



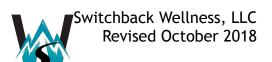
You have an upcoming appointment with me, Teddi Armstrong, *. I am a mental health nurse practitioner and provide brief psychotherapeutic intervention along with psychotropic medication management. You have been referred to see me for further evaluation regarding mental health issues. I look forward 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 in 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.

* This appointment is a video appointment. You will receive a text message or email with further information regarding how to access the appointment.



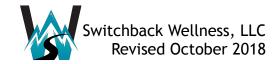
NAME			DATE				2
New	Patient Inform	mation					
Please versio	•	r insurance ca	ard. If you	are under	18 plea	se use the child/adole	escent
NAME	(First, Last)	M.I.	BIRTH DA	ГЕ		TODAY'S DATE	
STREE	T ADDRESS		CITY			STATE / ZIP	
WORK	PHONE	HOME P	HONE		CELL PHO	ONE	
		-					
	e which phone you p	,	•	vering ma	chine? Y	es No	
PHARN	MACY Name, Phone and Stree	t / City		MAIL ORD	ER PHARM	IACY (if using)	
In cas	se of an emergency,	is there some	one we can	n contact	(list belo	ow):	
NAME			PHONE			RELATIONSHIP	
Agre	ement to Treatm	ent					
2.	than 48-hours' note the missed appoint 2) <i>Payment:</i> I agree visa/mastercard/dison the following two	ice, I will pay ment (note: see to pay for secover). If usivo pages. I ur	for the full ometimes services at ng insuran iderstand t	Il cost of this charg the time ace, I will hat I will	the visit, ge is mor of my vi complet need to	regardless of the rease than the insurance of sit (by check, cash, do to the insurance information of the full cost of second or my deductib	son for copay). ebit, or mation ervices if
3.	3) Confidentiality.	I have receive	ved the atta	ached Pri	vacy No	tice.	
Please begin	e feel free to discuss	any aspects o	f these wh	en we me	eet. In sig	gning below, you agre	ee to
treatm	ent with the policies	s above and a	cknowledg	ge receipt	of the P	rivacy Notice.	

Date

Date

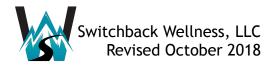
Signature of Patient

Signature of Parent/Guardian (if under 18)

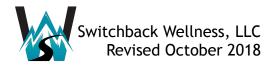


NAME	DA	ATE
Signature to Autho	orize E-mail and/	or Text Message Reminders (optional)
email and/or text messa	aging services for adr delivery of email can	ers by email and/or text message and agree to use ministrative and not clinical matters. I understand that mot be guaranteed, and accept responsibility 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

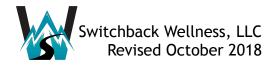
full cost for services while awaiting out-of-network reimbursements.



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 Insurance Bill	ling Policies	
myself and my insurer and acc release of any medical or othe	derstanding that my insurance cover- cept responsibility for any charges the er information to my insurer that is no al benefits to Switchback Wellness, I	ey do not cover. I authorize the ecessary to process my claims.
Guardian if under 18) Date	S	ignature of Patient (or Parent/Legal
,	nunication with others (option	nal)
If there are people whom you	would like to be involved in your treent with them in case they contact us	eatment, and would like us to
NAME OF PERSON INVOLVED	PHONE NUMBER	RELATIONSHIP
doctor, pharmacist or therapist	ment with anyone else without your at we need to speak to. If there is anyone ist their name here as an extra precau	one you want to make sure we
NAME OF PERSON WE SHOULDN'	'T SPEAK WITH	RELATIONSHIP
Giral OD divide 7		
Signature of Patient (or Parent/Lega	· · · · · · · · · · · · · · · · · · ·	TECNO WILL 1
WEIGHT:HEIGHT:	: Allergies to medications? Y	ES NO which ones?



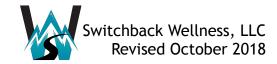
NAME	DATE

Current medications you take (including over-the-counter and vitamins):

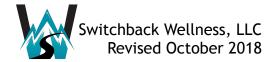
NAME	DOSE	WHEN DID YOU START IT?

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		
Psoriasis					



NAME		DATE				
Family History of Diabetes		Complications in months of life	Complications in your birth or first few months of life			
Other:						
For Women: Are	you currentl	y pregnant, breast-feedi	ng or considering pro	egnancy?		
Is your menstrual	l cycle active	?YESNO				
Are you in treatm	nent with any	one else (primary care o	doctor, therapist)?	_YESNO		
NAME	PHONE NUME	BER	FAX NUMBER			
Family Psyc	hiatric H					
You can help you	ır doctor und	erstand the genetic factors of your relatives.	ors in your condition	by describing the		
Have any of your	· blood-relati	ves had any of the follo	wing difficulties?			
Depression, Suic Attention Deficit anyone had "Ner	ide, Violence Disorder (A vous Breakd	ression, Anxiety problem e, Drug or Alcohol Abus DD or ADHD), Thyroid owns" or been hospitali yone had significant leg	se, Obsessive Comput d disorders, Dementia zed for mental health	ulsive Disorder (OCD) a or Alzheimer's. Has n? Has anyone heard		
		o mind, write their relat wn, any treatments they		•		



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):

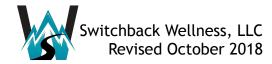
		Check your response to it:					
Medication Name	Approximate age or dates used	Felt better on it	No difference / unsure	Felt worse on it	Worked at first, wore off	Not es	

Samples Medication Names

Mood Stabilizers

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

Antipsychotics / Mood Stabilizers



NAME	DATE	

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

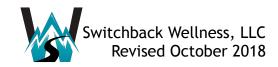
Anti-addiction

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

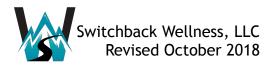
Stimulants (ritalin, methylphenidate, metadate, methylin, concerta, adderall, dexedrine, zenzedi, vyvanse, focalin, quillivant)

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 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

