G. William Salbador, MD, PC
Adult & Geriatric Psychiatry

Confidential Patient Information

Today's Date_____

Name_____
Last Name First Name Initial

Date of Birth_____Age_____

Home Phone_____Work Phone_____Cell Phone_____

Please circle which of the above numbers it is OK/you would prefer us to leave messages on.

Home Address_____City_____State_____

Zip_____ How long at this address?_____

Social Security Number _____Driver's License # & State_____

Responsible Party (for minors)_____Date of Birth_____Age_____

Employer_____Occupation_____

Employer's Address_____

Partner's / Spouse's Name_____ Partner's Date of Birth _____

Partner's Employer _____Partner's Occupation_____

Partner's Business Address_____

Person to Contact in Case of Emergency _____Relationship _____

Emergency Contact Home Phone _____Work Phone _____Other Phone _____

Primary Care Provider_____ Phone_____

Therapist/Mental Health Provider_____ Phone_____

Other Important Healthcare Provider_____ Phone_____

Pharmacy_____ Phone_____

Who May I Thank For Referring You? _____

727 SE Cass Ave, Suite 325
Roseburg, OR 97470
Phone: 541-957-5762
Fax: 541-343-6434

401 East 10th Ave, Suite 230
Eugene, OR 97401
Phone: 541-684-0154
Fax: 541-343-6434

G. William Salbador, MD, PC
Adult & Geriatric Psychiatry

OFFICE POLICIES AND INFORMATION

FEES
The initial psychiatric assessment involves about 1 to 1 ½ hours of information gathering. This does not include reviewing other doctor's notes. The follow-up rates are based on time spent. Telephone calls requiring physician assistance will be billed accordingly. Dr. Salbador reserves the right to request payment in advance for consultations and other related services. While our office accepts payment from the insurance company, you possess primary obligation of payment. In the event of nonpayment or a need to take legal action for collections, you will be financially responsible for any expenses incurred to collect overdue balances. You are additionally responsible for any mandatory services required by a third party (e.g., subpoena or court testimony). You will be responsible for no shows. You will be billed on a monthly basis; however, your co-payment is expected at the time of session. After 90 days, if no payments have been received and no alternative arrangements have been made; bills may be referred to a collection agency. Although no specific information regarding treatment will be revealed, your billing for therapy sessions and the information from the patient information sheet will be released to the agency. Please be aware that once your account is forwarded to a collection agency, our office is no longer in a position to negotiate your payment schedule. More importantly, please be informed that this process may adversely affect your credit status. $250 in collection fees will be added.

If there is an ongoing balance on the account, we reserve the right to charge a rollover fee of $25 per month. A fee of $50.00 plus the bank's returned check fee will be charged for returned checks (for example, for non-sufficient funds –NSF).

_____ Initial acceptance of fees

APPOINTMENTS
Cancellation of scheduled appointments should be avoided. If you cannot make the appointment you must cancel within 48 hours in order to avoid no show or cancellation charges. We reserve the right to charge a fee of $250 for the first no show or late cancel of your reserved appointment with less than a 48-hour reschedule notice. After the first no show or late cancel, you will be charged the full price of the session. Please be informed that insurance carriers cannot be billed for missed appointments. If you have an emergency, please contact us right away. Cancellations can be phoned into the office at any time day or night. We have voice mail available 24 hours a day, 7 days a week for your convenience.

_____ Initial acceptance of appointment cancellation policies

INITIAL EVALUATION APPOINTMENT
The first visit is very important in clarifying the treatment plan and whether the doctor and patient are a good match to continue working together.

TERMINATION OF CARE
Care may be terminated by the doctor or the patient at any time. The most common reason for the doctor terminating care is non-compliance from the patient. If care is terminated by the doctor, emergency

services and prescription refills will continue to be available for 30 days to allow the patient time to find another doctor.

PRESCRIPTIONS

Please give 72 business hours' notice for prescription refills. A $100 lost prescription fee will be charged per prescription for reissuing a hardcopy prescription. Lost prescriptions for controlled substances must be documented. If stolen, a police report is required. This policy protects both you and Dr. Salbador.

INSURANCE

If you are using health insurance benefits as payment for these services, you need to be aware of what this means. Your health plan requires cooperation between client, provider and insurance company to provide services as efficiently as possible. Many insurance policies authorize a limited number of sessions to work on your problem as intensely as possible with the focus of eliminating acute symptoms. I am contracted with a number of these managed care insurance companies to provide my services within these conditions. Sessions beyond those initially authorized is usually obtained by submitting a treatment plan to a utilization review committee or a case manager and sessions are authorized as determined to be medically necessary.

Please understand that insurance coverage is an agreement between you and your insurance company to pay a portion of your health care. This office will not accept responsibility for collecting your insurance claim or negotiating a settlement on a disputed claim. You are responsible for payment of your account with the limits of our credit policy, regardless of the status of your insurance. Insurance co-payment amounts are requested to be paid at the time of the office visit. As a service to you we will complete and submit insurance claims. Please be aware that some insurance carriers may not cover all mental disorders and clinical problems (e.g., marital counseling, etc.). It is your responsibility to make sure that your third party payer covers your mental health concerns. Moreover, it is important to note that insurance companies often require prior authorization. It is important that you check with your insurance company to see if a referral or prior authorization is required.

Dr. Salbador does not accept Medicare or OHP.

EMERGENCIES

In the event of an emergency, mental health provider may be reached through his voice mail, 24 hours a day, at (541) 677-2607 or call 911.

_____ _____

Signature Date

_____ _____

Signature of Parent, Guardian, or Legal Representative Date

G. William Salbador, MD, PC
Adult & Geriatric Psychiatry

Insurance Information

Primary Insurance_____

Claims Address_____

Contact Phone Number for Benefits _____

Name of Insured_____Insured's DOB_____Insured's Social # _____

Group Number _____ Policy Number_____
(Blue Cross / Blue Shield MUST include alpha prefix)

Secondary Insurance_____

Address_____

Contact Phone Number for Benefits _____

Name of Insured_____Insured's DOB_____Insured's Social # _____

Group Number_____ Policy Number_____
(Blue Cross / Blue Shield MUST include alpha prefix)

Authorization to Release Information and Assignment of Insurance Benefits

I hereby authorize G. William Salbador, M.D. to:

1) Furnish my insurance company with any/all information requested concerning my present claim(s).

2) Bill my insurance company, and to accept payment from that company on my behalf, for all services from time to time relating to my care.

I acknowledge that I am responsible for all charges not covered by my insurance. I understand that any money received from my insurance company by G. William Salbador, M.D., in excess of my bill will be refunded to me after completion of treatment. I also understand that I will be charged for any appointment I fail to keep or cancel at least 48 hours prior to the appointment time, and I agree to pay these charges in full.

_____ _____
Patient's signature Date Responsible party's signature if patient is a minor

727 SE Cass Ave, Suite 325
Roseburg, OR 97470
Phone: 541-957-5762
Fax: 541-343-6434

401 East 10th Ave, Suite 230
Eugene, OR 97401
Phone: 541-684-0154
Fax: 541-343-6434

G. William Salbador, MD, PC
Adult & Geriatric Psychiatry

Consent of Disclosure

(For the usage and/or Disclosure of Protected Health Information)

I hereby give consent to G. William Salbador, M.D., to use and disclose my protected health information for the purposes of treatment, payment, and health care operations.

You may cancel this consent at any time. Your cancellation must be in writing, signed by you on your behalf and delivered to the address at the bottom of this form. This may be delivered in person or by mail. It will only be effective when I actually receive it. Your cancellation will not be effective to the extent that others or I have acted in reliance upon this consent.

You have the right to request restrictions on the usage and disclosure of your protected health information for the purposes of treatment, payment, or health care operations. I am not required to grant your request; however, if I do, the restrictions will be obligatory to me.

My Posted Privacy Policy provides more detailed information about the usage and disclosure of your protected health information. You have the right to review my Posted Privacy Policy before you sign this consent.

I reserve the right to amend the terms of my Posted Privacy policy. You may obtain a copy of the current policy by requesting a copy from me.

Name of Patient (Print): _____

Signature:_____

If you are signing as the patient's representative:

Print Your Name: _____

Relationship:_____

Instructions for Communication of Personal Health Information

Please indicate by what means my office may communicate personal health information to you:

(Please check all that apply)

____ Fax……(Fax number)_____

____ Answering Machine / Voice Mail……(Phone number)_____

____ Authorized Person(s)……(Names of individuals)_____

We may___ / may not ___ phone you to confirm your appointments.
The authorized person(s) listed above may ___ / may not ___ schedule, cancel, or confirm appointments for you.

_____ _____
Print your full name Signature Date

727 SE Cass Ave, Suite 325
Roseburg, OR 97470
Phone: 541-957-5762
Fax: 541-343-6434

401 East 10th Ave, Suite 230
Eugene, OR 97401
Phone: 541-684-0154
Fax: 541-343-6434

G. William Salbador, MD, PC
Adult & Geriatric Psychiatry

New Patient Questionnaire

To help us to fully evaluate your concerns, please fill out the following intake form and questionnaire to the best of your ability. We realize that there is a lot of information requested, and you may not remember or have access to all of it, but please be as thorough as possible.

PATIENT IDENTIFICATION:

Name _____ Age _____ Sex _____

Birth Date _____ Marital Status _____

Address _____

City _____ State ____ Zip _____ - _____

Home Phone (___) ___ - _____ Work Phone (___) ___ - _____ Cell Phone (___) ___ - _____

Who do you currently live with? _____

REFERRAL SOURCE:

Name _____ Phone ___ / ___ - _____ Fax___ / ___ - _____

Address _____

MAIN PURPOSE FOR THE CONSULTATION [please give a summary of the main problem(s)]

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

WHY DID YOU SEEK THE EVALUATION AT THIS TIME? (What are your goals for this visit?)

_____

_____

_____

_____

_____

_____

MENTAL HEALTH HISTORY/PRIOR MENTAL HEALTH TREATMENTS (include any history of counseling/therapy as well as prior psychiatric care)

_____

_____

_____

_____

_____

PRIOR MEDICATIONS PRESCRIBED FOR MENTAL HEALTH REASONS (for depression, anxiety, mood stability or sleep)

_____

_____

_____

_____

MEDICAL HISTORY:

Current medical problems and/or medications:

_____

_____

Current Supplements/vitamins/herbs:

_____

_____

Past medical problems/medications:

_____

_____

Other doctors/clinics seen regularly:

_____

_____

Any history of head trauma? (describe)

_____

_____

Any history of seizures or seizure-like activity?

_____

_____

Prior hospitalizations:

_____

_____

Prior abnormal lab tests/values?

_____

_____

Allergies/ drug intolerance?

_____

_____

CURRENT LIFE STRESSES: (include anything that is currently stressful for you, such as relationships, job, school, finances, children)

_____

_____

_____

_____

YOUR PRENATAL AND BIRTH EVENTS: (Pregnancy complication, birth trauma, bleeding, medication, smoking, alcohol/drugs)

_____

_____

SLEEP BEHAVIOR: (trouble getting to sleep, trouble staying asleep, excessive snoring, sleepwalking, nightmares, recurrent dreams, excessive daytime sleepiness)

_____

_____

SCHOOL HISTORY: Last grade completed ___ Last school attended _____

Average grades received_____ Specific learning disabilities_____

Any behavior problems in school?

_____

_____

What have teachers said about your learning and behavior in school?

_____

_____

_____

EMPLOYMENT HISTORY: (summarize the jobs you have held; most favorite, least favorite)

_____

_____

_____

Any work-related problems?

_____

_____

What have your employers and supervisors said about your performance?

_____

_____

MILITARY HISTORY: _____

LEGAL PROBLEMS/DIFFICULTY WITH THE LAW:

_____

_____

ALCOHOL AND DRUG HISTORY: Please list the age you started, types of substances used through the years and any current usage. Also, describe how each of these substances made you feel; what benefit you got from them. This question includes alcohol (hard liquor, beer, wine), marijuana or hash, prescription tranquilizers or sleeping pills, inhalants, (glue, gasoline, cleaning fluids, etc.), cocaine or crack, amphetamines or crank or ice, steroids, opiates (heroin, codeine, morphine or other pain killers) barbiturates, hallucinogenic drugs (LSD, mescaline, mushrooms), PCP:

_____

_____

_____

_____

Did you ever experience withdrawal symptoms from alcohol or drugs? _____

Has anyone ever told you they thought you had a problem with drugs or alcohol? _____

Have you felt guilty about your drug or alcohol use? _____

Have you felt annoyed when someone talked to you about your use of drugs/alcohol? _____

Have you ever used alcohol or drugs first thing in the morning? _____

Caffeine use per day (coffee, tea, sodas, chocolate) _____

Nicotine use per day, past and present (cigarettes, cigars, chewing tobacco) _____

SEXUAL HISTORY: (answer if comfortable)

Age at time of first sexual experience _____ Number of sex partners _____

History of sexually transmitted diseases _____ History of abortion_____

History of sexual molestation, abuse or rape _____

_____ _____

Current sexual problems?

_____

_____

_____

FAMILY HISTORY:

Family structure (Who lives in your current household? Please give relationship to each)

_____

_____

_____

Current marital or relationship satisfaction:

_____

_____

Significant events (include marriages, divorces, separations, deaths, traumatic events)

_____

_____

_____

NATURAL MOTHER'S HISTORY: Age_____ Outside work _____

School-highest grade completed _____ Learning Problems_____

Behavioral Problems _____ Marriages _____

Medical Problems _____

Has mother or any maternal relatives had any learning problems or mental health problems including alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalization, physical or sexual abuse? If yes, please describe

_____

_____

_____

NATURAL FATHER'S HISTORY: Age_____ Outside work _____

School-highest grade completed _____ Learning Problems_____

Behavioral Problems _____ Marriages _____

Medical Problems _____

Has father or any paternal relatives had any learning problems or mental health problems including alcohol/drug abuse, depression, anxiety, suicide attempts, psychiatric hospitalization, physical or sexual abuse? If yes, please describe

_____

_____

_____

SIBLINGS: (names, ages, problems, strengths, relations with patient)

_____

_____

_____

_____

CHILDREN: (names, ages, problems, strengths, relations with patient)

_____

_____

_____

_____

CULTURAL /ETHNIC BACKGROUND:

_____

_____

DESCRIBE YOUR RELATIONSHIP WITH FRIENDS:

_____

_____

DESCRIBE YOURSELF/ YOUR STRENGTHS:

_____

_____

_____

GENERAL SYMPTOM CHECKLIST

Please rate yourself on each of the symptoms below using the following scale. If possible, to give us the most complete picture, have another person who knows you well (spouse, lover, or parent) rate you as well. List other person_____

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not applicable

Other| Self

____ |____ 1. Depressed, sad, down or blue mood

____ | ____ 2. Decreased interest in things that are usually enjoyable, including sex

____ |____ 3. Significant weight gain or loss, or marked appetite changes

____ |____ 4. Recurrent thoughts of death or suicide

____ |____ 5. Sleep changes, lack of sleep or marked increase in sleep

____ |____ 6. Physically agitated OR feeling slowed down physically

____ |____ 7. Low energy or feelings of tiredness

____ |____ 8. Feelings of worthlessness, helplessness, hopelessness, or guilt

____ |____ 9. Decreased concentration or memory

____ |____ 10. Periods of an elevated, high or irritable mood

____ |____ 11. Periods of a very high self-esteem, or grandiose thinking

____ |____ 12. Periods of decreased need for sleep (or not being able to sleep) without feeling tired

____ |____ 13. More talkative than usual or feel pressure to keep talking

____ |____ 14. Racing thoughts; frequent jumps from one subject to another

____ |____ 15. Easily distracted by irrelevant or low priority things

____ |____ 16. Marked increases in activity level

____ |____ 17. Excessive involvement in pleasurable activities which have the potential for painful consequences (spending money, sexual indiscretions, gambling, foolish business ventures)

____ |____ 18. Panic attacks, which are period of intense, unexpected fear or emotional discomfort (list number per month_____)

____ |____ 19. Periods of trouble breathing or feeling smothered

____ |____ 20. Periods of feeling dizzy, faint, or unsteady on your feet

____ |____ 21. Periods of heart pounding or rapid heart rate

____ |____ 22. Periods of trembling or shaking

____ |____ 23. Periods of sweating

____ |____ 24. Periods of choking

____ |____ 25. Periods of nausea or abdominal upset

____ |____ 26. Feeling of a situation “not being real” or feeling that you are disconnected from your body

____ |____ 27. Numbness or tingling sensation

____ |____ 28. Hot or cold flashes

____ |____ 29. Periods of chest pain or discomfort

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not applicable

Other| Self

____ |____ 30. Fear of dying

____ |____ 31. Fear of going crazy or doing something uncontrolled

____ |____ 32. Avoiding everyday places for fear of having a panic attack, or need to go with other people in order to feel comfortable

____ |____ 33. Excessive fear of being judged by others, which causes you to avoid or get anxious in situations

____ |____ 34. Persistent, excessive phobias (heights, closed spaces, specific animals, etc.) Please list_____

____ |____ 35. Recurrent, bothersome thoughts, ideas, images, which you try to ignore

____ |____ 36. Trouble getting "stuck" on certain thoughts, or having the same thought over and over

____ |____ 37. Excessive or senseless worrying

____ |____ 38. Others complain that you worry too much or get "stuck" on the same thoughts

____ |____ 39. Compulsive behaviors that you must do over and over or else you feel anxious (i.e., handwashing, checking locks), or compulsive spelling or counting

____ |____ 40. Needing to have things done a certain way or you become upset

____ |____ 41. Others complain that you do the same thing over and over to an excessive degree (cleaning, checking)

____ |____ 42. Recurrent and upsetting thoughts of a past traumatic event (molestation, accident, fire, etc)

____ |____ 43. Recurrent distressing dreams of a past upsetting event

____ |____ 44. A sense of reliving a past upsetting event

____ |____ 45. A sense of panic or fear to events that resemble an upsetting past event

____ |____ 46. You spend effort avoiding thoughts or feelings associated with a past trauma

____ |____ 47. Persistent avoidance of activities/situations which cause remembrance of upsetting events

____ |____ 48. Inability to recall an important aspect of a past upsetting event

____ |____ 49. Marked decreased interest in important activities

____ |____ 50. Feeling detached or distant from others

____ |____ 51. Feeling numb or restricted in your feelings

____ |____ 52. Feeling that your future is shortened

____ |____ 53. Startling easily

____ |____ 54. Feel like you are always watching for bad things to happen

____ |____ 55. Marked physical response to events that remind you of a past upsetting event (i.e., sweating when getting in a car long after you have been in an accident)

____ |____ 56. Marked irritability or angry outbursts

____ |____ 57. Unrealistic or excessive worry in at least a couple of areas in your life.

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not applicable

Other| Self

____ |____ 58. Trembling, twitching or feeling shaky

____ |____ 59. Muscle tension, aches or soreness

____ |____ 60. Easily fatigued

____ |____ 61. Feelings of restlessness

____ |____ 62. Shortness of breath or feeling smothered

____ |____ 63. Heart disease, cardiovascular symptoms, high blood pressure, exercise intolerant

____ |____ 64. Sweating or cold clammy hands

____ |____ 65. Dry mouth

____ |____ 66. Dizziness or lightheadedness

____ |____ 67. Nausea, diarrhea. or other abdominal distress

____ |____ 68. Hot or cold flashes

____ |____ 69. Frequent urination

____ |____ 70. Trouble swallowing or “lump in throat”

____ |____ 71. Feeling keyed up or on edge

____ |____ 72. Quick startle response or jumpy feeling

____ |____ 73. Difficulty concentrating or “mind going blank”

____ |____ 74. Trouble falling asleep or staying asleep

____ |____ 75. Irritability

____ |____ 76. Trouble sustaining attention or being easily distracted

____ |____ 77. Difficulty completing projects

____ |____ 78. Feeling overwhelmed with the tasks of everyday life

____ |____ 79. Trouble maintaining an organized work area or living area

____ |____ 80. Inconsistent work performance

____ |____ 81. Lack of attention to detail

____ |____ 82. Make decisions impulsively

____ |____ 83. Difficulty delaying what you want, having to have your needs met immediately

____ |____ 84. Restless or fidgety

____ |____ 85. Make comments to others without considering their impact

____ |____ 86. Impatient, easily frustrated

____ |____ 87. Frequent traffic violations or frequent near accidents

____ |____ 88. Refusal to maintain body weight above a level most people consider healthy

____ |____ 89. Intense fear of gaining weight or becoming fat even though underweight

____ |____ 90. Feelings of being fat, even though you are underweight

0	1	2	3	4	N/A
Never	Rarely	Occasionally	Frequently	Very Frequently	Not applicable

Other|Self

____ ____ 91. Recurrent episodes of binge eating

____ ____ 92. Feeling of lack of control over eating behavior

____ ____ 93. Persistent overconcern with body shape or weight

____ ____ 94. Engage in regular activities to end binges such as self-induced vomiting, laxatives, diuretics, dieting or strenuous exercise

____ ____ 95. Involuntary movements (tics) or vocal tics

____ ____ 96. Delusional or bizarre thoughts (that you know others would think are false)

____ ____ 97. Seeing objects, shadows or movements that are not real

____ ____ 98. Hearing voices or sounds that are not real

____ ____ 99. Periods of time where your thoughts or speech were disjointed or did not make sense to you or others

____ ____ 100. Social isolation or withdrawal

____ ____ 101. Severely impaired ability to function at home or work or socially

____ ____ 102. Peculiar behaviors

____ ____ 103. Lack of personal hygiene or grooming

____ ____ 104. Marked lack of initiative

____ ____ 105. Inappropriate mood for the situation (laughing at sad events)

____ ____ 106. Frequent feeling that someone or something is out to hurt you or discredit you

____ ____ 107. Do others complain that you snore loudly?

____ ____ 108. Have others said you stop breathing when you sleep?

____ ____ 109. Do you feel fatigued or tired during the day?

____ ____ 110. Do you often feel cold when others feel fine or warm?

____ ____ 111. Do you often feel warm when others feel fine or cool?

____ ____ 112. Do you have problems with brittle or dry hair?

____ ____ 113. Do you have problems with dry skin?

____ ____ 114. Do you have problems with sweating?