



You have an upcoming appointment with me, Teddi Armstrong, . 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,

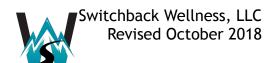
Teddi R. Armstrong, DNP-PMHNP P.O. Box 701 College Place, WA 99324 teddirosearmstrong@gmail.com (541)-371-2511 (Voicemail is confidential)

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 Inform	ation				
Please	bring this with your in	nsurance car	d.			
NAME	(First, Last)	M.I.	BIRTH DA	ГЕ		TODAY'S DATE
STREE	TADDRESS		CITY			STATE / ZIP
WORK	PHONE	HOME PH	ONE		CELL PHO	ONE
	e which phone you pre	·				
	eded, may we leave a n		our answ			
PHARM	MACY Name, Phone and Street / C	City		MAIL ORD	ER PHARM	1ACY (if using)
	se of an emergency, is	there someon		n contact	(list belo	
NAME			PHONE	NE .		RELATIONSHIP
_	ement to Treatme					
1.	than 48-hours' notice the missed appointme Additionally, two mis practice. In this case,	e, I will pay fent (note: some ssed appoint). I understand	For the full metimes ments will re	Il cost of this chargethout ware ceive a le	the visit, se is mor ming ma etter indi	el an appointment with less regardless of the reason for the than the insurance copay). By result in dismissal from the decating this and my 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 mastercard/discover). If using insurance, I will complete the insurance information or following two pages. I understand that I will need to pay the full cost of services if th information is incomplete, or if my insurer is out-of-network or my deductible has is met.					e insurance information on the full cost of services if this	
3.	3. Confidentiality: I have received the a			ed Privac	y Notice).
	e feel free to discuss an treatment with the poli	• •				gning below, you agree to f the Privacy Notice.
Signatu	re of Patient		ate	_		

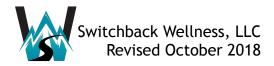
Date

Signature of Parent/Guardian (if under 18)

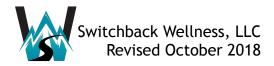


NAME	DA	ATE
Signature to Autho	orize E-mail and/	or Text Message Reminders (optional)
email and/or text messa	aging services for adr delivery of email can	ers by email and/or text message and agree to use ministrative and not clinical matters. I understand that mot be guaranteed, and accept responsibility for andelivered emails.
<i>Note:</i> If multiple family email address or mobile		atment with us, please make sure each uses a unique
Signature of Patient (or Pare	ent/Legal Guardian)	Date
Email Address		Mobile Phone Number
Insurance Certific	ation	
coverage. Unfortunated different insurer than yetheir insurer before the	y this can happen wit our medical plan. We ir first appointment. T	ke sure you avoid unpleasant surprises in your th mental health, which is often contracted to a require all patients to check the items below with To gather this information, call your insurer (use the card) and ask about your "Outpatient Mental Health
I wish to pay private	ely for services (you	may skip to page 5)
The payer for my ment AetnaBCBSBCBS-Federal EmpBCBS-State EmployBCBSCignaOEBBMODAConexusFirst Choice HealthRegenceUniform	loyee	
The payer is not list services at Switchback	· · · · · · · · · · · · · · · · · · ·	; I understand that

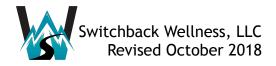
full cost for services while awaiting out-of-network reimbursements.



NAME	DATE	
		Medicare or Medicaid. I understand this will
	· =	ven if it is an in-network provider.
My insurance I	ID# is	_; my group # is My he primary policy holder I am <i>not</i> the
primary holder	and have listed their info below:	ne primary policy nolder I am <i>not</i> the
NAME	and have hold then him delet.	RELATIONSHIP TO ME
TVI IVIE		KLEATIONOIII TO WE
ADDRESS	CITY	STATE / ZIP
PHONE	BIRTH DATE	GENDER
Mental health o	claims should be sent to	
Deductible	for mental health visits is: \$	and renews on the month of each
year.		
I have met \$	of this deductible so far.	
Copays		
	insurance for mental health visits it is a coinsurance)	s: (enter a dollar amount, or a
Visit Limits		
		or caps on my outpatient mental health visits. Which renew on the month of each year.
Max number of	of therapy visits:	
Max number of	of psychiatrist or medication visits	
Max number of	of any mental health visits:	
Max dollar an	nount for mental health benefits:	
Authorization		
		on for outpatient mental health visits.
	r requires prior authorization and a supply a number, have them fax the	ne required forms to us at (541) 922-1753)



NAME	DATE			
Agreement to Insuran	ce Billing Policies			
myself and my insurer a release of any medical of	and accept responsibility or other information to a	y for any charges the my insurer that is ne	age is a contract between ey do not cover. I authorize cessary to process my clair LC for current and future	
Guardian if under 18) Date		Si	gnature of Patient (or Parent/Leg	gal
Signature to allow	communication wit	th others (option	al)	
	treatment with them in	=	atment, and would like us t , please list them and sign	o
NAME OF PERSON INVOLV	/ED	PHONE NUMBER	RELATIONSHIP	
-	erapist we need to spea	k to. If there is anyo	permission unless it is your one you want to make sure value.	
NAME OF PERSON WE SHO	OULDN'T SPEAK WITH		RELATIONSHIP	
Signature of Patient (or Pare	nt/Legal Guardian if under	Date		



NAME		DATE
WEIGHT:	HEIGHT:	Allergies to medications? YES NO Which ones?
Medications yo	ou take (including o	ver-the-counter medications, vitamins, and herbal remedies):

NAME	DOSE	WHEN DID YOU START IT?

Have you ever had any of the following conditions?

	Y E S	N O		Y E S	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				
1 certain y 1115cor y or		Complications in months of life	your birth or first few	
Other:				
For Women: Are	you current	ly pregnant, breast-feedi	ling or considering pregnancy?	
Is your menstrual	cycle activ	e?YESNO		
Are you in treatm	ent with an	yone else (primary care	doctor, therapist)?YESN	O
NAME	PHONE NUM	IBER	FAX NUMBER	
Family Psyc	hiatric I	History		
		derstand the genetic factors of your relatives.	tors in your condition by describing	ng the
Have any of your	blood-rela	tives had any of the follo	owing difficulties?	
Depression, Suici Attention Deficit anyone had "Ner	de, Violenc Disorder (A vous Breako	e, Drug or Alcohol Abus ADD or ADHD), Thyroid downs" or been hospitali	ems, Mood Swings, Bipolar or Ma use, Obsessive Compulsive Disord id disorders, Dementia or Alzheim dized for mental health? Has anyor gal problems or been unable to wo	er (OCD) her's. Has he heard
		*	ation to you and what you know ab y received and how they responde	

NAME	DATE

Past Treatments

Have you ever been admitted to a hospital for mental health? __YES __NO __YES to ER but not admitted

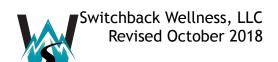
Please write psychiatric medications you remember trying below (refer to the list on the back to help recall):

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

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

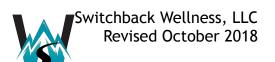
Anti-addiction

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
TURNE	DITTE

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 o	juestions you'd like us to address it's not forgotten:

NAME	DATE
Feedback & Suggestions	
_	ositive and negative – and ideas on how I can improve my and return to any office staff member after your first few
Comments on administration	n, billing, scheduling and office environment
Comments on brief psychoth	erapeutic intervention and/or medication treatment

