Print)

*Legal guardians – please provide a copy of your legal guardianship documents.

Ashland Integrative Care PC
1745 Ashland St
Ashland, Oregon 97520
Ph: 541.201.3173 Fax: 541.371.5551

Adult Checklist of Concerns

Name: _____ Date: _____

Please mark all of the items below that apply, and feel free to add any others at the bottom under "Any other concerns or issues." You may add a note or details in the space next to the concerns checked. (For a child, mark any of these and then complete the "Child Checklist of Characteristics.")

- ❑ I have no problem or concern bringing me here
- ❑ Abuse—physical, sexual, emotional, neglect (of children or elderly persons), cruelty to animals
- ❑ Aggression, violence
- ❑ Alcohol use
- ❑ Anger, hostility, arguing, irritability
- ❑ Anxiety, nervousness
- ❑ Attention, concentration, distractibility
- ❑ Career concerns, goals, and choices
- ❑ Childhood issues (your own childhood)
- ❑ Codependence
- ❑ Confusion
- ❑ Compulsions
- ❑ Custody of children
- ❑ Decision making, indecision, mixed feelings, putting off decisions
- ❑ Delusions (false ideas)
- ❑ Dependence
- ❑ Depression, low mood, sadness, crying
- ❑ Divorce, separation
- ❑ Drug use—prescription medications, over-the-counter medications, street drugs
- ❑ Eating problems—overeating, undereating, appetite, vomiting (see also "Weight and diet issues")
- ❑ Emptiness
- ❑ Failure
- ❑ Fatigue, tiredness, low energy
- ❑ Fears, phobias
- ❑ Financial or money troubles, debt, impulsive spending, low income
- ❑ Friendships
- ❑ Gambling
- ❑ Grieving, mourning, deaths, losses, divorce
- ❑ Guilt
- ❑ Headaches, other kinds of pains
- ❑ Health, illness, medical concerns, physical problems
- ❑ Housework/chores—quality, schedules, sharing duties
- ❑ Inferiority feelings

(cont.)

- ❑ Interpersonal conflicts
- ❑ Impulsiveness, loss of control, outbursts
- ❑ Irresponsibility
- ❑ Judgment problems, risk taking
- ❑ Legal matters, charges, suits
- ❑ Loneliness
- ❑ Marital conflict, distance/coldness, infidelity/affairs, remarriage, different expectations, disappointments
- ❑ Memory problems
- ❑ Menstrual problems, PMS, menopause
- ❑ Mood swings
- ❑ Motivation, laziness
- ❑ Nervousness, tension
- ❑ Obsessions, compulsions (thoughts or actions that repeat themselves)
- ❑ Oversensitivity to rejection
- ❑ Panic or anxiety attacks
- ❑ Parenting, child management, single parenthood
- ❑ Perfectionism
- ❑ Pessimism
- ❑ Procrastination, work inhibitions, laziness
- ❑ Relationship problems (with friends, with relatives, or at work)
- ❑ School problems (see also "Career concerns . . . ")
- ❑ Self-centeredness
- ❑ Self-esteem
- ❑ Self-neglect, poor self-care
- ❑ Sexual issues, dysfunctions, conflicts, desire differences, other (see also "Abuse")
- ❑ Shyness, oversensitivity to criticism
- ❑ Sleep problems—too much, too little, insomnia, nightmares
- ❑ Smoking and tobacco use
- ❑ Spiritual, religious, moral, ethical issues
- ❑ Stress, relaxation, stress management, stress disorders, tension
- ❑ Suspiciousness
- ❑ Suicidal thoughts
- ❑ Temper problems, self-control, low frustration tolerance
- ❑ Thought disorganization and confusion
- ❑ Threats, violence
- ❑ Weight and diet issues
- ❑ Withdrawal, isolating
- ❑ Work problems, employment, workaholism/overworking, can't keep a job, dissatisfaction, ambition

Any other concerns or issues:

- ❑ _____
- ❑ _____

Please look back over the concerns you have checked off and choose the one that you most want help with. It is:

_____

The first step in finding out whether you might have bipolar disorder is to have an in-depth discussion with your healthcare provider about your symptoms and how your condition may be affecting you. Answering the questions on this form will help you do that. It will take about 5 minutes to fill out. It is not meant to self-diagnose, so please print the form and bring it with you to your next appointment.

Mood Disorder Questionnaire

Name: _____ **Date:** ___/___/___

Please answer the questions as best you can by putting a check in the appropriate box.

1. Has there ever been a period of time when you were not your usual self and ...	Yes	No
... 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 that you didn't really miss it?		
... you were 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?	Yes	No

3. How much of a problem did any of these cause you? (like being unable to work; having family, money, or legal troubles; and/or getting into arguments or fights)	No Problem	Minor Problem	Moderate Problem	Serious Problem

The Mood Disorder Questionnaire (MDQ) was developed by Robert M. A. Hirschfeld, MD (University of Texas Medical Branch), and published in the *American Journal of Psychiatry*. (Hirschfeld RMA, Williams JBW, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry*. 2000;157(11):1873-1875.)

VRA125942-d 09/19

Patient Health Questionnaire (PHQ-9)

Patient Name: _____ **Date:** _____

	Not at all	Several days	More than half the days	Nearly every day
1. Over the *last 2 weeks*, how often have you been bothered by any of the following problems?				
a. Little interest or pleasure in doing things	☐	○	○	○
b. Feeling down, depressed, or hopeless	☐	○	○	○
c. Trouble falling/staying asleep, sleeping too much	☐	○	○	○
d. Feeling tired or having little energy	☐	○	○	○
e. Poor appetite or overeating	☐	○	○	○
f. Feeling bad about yourself or that you are a failure or have let yourself or your family down	☐	○	○	○
g. Trouble concentrating on things, such as reading the newspaper or watching television.	☐	○	○	○
h. 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.	☐	○	○	○
i. Thoughts that you would be better off dead or of hurting yourself in some way.	☐	○	○	○
2. If you checked off any problem on this questionnaire so far, 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
	☐	○	○	○

Ashland Integrative Care PC
1745 Ashland St
Ashland, Oregon 97520
Ph: 541.201.3173 Fax: 541.371.5551

PATIENT HISTORY FORM

Date: _____/_____/_____

NAME: _____ Birthdate: _____/_____/_____
Last First M. I.

Age:_____ Sex: ❑ F ❑ M

How did you hear about this clinic?

Describe briefly your present symptoms:

Please list the names of other practitioners you have seen for this problem:

Psychiatric Hospitalizations (include where, when, & for what reason):

Have you ever had ECT? Have you had psychotherapy?

CURRENT MEDICATIONS

Drug allergies: ❑ No ❑ Yes To what?
Please list any medications that you are now taking. Include non-prescription medications & vitamins or supplements:

	Name of drug	**Dose (include strength & number of pills per day):**	**How long have you been taking this?**
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			

Physician Initials _____

PAST MEDICAL HISTORY

Do you now or have you ever had:

- ❑ Diabetes
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Hypothyroidism
- ❑ Goiter
- ☐ Cancer (type) _____
- ❑ Leukemia
- ❑ Psoriasis
- ❑ Angina
- ❑ Heart problems
- ❑ Heart murmur
- ❑ Pneumonia
- ❑ Pulmonary embolism
- ❑ Asthma
- ❑ Emphysema
- ❑ Stroke
- ❑ Epilepsy (seizures)
- ❑ Cataracts
- ❑ Kidney disease
- ❑ Kidney stones
- ❑ Crohn's disease
- ❑ Colitis
- ❑ Anemia
- ❑ Jaundice
- ❑ Hepatitis
- ❑ Stomach or peptic ulcer
- ❑ Rheumatic fever
- ❑ Tuberculosis
- ❑ HIV/AIDS

Other medical conditions (please list):

PERSONAL HISTORY

Were there problems with your birth? (specify)

Where were your born & raised?

What is your highest education? ❑High school ❑Some college ❑College graduate ❑Advanced degree

Marital status: ❑ Never married ❑ Married ❑ Divorced ❑ Separated ❑ Widowed ❑ Partnered/significant other

What is your current or past occupation?

Are you currently working? : ❑ Yes ❑ No Hours/week _____ If not, are you ❑ retired ❑ disabled ❑ sick leave?

Do you receive disability or SSI? ❑ Yes ❑ No If yes, for what disability & how long?_____

Have you ever had legal problems? (specify)

Religion:

FAMILY HISTORY

	IF LIVING		IF DECEASED	
	Age (s)	Health & Psychiatric	Age(s) at death	Cause
Father				
Mother				
Siblings				
Children				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS PAST & PRESENT:

Maternal Relatives:

Paternal Relatives:

Physician Initials _____

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL
- ❑ Recent weight gain; how much____
- ❑ Recent weight loss: how much____
- ❑ Fatigue
- ❑ Weakness
- ❑ Fever
- ❑ Night sweats

MUSCLE/JOINTS/BONES
- ❑ Numbness
- ❑ Joint pain
- ❑ Muscle weakness
- ❑ Joint swelling

Where?

EARS
- ❑ Ringing in ears
- ❑ Loss of hearing

EYES
- ❑ Pain
- ❑ Redness
- ❑ Loss of vision
- ❑ Double or blurred vision
- ❑ Dryness

THROAT
- ❑ Frequent sore throats
- ❑ Hoarseness
- ❑ Difficulty in swallowing
- ❑ Pain in jaw

HEART AND LUNGS
- ❑ Chest pain
- ❑ Palpitations
- ❑ Shortness of breath
- ❑ Fainting
- ❑ Swollen legs or feet
- ❑ Cough

NERVOUS SYSTEM
- ❑ Headaches
- ❑ Dizziness
- ❑ Fainting or loss of consciousness
- ❑ Numbness or tingling
- ❑ Memory loss

STOMACH AND INTESTINES
- ❑ Nausea
- ❑ Heartburn
- ❑ Stomach pain
- ❑ Vomiting
- ❑ Yellow jaundice
- ❑ Increasing constipation
- ❑ Persistent diarrhea
- ❑ Blood in stools
- ❑ Black stools

SKIN
- ❑ Redness
- ❑ Rash
- ❑ Nodules/bumps
- ❑ Hair loss
- ❑ Color changes of hands or feet

BLOOD
- ❑ Anemia
- ❑ Clots

KIDNEY/URINE/BLADDER
- ❑ Frequent or painful urination
- ❑ Blood in urine

Women Only:
- ❑ Abnormal Pap smear
- ❑ Irregular periods
- ❑ Bleeding between periods
- ❑ PMS

PSYCHIATRIC
- ❑ Depression
- ❑ Excessive worries
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep
- ❑ Difficulties with sexual arousal
- ❑ Poor appetite
- ❑ Food cravings
- ❑ Frequent crying
- ❑ Sensitivity
- ❑ Thoughts of suicide / attempts
- ❑ Stress
- ❑ Irritability
- ❑ Poor concentration
- ❑ Racing thoughts
- ❑ Hallucinations
- ❑ Rapid speech
- ❑ Guilty thoughts
- ❑ Paranoia
- ❑ Mood swings
- ❑ Anxiety
- ❑ Risky behavior

OTHER PROBLEMS:

WOMENS REPRODUCTIVE HISTORY:

Age of first period:
Pregnancies:
Miscarriages:
Abortions:
Have you reached menopause? Y ◯ /N ◯ At what age?
Do you have regular periods? Y ◯ / N ◯

Physician Initials _____

SUBSTANCE USE					
DRUG CATEGORY (circle each substance used)	Age when you first used this:	How much & how often did you use this?	How many years did you use this?	When did you last use this?	Do you currently use this?
ALCOHOL					Yes ☐ No ☐
CANNABIS: Marijuana, hashish, hash oil					Yes ☐ No ☐
STIMULANTS: Cocaine, crack					Yes ☐ No ☐
STIMULANTS: Methamphetamine—speed, ice, crank					Yes ☐ No ☐
AMPHETAMINES/OTHER STIMULANTS: Ritalin, Benzedrine, Dexedrine					Yes ☐ No ☐
BENZODIAZEPINES/TRANQUILIZERS: Valium, Librium, Halcion, Xanax, Diazepam, "Roofies"					Yes ☐ No ☐
SEDATIVES/HYPNOTICS/BARBITURATES: Amytal, Seconal, Dalmane, Quaalude, Phenobarbital					Yes ☐ No ☐
HEROIN					Yes ☐ No ☐
CAFFEINE					Yes ☐ No ☐
CIGARETTES					Yes ☐ No ☐
METHADONE					Yes ☐ No ☐
OTHER OPIOIDS: Tylenol #2 & #3, 282'S, 292'S, Percodan, Percocet, Opium, Morphine, Demerol, Dilaudid					Yes ☐ No ☐
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT, mescaline, peyote, mushrooms, ecstasy (MDMA), nitrous oxide					Yes ☐ No ☐
INHALANTS: Glue, gasoline, aerosols, paint thinner, poppers, rush, locker room					Yes ☐ No ☐
OTHER: (specify) _____ _____ _____					Yes ☐ No ☐

Physician Initials _____

Ashland Integrative Care PC

Psychiatric Medication History

Please check all medications that you have previously taken or are currently taking.

Antidepressants

- ☐ Prozac (fluoxetine)
- ☐ Paxil (paroxetine)
- ☐ Zoloft (sertraline)
- ☐ Celexa (citalopram)
- ☐ Lexapro (escitalopram)
- ☐ Effexor (venlafaxine)
- ☐ Wellbutrin (bupropion)
- ☐ Remeron (mirtazapine)
- ☐ Cymbalta (duloxetine)
- ☐ Serzone (nefazadone)
- ☐ Anafranil (clomipramine)
- ☐ Luvox (fluvoxamine)
- ☐ Pamelor (nortriptyline)
- ☐ Elavil (amitryptiline)
- ☐ Tofranil (imipramine)
- ☐ Desyrel (trazodone)
- ☐ Sinequan (doxepin)
- ☐ Viibryd (vilazodone)
- ☐ Fetzima (levomilnacipran)
- ☐ Pristiq (desvenlafaxine)
- ☐ Other (write in) _____

Comments on Effects: _____

_____

_____

Mood Stabilizers

- ☐ Lithium
- ☐ Depakote (valproate)
- ☐ Lamictal (lamotrigine)
- ☐ Tegretol (carbamazepine)
- ☐ Trileptal (oxcarbamazepine)
- ☐ Topamax (topiramate)
- ☐ Neurontin (gabapentin)
- ☐ Other (write in) _____

Comments on Effects: _____

_____

_____

Antipsychotics

- ☐ Risperdal (risperidone)
- ☐ Seroquel (quetiapine)
- ☐ Zyprexa (olanzapine)
- ☐ Geodon (ziprasidone)
- ☐ Haldol (haloperidol)
- ☐ Prolixin (fluphenazine)
- ☐ Trilafon (perphenazine)
- ☐ Saphris (ascenapine)
- ☐ Latuda (lurasidone)
- ☐ Invega (paliperidone)
- ☐ Fanapt (iloperidone)
- ☐ Abilify (aripiprizole)
- ☐ Clozaril (clozapine)
- ☐ Rexulti (brexpiprazole)
- ☐ Vryalar (cariprazine)
- ☐ Other (write in) _____

Comments on Effects: _____

_____

_____

_____ _____ _____

Patient Name (please print) **Provider Initials** **Date**

Ashland Integrative Care PC

Psychiatric Medication History

Please check all medications that you have previously taken or are currently taking.

ADHD

- ☐ Ritalin (methylphenidate) AKA:
  - ☐ *Concerta*
  - ☐ *Metadate*
  - ☐ *Methylin*
  - ☐ *Daytrana*
- ☐ Dexedrine (dextroamphetamine)
- ☐ Focalin (dexmethylphenidate)
- ☐ Adderall (dextroamphetamine)
- ☐ Tenex/Intuniv (guanfacine)
- ☐ Catapress/Kapvay (clonidine)
- ☐ Strattera (atomoxetine)
- ☐ Wellbutrin (buproprion)
- ☐ Vyvanse (lisdexamfetamine)
- ☐ Other (write in) _____

Comments on Effects: _____

_____

_____

Anxiolytics

- ☐ Xanax (alprazolam)
- ☐ Ativan (lorazepam)
- ☐ Klonipin (clonazepam)
- ☐ Valium (diazepam)
- ☐ Tranzene (chlorazepate)
- ☐ Serax (oxazepam)
- ☐ Buspar (buspirone)
- ☐ Librium (chlordiazepoxide)
- ☐ Vistaril (hydroxyzine)
- ☐ Other (write in) _____

Comments on Effects: _____

_____

_____

Sedative/Hypnotics

- ☐ Ambien (zolpidem)
- ☐ Restoril (temazepam)
- ☐ Lunesta (eszopiclone)
- ☐ Sonata (zaleplon)
- ☐ Rozerem (ramelteon)
- ☐ Vistaril (hydroxyzine)
- ☐ Benadryl (diphenhydramine)
- ☐ Dalmane (flurazepam)
- ☐ Halcion (triazolam)
- ☐ Melatonin
- ☐ Other (write in) _____

Comments on Effects: _____

_____

_____

_____ _____ _____

Patient Name (please print) **Provider Initials** **Date**

Ashland Integrative Care PC
1745 Ashland St, Ashland, Oregon 97520
Ph: 541.201.3173 | Fax: 541.371.5551
www.AshlandIntegrativeCare.com

Patient Rights, Responsibilities & Consent for Treatment (Including AI Use, Email, and Text)

Patient Rights

You have the right to:

- Understand your diagnosis and treatment recommendations.
- Make informed decisions to accept or refuse treatment, and to voluntarily terminate treatment at any time (you remain financially responsible for services already provided).
- Be treated with dignity and respect regardless of race, religion, gender, ethnicity, age, or disability.
- Receive assistance in a prompt, courteous, and professional manner.
- Confidentiality of your personal and clinical information, except in cases of:
    - Life-threatening emergencies
    - Abuse/neglect of minors or elders
    - Danger to self or others
    - Required reporting by law
    - Insurance reimbursement (which may require sharing of diagnoses or treatment notes)

Patient Responsibilities

You agree to:

- Present valid ID and insurance at each visit.
- Inform the office of any changes in contact or insurance information.
- Disclose full and accurate health information, including current medications and use of alcohol/recreational drugs.
- Notify the office of other psychiatric providers you are seeing (dual prescribing may result in discharge).
- Allow 72 hours for prescription refill processing and contact the office if you encounter issues with your pharmacy.
- Treat all staff with respect. Verbal or physical abuse may result in dismissal from care.

Payment and Appointment Policies

- Payment (co-pays, fees for non-covered services, missed appointments) is due at time of service.
- You are responsible for remembering your appointments. A courtesy reminder will be provided via your preferred contact method.
- Missed appointments without 24-hour notice will result in:
    - 1st: $50 charge
    - 2nd: $100 charge
    - 3rd: Full visit fee (not covered by insurance) and potential discharge
    - We may refer you elsewhere if your needs exceed our scope or therapeutic relationship cannot be established.

Communication Policy

- Office Hours: Mon-Thu, 10:00 am-4:30 pm. Alternating Saturdays 10:00 am-3:00 pm. One Sunday/month. Closed on holidays.
- Emergencies: Call 911 or go to the nearest emergency room for immediate threats or severe medication reactions.

- Voicemail: Checked daily on business days.
- Phone Calls: Reserved for urgent issues and will be brief. No medication changes are made by phone.
- Text Messaging: Only used for appointment reminders. No clinical communication by text.
- Email: Email is not a secure platform and is not used for clinical issues. Messages will not be responded to if they include clinical content.

AI Use Consent:

To assist with accurate documentation and quality care, this practice may use HIPAA-compliant AI tools to transcribe and summarize session notes. This may involve session recording.
By signing below, you acknowledge and consent that:

- Sessions may be recorded (audio only) for note generation purposes.
- HIPAA-compliant AI software will transcribe or summarize notes.
- Data is encrypted, stored securely, and not used for automated decision-making.
- You may withdraw consent at any time, and alternative documentation methods will be used.
- No recordings will be used beyond clinical documentation without your explicit written permission.

Consent for Email and/or Text Messaging

By signing below, you consent to receive email and/or text communications (e.g., appointment reminders).
You:

1. Are the authorized user of the listed mobile number/email address.
2. Understand message/data rates may apply.
3. Can opt out at any time by notifying our office.

Medication Policies

- Side Effects: Discuss all medication side effects with your provider before stopping or changing doses.
- Benzodiazepines: Subject to random urine drug screens. Short-term use is strongly preferred. Monthly appointments are required.
- Stimulants: Prescribed based on formal diagnosis. Urine drug screening may be required. Monthly follow-up is required.
- Insurance Formularies: While we aim to prescribe covered medications, it is your responsibility to verify coverage.

Inactive Patients

If you have not been seen in over 90 days (unless otherwise arranged), we will consider you inactive and discontinue refills.

Acknowledgment & Signature

By signing below, you affirm that you understand and consent to the policies outlined above, including the use of AI tools and your communication preferences.

Patient Name (print): _____

Patient Signature: _____ Date: _____

Guardian Signature (if applicable): _____ Date: _____

Mobile Number (for texts): _____ Date of Birth: _____

Practitioner Signature: _____ Date: _____

Authorization for Use & Disclosure of Information

Ashland Integrative Care PC • 1745 Ashland St • Ashland, Oregon 97520
Ph: 541.201.3173 • Fax: 541.371.5551

Section A				
	Legal Last Name	First	MI	Date of Birth
	Other Names Used By Client/Applicant			Case ID#

By signing this form, I authorize the following record holder (individual, school, employer, agency, or medical or other provider) to disclose the following specific confidential information about me:

Section B	Release From	Specific Information to be Disclosed	Mutual Exchange: Yes/No

If the information contains any of the types of records or information listed below, additional laws relating to use and disclosure may apply. I understand that this information will not be disclosed unless I place my initials in the space next to the information:

HIV/AIDS_____ Mental Health_____ Alcohol/Drug diagnoses, treatment, referral_____ Genetic Testing _____

Section C	Release To (address required if mailed): If releasing to a team, list members.	Purpose	Expiration Date or Event*
	Joann Gruber, PMHNP-BC, FNP-BC		
	Ashland Integrative Care		
	1745 Ashland St		
	Ashland, OR 97520		

I can cancel this authorization at any time. The cancellation will not affect any information that was already disclosed. I understand that state and federal law protects information about my case. I understand what this agreement means and I approve of the disclosures listed. I am signing this authorization of my own free will.

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

Section D			
	Full Legal Signature of Individual OR Authorized Personal	Relationship to Client	Date
	Name of Staff Person (print)	Initialing Agency Name/Location	Date

*** The authorization is valid for one year from the date of signing unless otherwise specified.**

Full Legal Signature of Agency Staff Person Making Copies	**This is a true copy of the original Authorization document.**
Print Staff Name	

Important Information for the Client

Using This Form

1. **Terms Used: Mutual exchange:** A "yes" allows information to go back and forth between the record holder and the people or programs listed on the authorization. **Team:** A number of individuals or agencies working together regularly. The members of the team must be identified on this form.
2. **Assistance:** Whenever possible, your provider should fill out this form with you. **Be sure you understand the form before signing.** Feel free to ask questions about the form and what it allows. You may substitute a signature with making a mark or by asking an **authorized** person to sign on your behalf.
3. **Guardianship/Custody:** If the person signing this form is a personal representative, such as a guardian, a copy of the legal documents that verify the representative's authority to sign the authorization must be attached to this form. Similarly, if an agency has custody, and their representative signs, their custody authority must be attached to this form.
4. **Cancel:** If you later want to cancel this authorization, contact your Jackson County staff person. You can remove a team member from the form. You may be asked to put the cancellation request in writing. Federal regulations do not require that the cancellation be in writing for the Drug and Alcohol Programs. No more information can be disclosed or requested after authorization is cancelled. Jackson County can continue to use information obtained prior to cancellation.
5. **Minors:** If you are a minor, you may authorize the disclosure of mental health or substance abuse information if you are age 14 or older; for the disclosure of any information about sexually transmitted diseases or birth control regardless of your age; for the disclosure of general medical information if you are age 15 or older.
6. **Special Attention:** For information about **HIV/AIDS, mental health, genetic testing or alcohol/drug abuse treatment**, the authorization must clearly identify the specific information that may be disclosed.

Ashland Integrative Care PC
1745 Ashland St
Ashland, Oregon 97520
Ph: 541.201.3173 Fax: 541.371.5551

Notice of Privacy Practices
Receipt and Acknowledgment of Notice

Patient/Client Name:_____

DOB: _____

SSN:_____

I acknowledge that I have received a Summary and have been given an opportunity to read a copy of the Notice of Privacy Practices for Ashland Integrative Care PC. I understand that if I have any questions regarding the Notice or my privacy rights, I can contact Ashland Integrative Care PC, Privacy Information Officer at: 541.201.3173.

_____ _____
Signature of Patient/Client Date

_____ _____
Signature or Parent, Guardian or Personal Representative Date

If you are signing as a personal representative of an individual, please describe your legal authority to act for this individual (power of attorney, healthcare surrogate, etc.).

_____

☐ Patient/Client Refuses to Acknowledge Receipt:

_____ _____
Signature of Staff Member Date