G. William Slabador, MD, P.C.
THe Hult Plaza
401 E. 10th Ave, Suite 230
Eugene, OR 97401

Patient Demographic Form

Please complete this form in order to ensure proper billing of your services

Patient Information

Today's Date:_____.

Last Name:_____. First Name:_____.

Other Names: _____.

Address (street): _____. City, State, Zip: _____.

Home Phone:_____. Cell Phone: _____.

Work Phone:_____. Email:_____.

Social Security Number: _____.

Marital Status:_____. Race:_____.

Ethnicity:_____. Preferred Language:_____.

Primary Care Provider:_____.

Address (street): _____. City, State, Zip: _____.

Telephone:_____.
Referring Physician (If different):_____.

Address (street): _____. City, State, Zip: _____.

Telephone:_____.

Employment Information

Employer:_____.

Address (street):_____City, State, Zip:_____.

Phone:_____.Email:_____.

Employment Status: Full Time, Part Time, Not Employed, Self Employed, Active Military (Circle One)

Student Status: Full time Student, Part Time Student (Circle One)

Insurance Information

Primary Carrier:_____.Phone:_____.

Policy Holder:_____.Relationship to patient:_____.

Policy Holder DOB:_____.

ID#:_____.Group#:_____.

Address (street):_____City, State, Zip:_____.

Secondary Carrier:_____.Phone:_____.

Policy Holder:_____.Relationship to patient:_____.

Policy Holder DOB:_____.

ID#:_____.Group#:_____.

Tertiary Carrier: _____.Phone:_____.

Policy Holder:_____.Relationship to patient:_____.

Policy Holder DOB:_____.

ID#:_____.Group#:_____.

Address (street):_____City, State, Zip:_____.

Pharmacy Information

Pharmacy Name:_____.

Address (street):_____City, State, Zip:_____.

Phone: _____,Fax:_____.

Emergency Contact

Name:_____. Relationship to Patient:_____.

Home Phone:_____. Cell Phone: _____.

Work Phone:_____.Email:_____.

_____

Signature of Patient or Representative

_____

Print Name & Date

G. William Slabador, M.D., P.C.
The Hult Plaza
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Eugene, OR 97401

Authorization to Release Information

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 Slabador, 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 Signature & Date

Consent of Disclosure

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

This consent may be canceled at any time. A Cancellation must be in writing, signed by you on your behalf and delivered to the address: 401 E. 10th Ave Eugene, OR 97401. This may be delivered in person or by mail. It will only be effective when it is actually received.

As the patient, 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. Dr. Salbador is not required to grant your request, however, if he does, the restrictions will be obligatory to him.

For more information, please review the Privacy Policy in the Office Policies and Information portion of this packet.

Dr. Salbador reserves the right to amend the terms of the Privacy Policy.

Print Name

Sign & Date

Instructions for Communication of Personal Health Information

Please indicated by what means my office may communicate personal health information to you: (please check all that apply)

- ☐ Fax
- ☐ Answering machine/ Voice mail
- ☐ Email
- ☐ We MAY phone you to confirm
- ☐ We MAY NOT phone you to confirm
- ☐ Authorized Person(s)

Name(s) of individual(s)

- ☐ The authorized person(s) above MAY schedule, cancel, or confirm appointments for you
- ☐ The authorized person(s) above MAY NOT schedule, cancel or confirm appointments for you

Office Policies And Information

FEES

The initial psychiatric assessment involves about 1.5 to 2 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. Medication prior-authorizations that require substantial time will require payment from the patient as determined by Dr. Salbador.

Initial for understanding and acceptance of fee policy_____.

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 cancellation of your reserved appointment with less than a 48 hour notice. After the first no show or late cancellation, 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. Please note, in order to properly cancel within the 48 hour mark, you must call during our office hours. Calling when the office is closed will not be considered a proper cancellation and will result in a charge.

Initial for understanding and acceptance of appointment policies_____.

TERMINATION OF CARE

Care may be terminated by the doctor or the patient at any time. The most common reason for the doctor to terminate care is non-compliance from the patient. Failure to pay your bill and non communication regarding your account status is a form of non-compliance. Non-compliance can also be any disrespectful or intimidating behavior to anyone in our practice. Any type of threatening behavior will be documented and reported to the proper authorities immediately and we will discontinue care. 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.

Initial for understanding and acceptance of care termination policy_____.

PRESCRIPTIONS

Please give 72 business hours' notice for prescription refills. A $150 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.

Initial for understanding and acceptance of prescription policies_____.

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 the 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. Dr. Salbador is contracted with a number of these managed care insurance companies to provide services within these conditions. Sessions beyond those initially authorized are usually obtained by submitting a treatment plan to a utilization review committee or a case manager, 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 copayment amounts are due 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. 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. **Please note that Dr. Salbador does not accept Medicare or OHP.**

Initial for understanding and acceptance of insurance policies_____.

EMERGENCIES

In the event of a life threatening emergency, please call 911 and/or go to the emergency room. In the event of a non-life threatening emergency, Dr. Salbador may be reached through his voice mail, 24 hours a day at (541)684-0154.

Initial for understanding and acceptance of emergency policy_____.

OFFICE HOURS

Please keep in mind that the office is only open Monday through Friday from 8:30am to 5:30pm. The status of the office hours is subject to change at any moment due to holidays or vacation. The office reserves the right to disclose this information as seen fit.

Initial for understanding and acceptance of office hour policy_____.

PRIVACY POLICY

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) is a federal law of national standards to protect sensitive patient health information from being disclosed without the patient's consent or knowledge. This includes all medical records and other individually identifiable health information used or disclosed by a covered entity in any form, whether electronically, on paper, or orally. As a health provider, this clinic will do as much as possible to ensure safety and confidentiality of all patient's protected information. If more information regarding HIPAA, please request the Notice of Privacy Practices for Protected Health Information packet.

Initial for understanding and acceptance of privacy policy_____.

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NW Psychiatry Financial Agreement

I acknowledge that insurance will be billed on my behalf. I understand that my insurance policy is a contact between myself and my insurance. **I understand that any negotiating of payments or denial of payment by my insurance for whatever reason, is my responsibility.** It is my responsibility to know my insurance information (copays, deductible, coverage, etc.) I am ultimately responsible for any balance on my account.
Initial_____.

I assign medical benefits paid by my insurance carrier to Dr. Salbador, for the application of my bill. I understand that I will be billed for charges not covered under my insurance policy.
Initial_____.

If my insurance carrier refuses payment, I agree to pay for all services upon receiving written and/or verbal notice of the denial. After my insurance has processed the claim, I understand that a **$50.00** (minimum) **roll over fee** will be added to my account monthly until paid. If my account becomes delinquent after 90 days, the account balance will be forwarded to collections.

*Failure to contact our office regarding your balance will be documented, and if we have to contact you several times about a past due balance, you will be charged an additional $100 for our staff's time.
Initial_____.

All copays or self-pay fees MUST be paid on the day of your appointment.
Initial_____.

If you are a self-pay patient and do not pay for your visit at the time of service or day of service, you will be charged the full price of the visit. We are only able to offer the time of service discount if paid on the day of your appointment. Our staff will reach out once to collect payment. If they are unable to reach you, please call the office to make your payment on the day of your appointment. It is your responsibility to make sure this is collected.
Initial_____.

Returned/NSF checkers will incur a $35 fee. Please note, we DO NOT accept Medicare.

If an insurance carrier is given or not reported to us, and we have to submit a refund, you will be charged a $150 fee.

If we are out of network with your insurance company, you may request a single case agreement through your insurance provider. These are to be initiated by the patient and must be renewed yearly (or whatever timeline your insurance determines) by the patient for them to remain in effect.

In the unfortunate circumstances that you do not pay for services provided in a timely manner, you are aware that your account will be sent to collections. You are agreeing to pay all costs associated with collection, including any fees associated with the collection process. At this point, you will also be notified that Dr. Salvador will only be able to provide care and medication management for 30 days and you will be asked to find another provider at that time.

By signing below you agree to the following statement:

I have read and understand NW Psychiatry's Financial Agreement and I agree to be bound by these terms. I understand my financial responsibility for all care rendered to me as long as I am a patient of this practice.

Print Name

_____

Sign & Date

_____

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.

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?

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Print Name

Sign & Date

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- ☐ Fax
- ☐ Answering machine/ Voice mail
- ☐ Email
- ☐ We MAY phone you to confirm
- ☐ We MAY NOT phone you to confirm
- ☐ Authorized Person(s)

Name(s) of individual(s)

- ☐ The authorized person(s) above MAY schedule, cancel, or confirm appointments for you
- ☐ The authorized person(s) above MAY NOT schedule, cancel or confirm appointments for you