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

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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Child & Adolescent Psychiatric History

Patient Name: ____________________________ Date of birth: __________Age:_______

Mother's name: ______________________Father's Name: _______________________

Is this your Biological Child: ( ) Yes ( ) No If Adopted, what age? __________________

Referred By: _________________________________Telephone:___________________

Who is your child's pediatrician? ____

Address: _____________________________________Telephone:__________________

Who lives within the child's home?

____
____
____

Are there family members (including biological parents) who live outside of the home? If so, please describe. (If divorced or separated, describe visitation arrangements):

____
____
____

What is your main concern about your child? Describe in your own words:

____
____
____

What kind of services are you seeking for your child?

____
____
____

Symptom Checklist

For the following symptoms, please check those you believe apply to your child and are a significant problem at the present time. Please estimate when these problems were first noted and add any explanation that would be helpful.

- ❑ Often failing to give close attention to details/making careless mistakes______________________
- ❑ Often has difficulty sustaining attention in tasks or play____________________________________
- ❑ Often not seeming to listen when spoken to directly ("spacey") _____________________________
- ❑ Trouble following through on instructions or failing to finish schoolwork or chores (not due to oppositional behavior or failure to understand instructions) ________________________________
- ❑ Often has difficulty organizing tasks or activities____
- ❑ Often avoids or is hesitant to work on tasks that required sustained mental effort (such as schoolwork or homework) ____
- ❑ Often loses necessary things (toys, assignments, pencils, books, etc.) ________________________
- ❑ Often easily distracted (by sounds, conversations, activity, etc.) ____________________________
- ❑ Often forgetful in daily activities____
- ❑ Fidgets or squirms in seat____
- ❑ Difficulty remaining seated____
- ❑ Inappropriate running or climbing or feeling restless______________________________________
- ❑ Difficulty playing quietly____
- ❑ Often "on the go" or acts as if "driven by a motor" _______________________________________
- ❑ Often talks excessively____
- ❑ Often blurts out answers to questions before they have been completed______________________
- ❑ Has difficulty awaiting turn____
- ❑ Often interrupts or intrudes on others____
- ❑ Often loses temper ____
- ❑ Often argues with adults ____
- ❑ Often actively defies or refuses adult requests or rules ____________________________________
- ❑ Often deliberately does things that annoy other people____________________________________
- ❑ Often blames others for own mistakes____
- ❑ Is often touchy or easily annoyed by others____
- ❑ Is often angry or resentful____
- ❑ If often spiteful or vindictive ____
- ❑ Depressed or irritable mood most of the day, every day____________________________________
- ❑ Decreased or excessive sleep____

- ❑ Poor appetite or overeating ____
- ❑ Marked agitation or unusually slowed movement__________________________________
- ❑ Fatigue or unusually slowed movement_____________________________________
- ❑ Fatigue or loss of energy____
- ❑ Decreased pleasure or loss of interest in usual activities____________________________
- ❑ Poor concentration or difficulty making decisions_______________________________
- ❑ Feelings of worthlessness or excessive inappropriate guilt__________________________
- ❑ Suicidal thoughts or attempts ____
- ❑ Low self-esteem, negative "self-talk"______________________________________
- ❑ Feelings of hopelessness about the future____________________________________
- ❑ Drug or alcohol use? If yes, please explain? __________________________________
- ❑ Often swears or uses obscene language______________________________________
- ❑ Has stolen without confronting a victim (e.g.) shoplifting___________________________
- ❑ Often stays out at night, despite parental rules_________________________________
- ❑ Has run away from home overnight at least twice______________________________
- ❑ Lies often to obtain goods or avoid obligations__________________________________
- ❑ Deliberately sets fires____
- ❑ Often engages in physically dangerous activities_________________________________
- ❑ Is often truant, skips school____
- ❑ Has broken into someone's house, car or building_________________________________
- ❑ Has deliberately destroyed other's property____________________________________
- ❑ Has forced someone into sexual activity_______________________________________
- ❑ Used a weapon in a fight (e.g. bat, brick, gun, knife) ______________________________
- ❑ Often initiates physical fights____
- ❑ Has stolen with confrontation (mugging, purse-snatching) __________________________
- ❑ Physically cruel to people or animals____
- ❑ Bullies, threatens, or intimidates others_______________________________________
- ❑ Unrealistic and persistent worry about possible harm to family or friends_______________
- ❑ Unrealistic and persistent worry about future events or that a terrible event will separate the child from a close figure____
- ❑ Persistent refusal to go to school____
- ❑ Persistent refusal to sleep alone____
- ❑ Persistent avoidance of being alone____
- ❑ Repeated nightmares regarding separation____________________________________
- ❑ Physical pains or illness without a physical cause (headaches, stomachaches) ____________
- ❑ Excessive distress in anticipation of separation from attachment figure_________________
- ❑ Excessive distress when separated from home or attachment figures__________________

- ❑ Unrealistic concern about appropriateness of past behavior____________________________________
- ❑ Unrealistic concern about competence____
- ❑ Marked self-consciousness____
- ❑ Excessive need for reassurance____
- ❑ Marked inability to relax____
- ❑ Compulsive rituals____
- ❑ Obsessions (intrusive thoughts) ____
- ❑ Repetitive behavior____
- ❑ Preoccupation with firearms or knifes____
- ❑ Odd postures____
- ❑ Excessive reaction to noise or fails to react to loud noises_______________________________
- ❑ Overreacts to touch____
- ❑ Motor tics (muscle twitches) ____
- ❑ Vocal tics (e.g. grunts, sniffs, odd noises) ____
- ❑ Loose thinking (e.g. ideas that are hard to follow or don't make sense) _____________________
- ❑ Bizarre ideas (e.g. odd fascinations, delusions, hallucinations) __________________________
- ❑ Disoriented, confused, staring, or "spacey" ____
- ❑ Incoherent speech (mumbling, nonsense) ____
- ❑ Hearing voices____

Medical and Psychiatric History

Check if your child has had any of the following:

Serious illness

❑ No

❑ Yes If yes, please describe:

____

History of Diabetes:

❑ No

❑ Yes If yes, please describe:

____

Head injury

❑ No

❑ Yes If yes, please describe:

____

Surgery

❑ No

❑ Yes If yes, please describe:

____

Seizures

❑ No

❑ Yes If yes, please describe:

____

Hospitalizations

❑ No

❑ Yes If yes, please describe:

____

Asthma or breathing difficulties

❑ No

❑ Yes If yes, please describe:

____

Tobacco Use

❑ No

❑ Yes If yes, please describe:

____

Allergies to Medications

- ❑ No
- ❑ Yes If yes, please describe:

____

Trouble with hearing or vision

- ❑ No
- ❑ Yes If yes, please describe:

____

Does your child currently take any medications? If so, list name of medication, dosage, and time taken.

____

____

____

Has your child received any previous psychiatric, other mental health or drug/alcohol treatment?

- ❑ No
- ❑ Yes

If yes, who provided the mental health treatment? (Name, address & telephone if available).

____

____

____

When did the treatment occur and what was the outcome?

____

____

____

Has your child ever been treated with anti-depressants or other psychiatric medication?

- ❑ No
- ❑ Yes

If yes, please provide name of medication, dosage, frequency, length of time administered.

____

____

____

Family History

Previous psychiatric or emotional illness:

- ❑ No
- ❑ Yes If yes, please explain____

Drug or alcohol difficulties:

- ❑ No
- ❑ Yes If yes, please explain____

Major medical illness:

- ❑ No
- ❑ Yes If yes, please explain____

Birth Development

Was this child a planned pregnancy?

____

____

Describe any complications that occurred during the pregnancy:

- ❑ Difficulty in conception____
- ❑ Toxemia ____
- ❑ Abnormal weight gain____
- ❑ Measles____
- ❑ Excessive vomiting____
- ❑ German measles____
- ❑ Flu____
- ❑ Anemia____
- ❑ High blood pressure____
- ❑ Other (Rh incompatibility, etc)_________________________________

Did the patient's mother use or ingest any alcohol, legal medication, illegal drugs or cigarettes during pregnancy? If so, please state which, how often and how much.

____

____

____

At this child's birth, what was the mother's age? ____________Father's age?_________________

Where was this child born (home delivery or hospital)?

____

____

Length of pregnancy________________Weeks

Birth weight_____Lbs.______________Oz.

Length of labor____________________Hours

Apgar Score (if known)__________________

Were there any difficulties during birth? If yes, please explain.______________________________

Early Years Development

As best you remember, at what age did this child do the following?

Walked alone: __________________ Understood first words:___________________

Spoke first words: _______________ Spoke in sentences:______________________

When was this child toilet trained? Days: _________ Nights:___________

Did bed wetting occur after toilet training?
- ❑ No
- ❑ Yes If yes, until what age? ____

Did soiling occur after toilet training?
- ❑ No
- ❑ Yes If yes, until what age? ____

Were there any medical reasons for bed-wetting or soiling?
- ❑ No
- ❑ Yes If yes, please explain____

Has this child experienced any of the following problems? If yes, please describe:

Walking difficulty/difficulty with motor coordination or skills
- ❑ No
- ❑ Yes

Unclear speech
- ❑ No
- ❑ Yes

Feeding problem
- ❑ No
- ❑ Yes

Underweight problem
- ❑ No
- ❑ Yes

Overweight problem
- ❑ No
- ❑ Yes

Colic
- ❑ No
- ❑ Yes

Separating
- ❑ No

Sleep problem
- ❑ No
- ❑ Yes

Eating Disorder
- ❑ No
- ❑ Yes

Difficulty learning to ride a bike
- ❑ No
- ❑ Yes

Difficulty learning to skip
- ❑ No
- ❑ Yes

Difficulty learning to throw or catch
- ❑ No
- ❑ Yes

- ❑ Yes If yes, please describe____

Excessive crying
- ❑ No
- ❑ Yes If yes, please describe____

Social Development

How does your child relate to others children?
- ❑ Good
- ❑ Fair
- ❑ Poor

Can he or she socially make friends?
- ❑ Yes
- ❑ No If no, please describe____

Can he or she keep friends?
- ❑ Yes
- ❑ No If no, please describe____

Can he or she have fights frequently with siblings or peers?
- ❑ Yes If yes, please describe____
- ❑ No

What role does your child play in group activities?

- ❑ Leader, please describe____
- ❑ Follower, please describe____
- ❑ Refuses to cooperate, please describe____

What hobbies, sports or other activities does your child enjoy?
____
____

Describe your child's and your family's support system, including family, friends, church or other supports.
____
____
____

Has your child ever experienced any parental separation, divorces or death of a close family member?
____
____
____

Has your child ever been physically, sexually or emotionally abused or neglected, or has child protective services been involved with your family?

- ❑ No
- ❑ Yes If yes, please describe____

Have there been any episodes of family violence that your child has witnessed?

- ❑ No
- ❑ Yes If yes, please describe____

Does your child have access to guns or other weapons?

- ❑ No
- ❑ Yes If yes, please describe____

If guns or other weapons are present in the home are they in a locked safe or gun cabinet?

- ❑ No
- ❑ Yes

Throughout your child's history, has he or she ever had any suicidal ideation?

- ❑ No
- ❑ Yes If yes, please describe in detail____

What is your family's religious affiliation, if any? Are there any practices or beliefs that may influence treatment?

____

____

____

Education Development

School name: ____

School district: ______________________________Grade in school____________________

Is your child enrolled in any special program? ___________________________________

Special Education (specify program) ____

Tutoring (specify area) ____

Counseling ____

- ❑ Speech Therapy____
- ❑ Physical Therapy____
- ❑ Occupational Therapy ____
- ❑ Other ____

Is your child receiving any of the above services outside of school? If yes, please specify.
____
____

Please identify any school-related problem areas:

- ❑ School subjects (please specify areas) ____
- ❑ Relationship of child with teacher(s) (please specify) ______________________________
- ❑ Relationship of child with peers at school____
- ❑ Inappropriate placement (for example, child is placed in the wrong grade, child is not receiving appropriate services, etc) ____
- ❑ Child's attitude toward school ____
- ❑ Appropriate conduct in the classroom ____
- ❑ Appropriate conduct in the classroom ____
- ❑ Appropriate conduct after school on the playground, or in unstructured school activities

  ____

****

Any additional comments or concerns:
____
____
____