Welcome

You have an upcoming appointment with me, Teddi Armstrong, on_____ at_____. I am a mental health nurse practitioner and provide brief psychotherapeutic intervention along with psychotropic medication management. You have been referred to see me for further evaluation regarding mental health issues. I look forward to meeting with you and together developing a treatment plan that is realistic and meets your needs as a whole individual. Enclosed you will find some paperwork that must be completed prior to our first appointment. Please fill it out as completely as possible and either (1) mail it to the address provided below, (2) drop it by Encore Wellness 4 Life, LLC located at 82346 Bucks Lane, Umatilla, OR 97882, (3) Scan it to teddirosearmstrong@gmail.com or (4) fax it to (541)-922-1753 ***at least 24 hours prior to your appointment***. Doing so will ensure you are provided the best care possible. If you have any questions, I can be reached through the following avenues. Again, I am delighted you have chosen me to care for you and will do my best to provide you what you need.

Warmest regards,

Teddi R. Armstrong, DNP-PMHNP
P.O. Box 701
College Place, WA 99324
teddirosearmstrong@gmail.com
(541)-371-2511 (Voicemail is confidential)

You may also reach out to staff at Encore Wellness 4 Life, LLC in Umatilla, OR at (541)-922-1750 for urgent needs.

NAME _____ DATE _____

New Patient Information

Please bring this with your insurance card.

NAME (First, Last)	M.I.	BIRTH DATE	TODAY'S DATE
STREET ADDRESS		CITY	STATE / ZIP
WORK PHONE	HOME PHONE	CELL PHONE	

Circle which phone you prefer we call first.

If needed, may we leave a message on your answering machine? Yes No

PHARMACY Name, Phone and Street / City	MAIL ORDER PHARMACY (if using)

In case of an emergency, is there someone we can contact (list below):

NAME	PHONE	RELATIONSHIP

Agreement to Treatment

1. *Cancellations, Missed Appointments:* If I ever miss or cancel an appointment with less than 48-hours' notice, I will pay for the full cost of the visit, regardless of the reason for the missed appointment (note: sometimes this charge is more than the insurance copay). Additionally, two missed appointments without warning may result in dismissal from the practice. In this case, I understand I will receive a letter indicating this and my medications will be filled for no longer than 30 days past the date the letter is sent.
2. *Payment:* I agree to pay for services at the time of my visit (by check, cash, debit, or visa/mastercard/discover). If using insurance, I will complete the insurance information on the following two pages. I understand that I will need to pay the full cost of services if this information is incomplete, or if my insurer is out-of-network or my deductible has is not met.
3. *Confidentiality:* I have received the attached Privacy Notice.

Please feel free to discuss any aspects of these when we meet. In signing below, you agree to begin treatment with the policies above and acknowledge receipt of the Privacy Notice.

_____ _____

Signature of Patient Date

_____ _____

Signature of Parent/Guardian (if under 18) Date

NAME _____ DATE _____

Signature to Authorize E-mail and/or Text Message Reminders (optional)

I would like to receive appointment reminders by email and/or text message and agree to use email and/or text messaging services for administrative and not clinical matters. I understand that the confidentiality and delivery of email cannot be guaranteed, and accept responsibility for appointments that are missed as a result of undelivered emails.

Note: If multiple family members are in treatment with us, please make sure each uses a unique email address or mobile phone number.

_____ _____
Signature of Patient (or Parent/Legal Guardian) Date

_____ _____
Email Address Mobile Phone Number

Insurance Certification

If you plan to use insurance, we want to make sure you avoid unpleasant surprises in your coverage. Unfortunately this can happen with mental health, which is often contracted to a different insurer than your medical plan. We require all patients to check the items below with their insurer before their first appointment. To gather this information, call your insurer (use the Mental Health number on the back of your card) and ask about your "Outpatient Mental Health Benefits":

__ I wish to pay privately for services (you may skip to page 5)

The payer for my mental health benefits is:
__ Aetna
__ BCBS
__ BCBS-Federal Employee
__ BCBS-State Employee
__ BCBS
__ Cigna
__ OEBB
__ MODA
__ Conexus
__ First Choice Health
__ Regence
__ Uniform

__ The payer is not listed above; it is: _____; I understand that services at Switchback Wellness, LLC may not be covered by this insurer and agree to pay the full cost for services while awaiting out-of-network reimbursements.

NAME _____ DATE _____

__ I have secondary insurance coverage through Medicare or Medicaid. I understand this will likely cause my primary insurance to be denied even if it is an in-network provider.

My insurance ID# is _____; my group # is _____ My employer is _____. __ I am the primary policy holder __ I am *not* the primary holder and have listed their info below:

NAME		RELATIONSHIP TO ME
ADDRESS	CITY	STATE / ZIP
PHONE	BIRTH DATE	GENDER

Mental health claims should be sent to _____

_____

_____

Deductible

My deductible for mental health visits is: $_____ and renews on the ____ month of each year.

I have met $_____ of this deductible so far.

Copays

My copay / coinsurance for mental health visits is: _____ (enter a dollar amount, or a percentage if it is a coinsurance)

Visit Limits

___ My insurer has placed no yearly maximum or caps on my outpatient mental health visits.
___ My insurer has the following annual limits which renew on the ____ month of each year.

Max number of therapy visits:	
Max number of psychiatrist or medication visits:	
Max number of any mental health visits:	
Max dollar amount for mental health benefits:	

Authorization

___ My insurer does not require prior authorization for outpatient mental health visits.
___ My insurer requires prior authorization and as provided me with this auth #: _____
(if they do not supply a number, have them fax the required forms to us at (541) 922-1753)

NAME _____ DATE _____

Agreement to Insurance Billing Policies

In signing below, I express understanding that my insurance coverage is a contract between myself and my insurer and accept responsibility for any charges they do not cover. I authorize the release of any medical or other information to my insurer that is necessary to process my claims. I authorize payment of medical benefits to Switchback Wellness, LLC for current and future services.

_____ _____ Signature of Patient (or Parent/Legal Guardian if under 18) Date

Signature to allow communication with others (optional)

If there are people whom you would like to be involved in your treatment, and would like us to be able to discuss your treatment with them in case they contact us, please list them and sign below (you can change this at a later date).

NAME OF PERSON INVOLVED	PHONE NUMBER	RELATIONSHIP

We will not discuss your treatment with anyone else without your permission unless it is your doctor, pharmacist or therapist we need to speak to. If there is anyone you want to make sure we have no contact with, please list their name here as an extra precaution:

NAME OF PERSON WE SHOULDN'T SPEAK WITH	RELATIONSHIP

_____ _____

Signature of Patient (or Parent/Legal Guardian if under 18) Date

NAME _____ DATE _____

WEIGHT: _____ HEIGHT: _____ Allergies to medications? YES NO Which ones?
Medications you take (including over-the-counter medications, vitamins, and herbal remedies):

NAME	DOSE	WHEN DID YOU START IT?

Have you ever had any of the following conditions?

	YES	NO		YES	NO
Diabetes			Arthritis		
High blood pressure			Chronic pain		
High cholesterol or lipids			Sexually transmitted diseases		
Heart disease			Renal/kidney disease		
Thyroid illness			Restless leg syndrome		
Head injury			Sleep apnea		
Seizure			Glaucoma		
Migraines			Liver disease / hepatitis		
Multiple Sclerosis			Heartburn/reflux		
Stroke			Asthma		

NAME _____ DATE _____

Psoriasis			Complications in your birth or first few months of life		
Family History of Diabetes					
Other:					

For Women: Are you currently pregnant, breast-feeding or considering pregnancy?

Is your menstrual cycle active? ___YES ___NO

Are you in treatment with anyone else (primary care doctor, therapist)? ___YES ___NO

NAME	PHONE NUMBER	FAX NUMBER

Family Psychiatric History

You can help your doctor understand the genetic factors in your condition by describing the mental health and personalities of your relatives.

Have any of your blood-relatives had any of the following difficulties?

Depression, Post-partum Depression, Anxiety problems, Mood Swings, Bipolar or Manic-Depression, Suicide, Violence, Drug or Alcohol Abuse, Obsessive Compulsive Disorder (OCD), Attention Deficit Disorder (ADD or ADHD), Thyroid disorders, Dementia or Alzheimer's. Has anyone had "Nervous Breakdowns" or been hospitalized for mental health? Has anyone heard voices or seen things? Has anyone had significant legal problems or been unable to work?

For each relative that comes to mind, write their relation to you and what you know about their condition. Also record, if known, any treatments they received and how they responded.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

NAME _____ DATE _____

Past Treatments

Have you ever been admitted to a hospital for mental health? __ YES ___NO ___YES to ER but not admitted

Please write psychiatric medications you remember trying below (refer to the list on the back to help recall):

		Check your response to it:				
Medication Name	Approximate age or dates used	Felt better on it	No difference / unsure	Felt worse on it	Worked at first, wore off	Notes

Samples Medication Names

Mood Stabilizers

Lamictal, lamotrigine
Lithium, lithobid, eskalith Depakote, valproate
Trileptal, oxcarbazepine Tegretol, equetro, carbamazepine

NAME _____ DATE _____

Antipsychotics / Mood Stabilizers

Atypicals (aripiprazole, abilify, olanzapine, zyprexa, invega, risperdal, risperidone, seroquel, quetiapine, geodon, ziprasidone, saphris, asenapine, latuda, lurasidone, fanapt, iloperidone, symbyax)

Typicals (haldol, haloperidol, thorazine, chlorpromazine, stelazine, prolixin)

Clozaril, clozapine

Antidepressants

SSRIs (fluoxetine, prozac, sertraline, zoloft, paroxetine, paxil, fluvoxamine, luvox, citalopram, celexa, escitalopram, lexapro)

Vortioxetine, brintellix, vilazodone, viibryd SNRIs (effexor, venlafaxine, cymbalta, duloxetine,

pristiq, desvenlafaxine, savella, milnacipran,

levomilnacipran, fetzima)
Viibyrd (vilazodone)
Wellbutrin (buproprion, budeprion, aplenzin) Remeron, mirtazipine
Serzone, nefazodone, trazodone, desyrel, oleptrol Tricyclics (imipramine, clomipramine, amitriptyline,

nortriptyline, doxepin, protriptyline, elavil) MAOIs (emsam, selegiline, nardil, phenelzine,

parnate, tranylcypromine)
Naturals: St John's Wort, Deplin, SAMe, Omega3,

Fish oil, NAC, Chromium, Deplin, Lightbox, Vitamin B, Folate/folic acid, Kava Kava

Sleep Medicines

Newer hypnotics (ambien, zolpidem, sonata, zaleplon, lunesta, eszopiclone, intermezzo, edluar)

Melatonin agonist (rozerem, ramelton)

Benzodiazepines (ativan, lorazepam, klonopin, clonazepam, xanax, alprazolam, oxazepam, restoril, temazepam, prosom, doral, halcion)

Trazodone, desyrel. Silenor, doxepin

Anti-addiction

Anti-alcohol: Campral, antabuse, baclfen Anti-nicotine: Wellbutrin, chantix, nicotine

replacements Naltrexone

Antianxiety

Benzodiazepines (ativan, lorazepam, klonopin, clonazepam, xanax, alprazolam, oxazepam, restoril, temazepam, etc.)

SSRIs (fluoxetine, prozac, sertraline, zoloft, paroxetine, paxil, fluvoxamine, luvox, citalopram, celexa, escitalopram, lexapro)

NAME _____ DATE _____

SNRIs (effexor, venlafaxine, cymbalta, duloxetine, pristiq, desvenlafaxine, savella, milnacipran)

Buspar, buspirone Remeron, mirtazipine Neurontin, gabapentin Pregabalin, lyrica

Stimulants and ADHD Treatments

Stimulants (ritalin, methylphenidate, metadate, methylin, concerta, adderall, dexedrine, zenzedi, vyvanse, focalin, quillivant)

Guanfacine, intuniv, clonidine, kapvay Strattera, atomoxetine
Provigil, modafinil, nuvigil, vayarin, vayacog

Other

Anticonvulsant (lyrica, pregabalin, gabatril, tiagabine, neurontin, gabapentin, keppra, levetiracetam, topamax, topiramate)

Provigil, modafinil, nuvigil
Synthroid, levothyroxine, cytomel, T3, T4 Mirapex, pramipexole, requip, ropinorole, neupro
Electroconvulsive Therapy (ECT)
Transcranial Magnetic Therapy (TMS)

NAME _____ DATE _____

Questions You'd Like Addressed

It may help to write down questions you'd like us to address it's not forgotten:

_____

_____

_____

_____

NAME _____ DATE _____

Feedback & Suggestions

I welcome your comments – positive and negative – and ideas on how I can improve my services. Please keep this page and return to any office staff member after your first few appointments.

Comments on administration, billing, scheduling and office environment

_____
_____
_____
_____
_____

Comments on brief psychotherapeutic intervention and/or medication treatment

_____
_____
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_____
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