Anthropos Health & Counseling Center PLLC

PLEASE PROVIDE THE RECEPTIONIST YOUR INSURANCE CARD(S) AND PHOTO ID. IT WILL BE COPIED AND RETURNED TO YOU. ● *cash pay*

Last Name:				☐ MALE ☐ FEMALE
First Name:	MI:	SSN:		Home Phone:
Address:	Date of Birth:	Age:		Cell Phone:
City:	State:	ZIP + 4:	Date of Injury:	Work Phone:
Employer:		Occupation:		
Email Address:		Referring / PCP:		
Name & Relationship to insured:	Insured DOB:	Insured SS#:	Insured Employer:	

If this is an Injury claim, does an Attorney represent you? ☐ YES ☐ NO
Name and phone number of Attorney:

Restrictions:

May we EMAIL or TEXT your cell phone with information or questions?	☐ YES	☐ NO
May we call and leave message(s) with anyone who answers your phone?	☐ YES	☐ NO
May we call and leave message(s) on your home phone?	☐ YES	☐ NO

Emergency Contact Person Last Name:	First Name:	Phone:

Please indicate the name(s), DOB(s), and relationship of person(s) you authorize to have access to your medical information.

☐ **PROVIDED A COPY OF INSURANCE CARD?** ☐ **PROVIDED A COPY OF PHOTO ID?**

Would you like your credit/debit card to remain on file and used for outstanding balances?

Signature _____ *Date* _____ *Name on Card* _____

ID# _____ *Exp Date* _____ *3 digit Security* _____

ACKNOWLEDGEMENT OF *Notice of Privacy* PRACTICES

I have been informed - either in writing or verbally - of the "Notice of Privacy" practices *(HIPAA regulation)*

Signature: _____ Date: _____

NON MEDICARE LIFETIME AUTHORIZATION, Assignment and Release: I hereby authorize payment directly to my provider for all insurance benefits otherwise payable to me for medical services rendered. I understand that I am financially responsible for all charges, whether or not allowed or paid by my insurance, and for all services rendered on behalf of my dependents. I also understand that it is my responsibility to know when my maximum insurance benefits have been met and I agree to pay for services at full fee thereafter. I authorize my provider to release the information required to secure the payment of benefits. I authorize the use of this signature on all insurance submissions. I AM AWARE AND AGREE TO A "NO SHOW FEE" OF $50.00 IF I FAIL TO CALL AND CANCEL MY APPOINTMENT WITHIN 24 HOURS OF MY SCHEDULED APPOINTMENT TIME. *I have read, understand, and agree to the above.*

_____ _____
Date Signature of Guarantor

Office Use only:

SCANNED ☐ This form ☐ Copies of the insurance cards – front and back ☐ Photo ID

REV: 02012019

ANTHROPOS
HEALTH & COUNSELING CENTER
Leslie C. Rodriguez, A.R.N.P.
2807 W. Washington Ave., Rm135
Yakima, WA 98903
Tel: (509) 383-4325 • Fax: (509) 383-4324

I would like to take this opportunity to thank you for choosing me as your mental health care provider. Because you are placing your trust in me, I feel it is necessary to thoroughly evaluate your symptoms and concerns.

The office staff is committed to assist you in any way possible. However, it is your responsibility to contact your insurance company for mental health benefit information. Be aware that a quote of benefits is not a guarantee of payment. It is important for you to have a clear understanding of your mental health benefits prior to pursuing any treatment.

OFFICE POLICIES

HOURS

We are open Monday through Friday by appointment only. Occasional evening and Saturday appointments are also available.

APPOINTMENT CANCELLATIONS & RESCHEDULING

My office requires **24 hours** notice for appointment cancellations. Missed or cancelled appointments without the required **24 hour** notice will be charged the full rate and will be the patient's responsibility, as insurance does not reimburse for missed appointments.

Guarantor/Patient Acknowledgement Initials: _____

FEES

Initial consultation for a new patient (45-50 minutes)	$260-$360*
Consultation for an established patient (45-50 minutes)	$170-$285*
Individual therapy (20-25 minutes)	$120-$210*
Medication Management (10-15 minutes)	$86-$136*

Services not covered by insurance:

Prescription in lieu of office visit	$33.50*
Letters/Reports/Phone calls on patients' behalf	$25-$285*
Depositions, Court Appearances and Legal Correspondence	To be arranged

**Charges determined by Provider, Length and Complexity*

Guarantor/Patient Acknowledgement Initials: _____

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PHONE CALLS, LETTERS AND REPORTS

I understand that circumstances may require phone calls, letters and reports on the patient's behalf; however, they are not covered under insurance. Phone calls, letters and reports will be the patient's financial responsibility and will be charged based on complexity. I require 7 days prior notice for all letters and reports written on the patient's behalf, as well as advance payment. The office line has a confidential voice mail box where patients can leave a detailed message regarding appointments, billing concerns or messages. Phone calls are returned at the end of the day and are your financial responsibility. Guarantor/Patient Acknowledgement Initials: _____

MEDICATION REFILLS

Please allow 72 hours for all prescription refills. To refill your prescription please notify your pharmacy and have them fax (509) 383-4324 and EScript request. In addition, please leave a voice message at the office line. Requests for refills beyond scheduled intervals or written prescriptions will be charged a $33.50 processing fee. **I do not mail prescriptions**. Patient also agrees to use one assigned prescriber at office for all medications which have been taken over by office. Use of multiple prescribers for medicines which are prescribed by this office are cause for immediate termination. Guarantor/Patient Acknowledgement Initials: _____

INSURANCE AND PAYMENT

This office will bill your contracted insurance companies and if you have out-of-network benefits with other insurance companies, this office will bill, however, patients are responsible for co-pay, co-insurance and deductibles at the time of service.
Patients with insurance not contracted with this office are responsible for billing their own insurance company after paying for charges at the time of service. This office will provide you with a receipt that can be submitted to your insurance company for reimbursement. The undersigned agrees to pay 1% interest per month on unpaid balances after 60 days past due, per Washington State RCW 19.52. Payments not received after 120 days are subject to collection procedures. There is a $35.charge for all returned checks. Guarantor/Patient Acknowledgement Initials: _____

PLEASE NOTE: YOUR INSURANCE IS A CONTRACT BETWEEN YOU AND YOUR CARRIER. YOU ARE RESPONSIBLE FOR SERVIDES RENDERED, REGARDLESS OF COVERAGE. BENEFITS QUOTED BY INSURANCE ARE NOT A GUARANTEE OF PAYMENT.

I have read and understand the office policy, and am aware that regardless of any insurance coverage I may or may not have, I am still financially responsible for all charges. I agree that in the event cost and/or fees are incurred in connection with the collection of my account, I will pay such costs and fees.

Print Patient's Name: _____Date: _____
Signature of Responsible Party (Guarantor) _____
Relationship to Patient_____

CONSENT TO ELECTRONIC TRANSMISSION OF HEALTH CARE INFORMATION

DATE:
PATIENT:
Name:
Date of Birth:
Address:
PROVIDER:
Leslie C. Rodriguez, A.R.N.P.
Anthropos Health & Counseling Center
2807 W. Washington Ave., Rm 135
Yakima, Wa 98903

Provider is providing mental health care and related services to Patient in the form of evaluation, diagnosis, counseling, therapy, medication and medication management, or some combination thereof. Patient desires to communicate with Provider by means of electronic media, including, but not limited to, electronic mail (e-mail) transmitted by computer over the internet, facsimile transmission of documents by computer or telephone, cellular (wireless) telephone communications, cellular telephone (wireless) text messages, and video conferencing or communications over the internet (Skype or Facetime, for example) (collectively "Electronic Communications"). Provider is unwilling to communicate with Patient by Electronic Communications unless Patient consents to and approves the communication and transmission of confidential, personal, sensitive and/or protected health care information ("Protected Information") concerning the Patient by Electronic Communications. Patient understands that Electronic Communications between Patient and Provider will not be encrypted or otherwise protected against interception by third parties prior to or during transmission. Provider will make reasonable efforts to ensure that Electronic Communications of or concerning Protected Information directed to Patient by Provider are properly addressed and not intentionally disclosed to third parties; however, Provider cannot guarantee or promise to Patient that Protected Information communicated by Provider to Patient by Electronic Communications will not be intercepted by, viewed by or otherwise unintentionally disclosed to third parties, not withstanding Provider's reasonable efforts to avoid unauthorized disclosure.

Patient hereby consents to and requests Provider to communicate with Patient by Electronic Communications and to transmit Protected Information concerning Patient by Electronic Communications. **In consideration for receiving Protected Information from provider by Electronic Communications, Patient hereby waives, releases and discharges Provider from any and all liabilities, damages, penalties and claims arising under state or federal law caused by or attributable to Provider's transmission or delivery of Protected Information to Patient by Electronic Communications**.

Patient hereby authorizes and instructs Provider to send Electronic Communications to Patient at the following electronic addresses or numbers:

_____

Patient acknowledges that Patient has read and understands the foregoing Consent and voluntarily executes the same.

DATED this _____day of _____, _____.

_____ _____

(Patient) (Witness) (date)

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HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164) **

1. Authorization
I authorize _____ (healthcare provider) to use and disclose the protected health information described below to Anthropos Health & Counseling Center, PLLC/Leslie C. Rodriguez, A.R.N.P. (individual seeking the information).

2. Effective Period
This authorization for release of information covers the period of healthcare from:

- ✓ All past, present, and future periods while under care.

3. Extent of Authorization

- ✓ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.
5. This authorization shall be in force and effect until care ends, at which time this authorization expires.
6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.
7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.
8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____Date_____
Signature

_____Date _____
Signature of Guardian if Patient is Under 18

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 ("HIPPA"), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple health care providers who may be involved in that treatment directly and indirectly.
- Obtain payment from third-party payers.
- Conduct normal health care operations such as quality assessments and physician certifications.

I have received, read and understand your *Notice of Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Privacy Practices* from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the *Notice of Privacy Practices.*

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree than you are bound to abide by such restrictions.

_____Date_____
Signature

_____Date _____
Signature of Guardian if Patient is Under 18

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement of this *Notice of Privacy Practices Acknowledgement* but was unable to do so as documented.
Date: _____Initials: _____ Reason:_____
_____

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PATIENT INFORMATION FORM/CONFIDENTIAL INFORMATION

This form will save both you and your practitioner time, providing you with the best service possible. All information provided on this form is considered confidential. Please answer as carefully and completely as possible.

Today's Date_____

Name _____Date of Birth _____Age_____

Marital Status ( ) Never Married ( ) Married ( ) Living as Married
( ) Separated ( ) Divorced ( ) Widowed

Partner's Occupation _____ Partner's age_____

Race/Culture_____

Do you have any children? ( ) No ( ) Yes If yes, give names, ages and where they live:

Name	Sex	Age	Whereabouts
_____	_____		_____
_____	_____		_____
_____	_____		_____

Anyone else living in the household? ( ) No ( ) Yes If yes, who? _____

You were referred by _____Relationship to you_____

Who is your primary care physician? _____

Previous therapy or counseling? (Please list names of clinicians and approximate dates of therapy)

_____
_____
_____

Previous psychiatric medications. (Please approximate when used, how long and why medication was discontinued or changed)

_____
_____
_____

Current psychiatric medication

_____
_____
_____

Issues that bring you into therapy at this time

_____
_____
_____

FAMILY HISTORY

Frequently it is helpful for the clinician to have a sense of your family of origin issues as they allow us to gather a more complete picture of your psychological functioning. Please take a moment to complete this section.

Father: Age_____ ( ) Living ( ) Deceased If deceased, **YOUR** age at time of death _____
Occupation: _____
Health: _____
Frequency and kind of contact with him: _____

Mother: Age_____ ( ) Living ( ) Deceased If deceased, **YOUR** age at time of death _____
Occupation: _____
Health: _____
Frequency and kind of contact with her: _____

Brothers and/or Sisters:

Full Name Sex Age Whereabouts
_____
_____
_____
_____

Please place a check mark in the appropriate box if these are or have been present in your relatives.

	Children	Brother	Sister	Mother	Father	Uncles/Aunt	Grandparents
Nervous Problems							
Depression							
Drinking Problem							
Drug Problem							
Psychiatric Treatment							
Attention Deficit							
Hyperactivity							
Epilepsy							
Suicide							
Mental Illness							
Mental Retardation							
Learning Disorder							

EDUCATIONAL HISTORY

Did you have any difficulties in school please describe them_____

_____

_____

Were you considered hyperactive/ADHD in school? ( ) No ( ) Yes If yes, did you take medication? ( ) No ( ) Yes If yes, list medication and dosage:

_____

_____

History of problems with learning? _____

What kind of grades did you get in school? _____

Please list the higher degree you completed in school. _____

ALCOHOL USE HISTORY

Do you drink alcohol? ( ) No ( ) Yes If yes, age of first use _____

How frequently do you drink? **(Please circle one)**: daily twice a week weekly monthly or less

How much alcohol do you consume when you drink? _____

Have you ever had a Black out when drinking? ( ) No ( ) Yes if yes, how often? _____

Have you ever had a seizure due to your alcohol use? ( ) No ( ) Yes If yes, how often? _____

C.A.G.E.

1. Have you ever felt you should cut down on your drinking/drug use? ( ) No ( ) Yes
2. Have people annoyed you by criticizing your drinking/drug use? ( ) No ( ) Yes
3. Have you ever felt bad or guilty about your drinking/drug use? ( ) No ( ) Yes
4. Have you ever drank/used drugs in the morning to steady your nerves or to relive a hangover (eye opener)? ( ) No ( ) Yes

Do you use tobacco? ( ) No ( ) Yes If yes, describe? _____

Do you drink caffeinated beverages (coffee, tea, cola)? ( ) No ( ) Yes If yes, describe type and amount?

_____

_____

SUBSTANCE USE HISTORY

Have you ever had a history of substance use or abuse with prescription pain medication? (e.g., Percodan, Percocet, Tylenol with Codeine, Demerol, Darvocet, Vicodin)

_____

_____

_____

Ever used for GREATER THAN ONE MONTH? ( ) No ( ) Yes If yes, please list:

Type _____Age of 1st use _____Time since last use _____
Approximate use in past 30 days_____

Type _____Age of 1st use _____Time since last use _____
Approximate use in past 30 days_____

Have you ever had a history of substance use or abuse with anti-anxiety agents (e.g., Valium, Ativan, Xanax, K1onopin, Librium)

_____

_____

_____

Ever used for GREATER THAN ONE MONTH? ( ) No ( ) Yes If yes, please list:

Type _____Age of 1st use _____Time since last use _____
Approximate use in past 30 days_____

Type _____Age of 1st use _____Time since last use _____
Approximate use in past 30 days_____

Please indicate below whether you ever have used any other substances:

"Street "Drugs (e.g., Marijuana, Heroin, Methamphetamine, Cocaine, Crank, PCP, Uppers, Downers,

Magic Mushrooms, "Sniffing/Huffing" Paint, LSD, Ecstasy): Other: _____

_____

Ever Used? ( ) No ( ) Yes If yes, please list below:

Type _____Age of 1st use _____Time since last use _____
Approximate use in past 30 days_____

Type _____Age of 1st use _____Time since last use _____
Approximate use in past 30 days_____

Type _____Age of 1st use _____Time since last use _____
Approximate use in past 30 days_____

OCCUPATIONAL HISTORY

Have you ever served in the military? ( ) No ( ) Yes If yes, describe? _____

What type of discharge did you get? _____

_____

Current Employment Status:

_____

Please give a brief list of your job history:

Type of Job	Date	Reason for Leaving

PSYCHOSOCIAL HISTORY

Have you ever been arrested? ( ) No ( ) Yes If yes, describe:

Year _____ Reason for arrest_____ Disposition_____

Year _____ Reason for arrest_____ Disposition_____

Do you have a religious affiliation? ( ) No ( ) Yes If yes, describe _____

What kind of social activities hobbies do you participate in? _____
_____
_____
_____

Who do you turn to for support or help with your problems? _____

_____

Have you ever been abused? ( ) verbally ( ) emotionally ( ) physically ( ) sexually ( ) neglected

( ) No ( ) Yes If yes, please describe_____
_____

MEDICAL STORY

Any prior major illnesses, operations, and/or accidents (please provide dates)
_____
_____
_____

Do you suffer from sleep problems (too much/too little)? _____
_____

Do you feel rested when you wake up? ( ) No ( ) Yes

Do you suffer from Allergies? ( ) No ( ) Yes If yes, list the allergens: _____

_____If yes, what medications are used for treatment? _____
_____

Indicate CURRENT medical conditions. Check the appropriate box and if YES, specify condition (s)

	Yes	No	
1. Ear, nose, and throat	( )	( )	_____
2. Eyes	( )	( )	_____
3. Respiratory	( )	( )	_____
4. Cardiovascular	( )	( )	_____
5. Gastrointestinal	( )	( )	_____
6. Pancreas	( )	( )	_____
Liver	( )	( )	_____
7. Urinary system	( )	( )	_____
8. Reproductive system	( )	( )	_____
Birth control method	( )	( )	_____
9. Neurology	( )	( )	_____
Tics	( )	( )	_____
Movement problems	( )	( )	_____
Tremors, shakes, jitters	( )	( )	_____
Strokes	( )	( )	_____
10. Blood & lymphatic	( )	( )	_____
11. Endocrine & metabolic	( )	( )	_____
12. Musculoskeletal	( )	( )	_____
13. Skin	( )	( )	_____
14. Head Injury	( )	( )	_____
15. Loss of consciousness	( )	( )	_____
16. Recurrent headaches	( )	( )	_____
17. Migraines	( )	( )	_____
18. Asthma	( )	( )	_____
19. Diabetes	( )	( )	_____
20. Seizure Disorder	( )	( )	_____
21. Sexually Transmitted Diseases	( )	( )	_____
HIV/ AIDS	( )	( )	_____
22. Hepatitis	( )	( )	_____
23.0ther	( )	( )	_____

When was your last complete physical exam? _____
Who performed the physical? _____
Did you have blood work done? ( ) No ( ) Yes If yes, what were the results_____

LIFE EXPERIENCE CHECKLIST

The following lists refer to your present level of experience. Please place an X in the column next to the items that best describe how you currently feel. Then, describe how long you have felt that way (e.g., days, weeks months, years).

I am experiencing… **For how long (days, weeks, months, years)**

( ) Feelings of tiredness _____
( ) Feelings of anger _____
( ) Outbursts of anger _____
( ) Feeling numb _____
( ) Feeling down_____
( ) Feelings of guilt_____
( ) Feelings of anxiety _____
( ) A desire to be socially isolated _____
( ) Frustration _____
( ) Irritability_____
( ) Pain symptoms_____

Persistent feelings of:

( ) Worthlessness_____
( ) Helplessness_____
( ) Hopelessness _____
( ) Fear_____

Persistent loss of interest in previously enjoyed activities:

( ) Withdrawing from other people_____
( ) Spending increased time alone _____
( ) Problems with friends_____

Avoidance of:

( ) People _____
( ) Places_____
( ) Activities or specific things_____
( ) Leaving your home_____

Repetitive behaviors or mental acts:

( ) Counting ( ) Checking doors ( ) Washing hands_____

Fear of certain objects or situations: ( ) Crowds ( ) Traffic ( ) Being alone ( ) Dark _____
( ) Strangers ( ) Animals

( ) Difficulty catching breath
( ) Increased energy
( ) Startle easily, feeling "jumpy"
( ) Tremor
( ) Dizziness
( ) Increase in appetite
Wt. Gain_____lbs Over what period of time_____
( ) Decrease in appetite
Wt. Loss_____lbs Over what period of time_____
( ) Purging _____
( ) Voluntary vomiting _____
( ) Use of laxatives _____
( ) Excessive exercise (avoids weight gain) _____
( ) Binge eating _____
( ) Overeating _____

Difficulty with sleep:

( ) Falling asleep _____
( ) Staying asleep _____
( ) Getting out of bed _____
( ) Physical sensations others don't have _____
( ) Racing thoughts _____
( ) Difficulty concentrating or thinking _____
( ) Difficulty making decisions _____
( ) Persistent thought about harming or killing yourself _____
Have you ever attempted suicide? ( ) Yes ( ) No
( ) Persistent thoughts about harming or killing someone else_____
Have you ever acted on your thoughts? ( ) Yes ( ) No
( ) Frequent worry_____
( ) Intrusive memories (flashback, nightmares) _____
( ) Large gaps in your memory _____
( ) Occupational problems_____
( ) Sexual dysfunction _____
Problems with desire _____
Problems with arousal _____
Problems with organism _____

( ) Difficulty starting tasks _____
( ) Difficulty finishing tasks _____
( ) Feeling as if you were outside yourself, detached, observing what you are doing_____
( ) Feeling puzzled as to what is real and unreal _____
( ) Persistent, repetitive, intrusive thoughts, impulses or images _____
( ) Unusual visual experience such as flashes of light, shadows _____
( ) Hear voice(s) when no one else is present _____
( ) Feeling that your thoughts are controlled or placed in your mind _____
( ) Feeling that the television or the radio is communicating with you _____
( ) Difficulty problem solving _____
( ) Difficulty meeting role expectations _____
( ) Dependency on others _____
( ) Manipulation of other to fulfill own desires _____
( ) Inappropriate expressions of anger_____
( ) Self-mutilation_____
Cutting _____
Burning _____
Jumping _____
Hitting _____
( ) Difficulty or inability to say "no" to others _____
( ) Problems with communication _____
( ) Sense of lack of control _____

( ) Decreased ability to handle stress _____
( ) Abusive relationship _____
( ) Difficulty expressing emotion _____
( ) Often experience physical problems in place of feeling emotional problems _____
( ) Concerns about sexuality_____
Hypersexuality _____
Sexually risk taking behavior_____
Gender Orientation _____
Other_____

Sexual Orientation ( ) heterosexual ( ) homosexual ( ) bisexual

I think....
( ) My life is out of control _____
( ) I have hallucinations _____
( ) Alcohol or drugs affect my life _____
( ) Life is without opportunities_____
( ) I am without hope _____
( ) I am unable to understand the things I do _____
( ) I have blackouts _____
( ) I am unable to change my circumstances_____
( ) I abuse prescribed medication_____

Please describe any other symptoms or experience you have had problems with:
_____
_____
_____
_____
_____

If you had 3 wishes what would they be?

1._____

2._____

3._____