Ashland Integrative Care PC
Joann Gruber PMHNP-BC, FNP-BC
1607 Siskiyou Blvd
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 Security #:
Primary Care Physician:			PCP Phone: ( )

Referred by (please check one box): ❑ Family ❑ Friend ❑ Dr. _____ ❑ Insurance Plan ❑ Hospital ❑ Website ❑ Close to home/work ❑ Other

Previous Counseling? ❑ Yes ❑ No Other family members seen here:

Current Counselor Name:

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

Name of local friend or relative (not living at same address):	Relationship to Patient:	Home Phone no.: ( )	Work Phone no.: ( )

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.

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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
	☐	○	○	○

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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**

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Patient Rights and Responsibilities/Consent for Treatment

Thank you for choosing our office to meet your healthcare needs. We ask that you take the time to read and sign the following to help better understand what to expect of your patient/provider/insurance company relationship including office policies. By signing this form, you agree and consent to treatment at this office.

Patient's Rights:

- You have the right to an explanation of your diagnosis as well as treatment recommendations.
- You have the right to make an informed decision whether to accept or refuse treatment.
- You have the right to voluntarily terminate treatment any time. You will still be financially responsible for unpaid services already rendered.
- You have the right to be treated with dignity and respect regardless of race, religion, gender ethnicity, age or disability.
- You have the right to receive assistance in a prompt, courteous and responsible manner. This may include having a friend, family member, caregiver or interpreter come to your appointment with you if desired.
- You have the right to confidentiality. Only in a life threatening emergency, or if required by law, can records be released without patient authorization. State and local law require reporting of abuse or neglect of the elderly or minors. The law also requires the practitioner to report any danger to self or others.
- You have the right to see and request a copy of your health records.
- You have a right to limit who can see your health records. Furthermore, if you request a copy be sent to your insurance company or third party payer for billing or reimbursement purposes, we cannot guarantee absolute confidentiality of your insurance company or third party payer. It is a routine process of insurance companies to request written treatment plans and to review psychiatric records and diagnosis codes. Any agent of your insurance company may be privy to information regarding your treatment.

Patient's Responsibilities Are:

- To present your ID and insurance card and make authorization arrangements prior to receiving services.
- To inform our office of any address, phone number or insurance changes before appointments.
- To provide honest and complete information to those providing care, including drug or alcohol information.
- To know what medication you are taking, why you are taking it, and the proper way to take it.
- To inform us of any medication or supplements you are taking this includes alcohol and recreational drugs.
- If you are seeing other psychiatric prescribers concurrently we will not be considered your provider and may discharge you unless otherwise arranged. This is a safety risk issue.
- To allow the office a 72-hour response time when requesting refills, which need to be initiated by your pharmacy. If you are unable to get your medication contact this office so that we can intervene with your pharmacy.
- To give the staff the same respect you are given. Any conflicts should be discussed with your clinician. Verbal, physical or written abuse may be result in dismissal from this office.

Paym**ents and Appointments:**

- To pay all applicable charges at time of service, including any co-payments, co-insurance, or charges for missed appointments, bank charge for any returned checks and services non-covered by your insurance carrier.
- To assume responsibility for the date and time of your appointments you will get one courtesy reminder call, or e-mail depending on your preference.
- To keep scheduled appointments or provide a minimum of 24 hours notice when canceling or rescheduling.
- We reserve the right to refer you to another healthcare provider if we feel that your needs are beyond what this office can provide you or we are not able to establish a therapeutic relationship. We will do the best to make an appropriate referral or refer you back to your insurance company.

Contact/ Clinical Information:

Office Hours: Mon-Fri, 9:00 am-5:30 pm. Every other Saturday 9:00 am-3:00 pm. Closed for all major holidays
Voicemails are checked daily with the exception of closed days.

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Emergencies: If you have an emergency and need to reach the on call provider follow the prompts on the voicemail. Please reserve this for true emergencies. If you are having feelings of harming yourself or others call 911 or seek help at your local emergency room. If you are having a reaction to your medication that includes shortness of breath, rash or allergic reactions call or seek medical help.

Phone Calls: Phone calls between visits are reserved for urgent issues and will be brief. **No changes in medications will be made without a visit.** A temporary solution will be arranged and a visit will be made to discuss long-term plans**.** Phone calls lasting more than 10 minutes will be billed at a rate of $200.00 per hour.

Email/Text: We do not text at this office other than for appointment reminders. **We will not respond to any clinical issues nor assume responsibility for clinical issues presented via email.**

Medication side effects: It is your responsibility to discuss your side effects or reactions with your prescriber so that changes can be made to your treatment plan. Do NOT stop your medication without notifying your prescriber as this may affect you in a negative way.

Benzodiazepines: If you are using these medications routinely you will be subject to random urine drug screens. Benzodiazepines are best used for short-term use only. Long-term effects include memory loss and dementia. Benzodiazepines have also been found to be the cause of some unintended deaths. It is expected you will be actively involved with alternative therapies including counseling, cognitive behavioral therapy, and/or using non-benzodiazepine medications to treat your anxiety. If you are not willing to participate in any other treatment options for your anxiety, you may want to look for a different mental health provider. Monthly visits are required for this type of medication to be prescribed.

Stimulants: These medications are reserved for specific diagnosis and if taking these, you will be subject to urine drug screening as they are considered to be highly abused medications. If you are not willing to participate in the necessary testing for proper diagnosis and trying non-stimulant alternatives, you may want to look for a different mental health provider. Monthly visits are required for this type of medication to be prescribed.

Insurance and medications: Your insurance has a unique list of “covered” medications (formulary). Once the best medication for your diagnosis has been determined, we will try to prescribe within that formulary to the best of our ability. Ultimately, it is your responsibility to know your insurance formulary.

If you have not had an appointment in 90 days (unless agreed upon with your practitioner) you will no longer be considered a patient and no refills will be given.

My signature below indicates that I understand, consent to, and agree with the above statements.

Patient Name (print): _____ Date: _____

Patient Signature: _____ Date: _____

Guardian Signature: _____ Date: _____

I have discussed the above information with the named individual and/or parent/guardian if a minor. My observations and clinical impression of the mental status, behavior and responses of named individual or representative give me no reason to believe that they are not fully competent at this date and time to give informed, voluntary consent to treatment.

Practitioner Signature: _____ Date: _____

Authorization for Use & Disclosure of Information

Ashland Integrative Care PC • 1607 Siskiyou Blvd • 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		
	1607 Siskiyou Blvd		
	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
1607 Siskiyou Blvd
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

Ashland Integrative Care P.C.
1607 Siskiyou Blvd
Ashland, Oregon 97520
www.AshlandIntegrativeCare.com

CONSENT FORM FOR EMAIL and/or TEXT MESSAGING

I give permission and consent to send and receive email and/or text messages from Ashland Integrative Care or others acting on Ashland Integrative Cares behalf. As part of this consent, I represent and warrant the following:

(1) Ashland Integrative Care or others acting on their behalf may send email and/or text messages in various formats and with various contents, including but not limited to, text messages about appointment reminders.
(2) I am the owner or authorized user of the mobile phone number identified below. I will notify you immediately if I am no longer the owner or authorized user of the mobile phone number identified below.

(3) I am solely responsible for any message and data charges associated with such email and/or text messages.

* If you do not wish to receive email and/or text messages from Ashland Integrative Care or others acting on their behalf, you should not sign this form.

_____ Printed Name

_____ Signature

_____ Date

_____ Mobile Phone Number

_____ Date of Birth