PACIFIC PHOENIX PSYCHIATRY & TMS

Vancouver: 1499 SE Tech Center Place, Suite 190, Vancouver, WA 98683
Salmon Creek: 2501 NE 134th St, Suite 104, Vancouver, WA 98686
Lakewood: 8524 Steilacoom Blvd SW, Suite 102B, Lakewood WA 98498
Phone: 360-828-7802 | Fax: 360-326-2606 | https://www.pacpx.com

Today's Date: _____

Patient's Name: _____

Date of Birth: _____ SSN: _____

Address: _____

City, State, Zip: _____

Home Phone: _____ Work Phone: _____

Mobile: _____ E-mail _____

Where can we leave a message? _____ address: _____

Sex: ☐ M ☐ F ☐ Other (please specify): _____ Preferred Pronouns: _____

Employed: Y ☐ N ☐ Student: Y ☐ N ☐

Marital Status: M S D W O Employer: _____

Emergency contact and number

_____

Patient Signature _____ Date _____

Insurance Information

Insurance Provider: _____

Subscriber Name: _____

Subscriber DOB: _____

Member/ Subscriber ID: _____

Group Number: _____

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SYMPTOM CHECK LIST: Please circle (use blank space to add items not listed)

□ Agitated	□ desperate	□ distracted	□ impaired performance
□ Fearful	□ overly tired	□ see things	□ obsessive/compulsive
□ Cry often	□ hear voices	□ suspicious	□ anxiety attacks
□ Hopeless	□ rapid speech	□ aggressive	□ avoidance of people
□ Withdrawn	□ anger/aggression	□ racing thoughts	□ headaches
□ Chest pain	□ irritable	□ appetite increase	□ indecisive
□ Mood swings	□ anxious	□ appetite decrease	□ sexual difficulties
□ Homicidal	□ depressed	□ helpless	□ self-harm thoughts/actions
□ Restless/on edge	□ confused	□ feeling "out of control"	□ guilt
□ Worry a lot	□ sad	□ personality changes	□ can't concentrate

SLEEP CHANGES? DESCRIBE: _____

_____

Energy Level: □ Tire easily □ Average energy □ High energy

DESCRIBE CURRENT STRESSORS: _____

_____

TREATMENT HISTORY: (CHECK ALL PRIOR Psychiatric/Psychological Treatment or Counseling) Please identify when/where treated or who provided the following treatment:

□ Inpatient Care: _____

□ Individual OP Therapy: _____
□ Family Therapy/Marital: _____
□ Partial/Day Hospital: _____
□ Medication Management: _____
□ None

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Referral Source / Primary Care Physician Notification

The undersigned hereby authorizes providers of Pacific Phoenix Group to notify the referral source of the patient's contact with Elia Gonzalez- Rodriguez, MD and providers. The undersigned also authorizes Elia Gonzalez- Rodriguez, MD and providers to notify the primary care physician listed below to share diagnosis and treatment plan to insure integrated treatment.

Put your initials on the line for "yes, you may contact" or "no, you may not contact"

Initial:_____ Yes _____

No Referral Source (name): _____

Address: _____

_____

Phone number: _____

Please enter the information of your primary care provider below:

Initial: _____ Yes _____

No Provider Name: _____

Address: _____

_____

Phone number: _____

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CHEMICAL ABUSE/DEPENDENCY HISTORY

Have you ever felt you should cut down on your drinking? □ NO □ YES

Have people annoyed you by criticizing your drinking? □ NO □ YES

Have you ever felt bad or guilty about your drinking? □ NO □ YES

Have you ever had a drink first thing in the morning to get rid of a hangover? □ NO □ YES

Is there a history of alcohol, marijuana, street drugs, or medication abuse/dependence? □ NO □ YES

If YES please explain: _____

Drug abused	Age at Onset	Dose/Amount	How Often	Last Used

Do you smoke? □ NO □ YES If yes, how much? _____ Trying to Quit? □ NO □ YES
Amount of caffeine consumed in a day: _____
Has there been exposure to toxic substances? □ NO □ YES _____

FAMILY HISTORY

Describe current home living arrangements, including who is living in your home with you:

□ Parents □ Spouse/Significant other □ Children □ Group Home □ Nursing home/Assisted Living

Has there been exposure to abusive behavior(s)? □ NO □ YES If yes, answer the following:

Current exposure? □ NO □ Past exposure? If so, when? _____
YES Who was the abuser? _____ Type of abuse: □ Physical □ Sexual □ Verbal

Did it occur: □ within the family □ outside the family?

Have any other family members sought or received mental health treatment? □ NO □ YES

Relationship: _____

Type of Problem/Care Needed: _____
_____

Is there a family history of alcohol or drug abuse/dependency? □ NO □ YES

If yes, please describe: _____

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MEDICAL HISTORY :

Family Physician: Name:_____ Phone: _____
Date of your last complete physical exam? _____ Problems?_____
Accidents/Surgeries: _____

_____

PREFERRED PHARMACY

Name:_____
Address: _____
Phone: _____

PREFERRED LAB

Name: _____
Address: _____
Phone: _____

MEDICATIONS CURENTLY IN USE: (Prescribed or over-the-counter)
Please note dosages, frequency and duration if known.

_____

_____

_____

_____

_____

Medication allergies: _____
Other allergies: _____

REVIEW OF SYSTEMS:

VISUAL

□ No Problem □ State Problem: _____

HEARING

□ No Problem □ State Problem: _____

RESPIRATORY

□ No Problem □ Asthma □ Hay Fever □ Congestion □ Short of Breath
□ Emphysema □ Wheezing □ Tuberculosis □ Sputum production □ Cough up blood

CARDIOVASCULAR
□ No Problem □ High blood pressure □ Low blood pressure □ Chest pain □ Palpitations □ Prior heart attack □ Fainting episodes

EXCRETORY

□ No Problem □ Urinary infections □ Bladder infections □ Incontinence of ___Urine ___Stool
□ Excessive night urination

NEUROLOGICAL
□ No problem □ Seizures □ Frequent headaches □ Migraines Cluster headaches □ Dizziness
□ Tremors □ Memory problems □ One-Sided body Weakness □ Pins and Needles Sensations
□ Past history of head injuries □ Loss of consciousness □ Meningitis

REPRODUCTIVE
Sexual orientation (is helpful to your therapy) □ Heterosexual □ Homosexual □ Bisexual

□ HIV+ □ Genital herpes □ Sexually transmitted diseases □ High risk for HIV/AIDS
□ Sexual worries □ Birth control issues

ENDOCRINE
□ No Problem □ Diabetes □ Hypoglycemia □ Thyroid dysfunction □ Edema or Swelling

GASTROINTESTINAL
□ No Problem □ abdominal pain □ frequent nausea □ frequent vomiting □ frequent diarrhea
□ frequent constipation
Weight □ Loss □ Gain Amount? _____ Appetite □ Poor □ Ravenous

MUSKULOSKELETAL
□ No Problem □ Muscle impairment/tenderness □ Joint pain □ Back pain

CANCER Describe (type & treatment): _____
_____
_____

EDUCATION-OCCUPATION-COMMUNITY BACKGROUND

Highest level of education

□ BA or BS Degree □ High School Diploma □ Elementary education, level completed
□ GED □ Master's Degree □ Technical Degree □ Doctoral Degree
Have you been told you have learning difficulties/impairments? □ NO

□ YES If yes, please describe: _____

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RISK ASSESSMENT

	Past	Present
Have you ever had thoughts of hurting yourself?	_____	_____
Have you ever had thoughts of committing suicide?	_____	_____
Have you ever had a plan to commit suicide? Have	_____	_____
you made threats to kill yourself?	_____	_____
Have you ever made a suicide attempt?	_____	_____
Have you ever mutilated yourself?	_____	_____
Have you ever had thoughts of harming someone?	_____	_____
Have you ever had plans to harm someone?	_____	_____
Have you ever attempted to harm someone? Have	_____	_____
you made any threats to harm someone?	_____	_____

Signature _____ Date _____

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CONSENT TO RELEASE/RECEIVE CONFIDENTIAL INFORMATION

I, _____ , DOB: _____ , authorize PACIFIC PHOENIX PSYCHIATRY & TMS at the above address to:
Patient Name (Print)

Provider Name(s): Dr. Elia Gonzalez-Rodriguez M.D.
Dr. Vaishali Shah M.D.
Dr. Darcy Trenkle M.D.
Brooke Music, PMHNP-BC
Tate Lander, PMHNP

Check all that apply

☑ Receive and release my medical history information to/from the following provider(s):
(name, address)_____

(name, address)_____

☑ Receive and release my treatment records to/from the following therapist:
Therapist (name, address)_____

☑ Release my treatment information to the health insurance company listed below, for billing purposes:
Insurance provider (name, address)_____

☑ Receive information from:
(name, address)_____

☑ Receive and release my treatment information and medical history to/from:
_____

_____

This information is for the following purposes (any other use is prohibited): _____

I understand that I may withdraw this consent at any time, either verbally or in writing, except to the extent that any action has been taken on reliance on it. This consent will last while I am being treated by the provider(s) specified above unless I withdraw my consent during the treatment. This consent will expire 365 days after I complete my treatment, unless an expiration date is indicated above, or the provider(s) specified above is otherwise notified by me.

I understand that the records to be released may contain information pertaining to psychiatric treatment and/or treatment for alcohol and/or drug dependence. These records may also contain confidential information about communicable diseases including HIS (AIDS) or related illnesses. I understand that these records are protected by the Code of Federal Regulations Title 42 Part 2 (42 CFR Part 2) which prohibits the recipient of these records from making any further disclosures to third parties without the express written consent of the patient.

I acknowledge that I have been notified of my rights pertaining to the confidentiality of my treatment information/records under 42 CFR Part 2, and I further acknowledge that I understand those rights.

_____ _____ _____
Patient Signature Patient Name (Print) Date

_____ _____ _____
Witness Signature Witness Name (Print) Date



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Financial Agreement

1. I acknowledge and understand that Pacific Phoenix Group PLLC, doing business as Pacific Phoenix Psychiatry and TMS, only accepts new patients with in-network commercial insurance or those paying cash.
2. I acknowledge and understand that Pacific Phoenix Group PLLC does not accept or file claims with Medicaid or its subsidiaries.
3. I acknowledge and understand that I will not file or submit claims or superbills to Medicaid or its subsidiaries as primary or secondary insurance carriers.
4. I acknowledge and understand that I am responsible for informing Pacific Phoenix Group PLLC immediately if I obtain Medicare, Medicaid, or similar policies.
5. I acknowledge and understand that I may be subject to immediate termination of services and discharge from Pacific Phoenix Group PLLC if I intentionally do not disclose having Medicaid, or similar policies.
6. I acknowledge and understand that I accept full financial responsibility for all services rendered by Pacific Phoenix Group PLLC.
7. I acknowledge and understand that payment is due at the time of service unless alternative financial arrangements have been made and agreed upon by the Financial Manager or other authorized Pacific Phoenix Group PLLC management personnel.
8. I acknowledge, understand, and accept that I will pay all reasonable attorney's fees and collection costs in the event of default payment of my charges for services rendered.
9. I request and authorize that insurance payments be made directly to Pacific Phoenix Group PLLC by my health insurance carrier.
10. I acknowledge and understand that benefits verification of my health insurance is a courtesy performed by Pacific Phoenix Group PLLC.
11. I acknowledge and understand that it is my responsibility to understand my health insurance policy coverage, benefits, and verify eligibility. Pacific Phoenix Group PLLC will offer assistance in the process as a courtesy.
12. I acknowledge and understand that Pacific Phoenix Group PLLC offers insurance billing services as a courtesy to patients. I understand that Pacific Phoenix Group PLLC assists with processing single insurance carrier claims, and it is my responsibility to know which insurance carrier is my primary insurance provider. I understand that the secondary insurance policy will be processed as an additional biller fee at a rate of $50.00 per hour in 30-minute increments.$50.00 for setup and initial secondary insurance carrier filing, $50.00 per hour for any billing services exceeding one hour of billing time
13. I acknowledge, understand, and accept that any disputes of covered benefits are my responsibility to resolve with my insurance company. I understand that Pacific Phoenix Group PLLC may assist in the dispute process as a courtesy.
14. I acknowledge, understand, and accept that my health insurance policy is a contract between me, the patient, and the policyholder or insurance company, and has no relation to Pacific Phoenix Group PLLC.
15. I acknowledge, understand, and accept that it is my responsibility to update Pacific Phoenix Group PLLC of any changes to my insurance information, including policy changes, ID cards, carriers, subscribers, address changes, and other relevant details.
16. I acknowledge, understand, and accept the no-show and late cancellation policy, which applies to notifications given less than 24 business hours (Monday through Friday, 9 AM to 5 PM) prior to the scheduled appointment. The fees are as follows:
17. $200 per no-show/late cancellation for new intake appointments
18. $75 per no-show/late cancellation for follow-up or TMS treatment appointment
19. These no-show/late cancellation fees are separate from any fees associated with professional services rendered by our providers and/or clinic. To be fair, these fees are applied to all patients regardless of the reason for the cancellation, as the time slot cannot be filled by another patient.

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22. I acknowledge, understand, and accept that Pacific Phoenix Group PLLC may discharge me from the clinic for two or more consecutive no-shows/late cancellations.
23. I acknowledge, understand, and accept that I am solely responsible for keeping track of my appointments and scheduling obligations, as well as any fees accrued for missed appointments. Appointment reminders provided by the clinic are a courtesy and not a requirement.
24. I acknowledge, understand, and accept that my credit card will be placed on file and I authorize it to be used to pay outstanding balances for charges accrued.
25. If the patient signs, the card must bear the patient's name.
26. If someone else provides the card, that person must sign the Credit Card authorization form to be responsible for the patient's balance.

Auto Billing Process:
Upon processing by your insurance, we will automatically collect up to $150 of your remaining balance using the card on file. If any amount remains, a statement will be sent, and the balance will be collected the following month. You have the option to pay in full or arrange payment plans by contacting our billing team directly

Additional Office Fees:

General letters and form completion (requiring more than 15 minutes):

ESA letter: $75.00 per animal
General letters (excluding work and school excuse): $75.00 each

Medical Records Access Fees (per HIPAA & WA Law)
This fee schedule outlines the charges associated with accessing or requesting medical records from Pacific Phoenix Psychiatry and TMS. All fees comply with HIPAA regulations and Washington State law.

Requester Type	Format	Fee
Patient (self)	Electronic via Portal	Free – Access through secure patient portal
Patient (self)	Electronic (Email, USB)	Labor: 30 minutes at $22/ hour = $11 Tax (6.5%)
Patient (self)	Paper	Labor: 30 minutes at $22/hour = $11 Supply: $0.10/page Tax: 6.5%, Postage: $10.10
Provider (Continuity of Care)	Electronic/Paper	Free for electronic records transmission. Physical copies will require a .10 fee per page supply charge + tax (6.5%) and postage $10.10.
Insurance Company	Any Format Per page applies to paper copies only.	WA State Fee Schedule applies: Clerical fee: up to $28 Pages 1–30: $1.24/page Pages 31+: $0.94/page
Attorney / Legal / Other Third Party/ SSDI/ State	Any Format Per page applies to paper copies only.	WA State Fee Schedule applies: Clerical fee: up to $28 Pages 1–30: $1.24/page Pages 31+: $0.94/page
Patient Portal Access	Electronic	Free – 24/7 access to visit notes, documents, and records

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To note:
Postage costs: Mailing of records: $10.10 – Flat rate USPS tracked envelope if mailed.
Postage = not taxable, only labor and supply costs.
Patient must provide their own USB – We do not provide, and they must drop off for us to upload files. CDs are not supported in our practice.

Disclaimer:

All fees outlined in this schedule for medical records access are in full compliance with the **Health Insurance Portability and Accountability Act (HIPAA)** and **Washington State law** (RCW 70.02 and WAC 246-08). The fees are based on the cost of labor, supplies, and postage, as allowed under these regulations.

Federal Law (HIPAA) on Record Requests:

Under **HIPAA** (45 CFR 164.524), individuals have the right to access their medical records. Covered entities can charge a reasonable, cost-based fee, which may include:

- Labor for copying the records
- Supplies (e.g., paper, USB)
- Postage

Washington State Law on Record Requests:

Washington State's Health Care Information Access law (RCW 70.02 and WAC 246-08) governs fees for medical records. Washington law allows healthcare providers to charge:

• $1.24 per page for the first 30 pages,
• $0.94 per page for pages 31 and beyond,
• A clerical fee up to $28.00 for requests handled by administrative staff.

Providers must fulfill a **patient's request for access to their health records** within **15 business days after payment is rendered,** as stipulated in **RCW 70.02.030.**

I have read and fully understand the above:

Patient Signature *Date:*

_____

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Our psychiatric office maintains a stringent office policies to ensure the highest level of care for our patients. Please carefully review the following guidelines:

1. Location Requirement: All patients must be located within Washington or Oregon to obtain prescriptions of any kind, unless you are active duty military. Our office can provide one 30-day refill before a patient moves out of state to allow time to find a new provider.

2. Mandatory Comprehensive Evaluation: To receive a prescription for medication, every patient must undergo a comprehensive psychiatric evaluation conducted by one of our authorized providers at our office. This evaluation is an essential requirement without exceptions.

3. Follow-Up Medication Management Sessions: Patients must adhere to a strict follow-up schedule for medication management review sessions. Missing or neglecting these appointments will not be tolerated.

4. Automatic Dismissal for Non-Compliance: Failure to adhere to our medication policy may result in immediate dismissal from our office. We take non-compliance seriously and will not hesitate to enforce this consequence to uphold the integrity of our care.

5. Refusal to Fill Prescriptions: Disregarding the policy will also result in the refusal to fill prescriptions, regardless of when the patient was last seen in our office. Our commitment to patient well-being and safety supersedes any other considerations.

6. Patient Responsibility: It is the sole responsibility of each patient to remain vigilant about their medication supply, upcoming appointments, and any other medication-related matters. Our office will not make exceptions or alter policies due to a patient's lack of attentiveness.

7. Zero Tolerance for Harassment: Any form of harassment directed towards our staff regarding the medication policy will not be tolerated. Engaging in such behavior will lead to immediate dismissal from our office.

8. Mandatory Return Visit: All new patients must return to the clinic within 3 months (no exceptions) to obtain refills of any kind. This follow-up visit is essential for ongoing evaluation and prescription management.

9. Minimum Refill Request Notice: Refill requests must be made a minimum of 72 business hours before the patient is due to run out of their prescription. This notice period allows us to process the request and ensure timely availability of medication. We will not expedite any scripts.

10. Refill Limitations: Prescriptions will not be refilled on weekends, holidays, or after 12:00 PM on Friday. To facilitate efficient communication, please provide a phone number where you can be easily reached during office hours when leaving a message on our voicemail.

11. Refill Processing: Refills will only be processed if they come directly from a pharmacy to our fax at 360-326-2606 or via a medical record request. Direct calls to the office or messages sent via the Tebra EMR system will be redirected to your pharmacy.

12. Prescription Delivery: Prescription release to third-party couriers is subject to provider discretion. If you wish to have prescriptions delivered, please formally request it through our office. This service is available for non-controlled prescriptions only.

13. Medication Changes: Medication changes will only be addressed during scheduled appointment times. If you are experiencing side effects or urgent issues with your current medication, our support staff can assist you over the phone. For after-hours issues, please seek assistance from urgent care or emergency facilities.

14. 90-Day Prescriptions: Requests for 90-day prescriptions will only be addressed during scheduled appointments. Providers cannot provide 90-day prescriptions for controlled substances such as stimulants and benzodiazepines.

15. Non-Controlled Substances:

○ Non-Controlled Prescriptions: Patients prescribed non-controlled psychiatric medications, such as SSRIs (selective serotonin reuptake inhibitors) and SNRIs (serotonin-norepinephrine reuptake inhibitors), must be seen based on the provider's recommendations. The frequency of appointments will depend on the individual patient's needs and treatment plan.

○ Refill Requirements: To continue receiving refills for non-controlled psychiatric medications, patients must be seen at least every 9 months. This ensures ongoing evaluation, monitoring, and adjustment of the treatment regimen if necessary.

16. Controlled Substance Policy (Schedule II or IV):

○ Drug Tests: Patients receiving prescriptions from the above controlled substances categories are subject to randomized drug tests. Failure to comply with the drug testing requirement will result in the loss of prescription refills.

○ Lost or Stolen Prescriptions: Lost or stolen prescriptions for Schedule II or IV controlled substances, including benzodiazepines and ADHD stimulants, will not be replaced or re-written without a police report.

○ Refill Request for Controlled Substances: Patients must leave a message with our office staff or via the Tebra EMR system a minimum of 72 business hours before running out of their prescription.

○ Buprenorphine: Patients must be seen a minimum of once per month to receive a refill on this prescription.

○ ADHD Medications & Stimulants: The following medications fall under this category: Adderall (dextroamphetamine-amphetamine), Concerta (methylphenidate HCL extended release), Vyvanse (lisdexamfetamine dimesylate), Provigil (modafinil), Nuvigil (armodafinil), Ritalin (methylphenidate), etc. Each office visit is worth a 3-month supply of medication.

○ Benzodiazepines/Sleep Medications: The following medications fall under this category: Ativan (lorazepam), Klonopin (clonazepam), Valium (diazepam), Xanax (alprazolam), Restoril (temazepam), Ambien (zolpidem or zolpidem tartrate). Each office visit is worth a 6-month supply of medication.

○ Doctor Shopping Policy: All patients considered candidates for controlled substance prescriptions must agree to receive such prescriptions from a designated and identified provider, and all refills must be done in coordination with such designated provider. Any effort to obtain or attempt to obtain a controlled substance by fraud, deceit, misrepresentation, subterfuge, or concealment of material facts will be deemed a violation of controlled substance prescription policy and will result in immediate termination of such prescribing privileges. Patients violating the "Doctor Shopping" policy will be subject to termination from the clinic.

17. In-Person Follow-Ups:

All patients receiving stimulant medications and/or buprenorphine will be required to have in-person follow-ups for compliance; telehealth will not permit refills of these substances.

18. FMLA/Disability:

○ **Completion of FMLA/Disability Requests:** FMLA/Disability requests will ONLY be completed if the patient has been seen within the last 30 days by the provider, and the paperwork must be discussed during that visit. Paperwork may take up to 10 business days to complete. It will ONLY be submitted directly if a valid ROI is available; otherwise, patients will need to pick it up in the office. Patients receiving FMLA/disability benefits must be actively involved in treatment with us and must be seen every 30 days or as indicated by the physician while on leave. Failure to comply will result in non-completion of further certifications.

OFFICE POLICIES - Continued

Turn Around Times for Requested Letters and Forms:
While we strive to accommodate all timeline requests for letters, please note that we cannot expedite any requests, including those with deadlines that fall before our expected completion date. Continued calls and harassment of our staff for faster completion will not expedite the process and will not be tolerated under our behavioral policy.
Processing Times for Letters:

1. **Work/School Excuse Letters**: 1-2 business days
2. **General Letters** (ESA, Accommodations, Travel/Medication, Dx Letters, Jury Excuse, Testing Accommodations, Absence Letters exceeding 1 day): 3-5 business days
3. **FMLA, LOA, Leave (including disability):** 7-14 days
4. **Legal/Claim Letters:** Up to 30 days

Privacy Practices and Procedures

Notice of Privacy Practices and Policies, effective Oct 1, 2016
As Required by Federal Legislation: This notice describes how healthcare information about you may be used and disclosed and how you can obtain access to this information. Please review it carefully. Applicability: This notice applies to all of the paper and electronic records of your care maintained by Dr. Elia Gonzalez-Rodriguez and other providers under our group and employed by us, whether created by Dr. Gonzalez-Rodriguez, office personnel, or records acquired from outside resources such as other clinicians involved in your care and laboratory reports.

I. **Uses and Disclosures of Protected Health Information (PHI):**
1. Permissible Uses and Disclosures without Your Written Authorization:

A. Routine Situations:
1. For Treatment: PHI may be used and disclosed to provide treatment and coordinate care with other health care providers.
B. 2. For Payment: PHI may be used for billing and payment collection from you, insurance companies, or third parties.
3. For Health Care Operations: PHI may be used for administrative functions, quality care review, and business associate services.
4. Communicating with You and Others Involved in Your Care: PHI may be used to provide appointment reminders, treatment alternatives, or information to individuals involved in your care.

2. B. Special Situations:

As Required by Law: PHI may be disclosed for legal requirements, health oversight activities, judicial proceedings, public health risks, law enforcement, worker's compensation, and medical emergencies.
3. Uses and Disclosures That Require Your Written Authorization: Any use or disclosure not describe above requires your written authorization. You may revoke any such authorization in writing at any time.

II. **Your Rights as a Patient:**

1. **Right to Request Restrictions:** You have the right to request restrictions on the use and sharing of your information. Requests must be in writing.
2. **Right to Receive Confidential Communications:** You can request to communicate in a specific way or location. Requests must be in writing.
3. **Right to Inspect and Obtain Copies:** You may review and obtain copies of information used to make decisions about your care. This does not include psychotherapy notes.
4. **Right to Amend Confidential Information:** You may request amendments to your information. Requests must be in writing and provide reasons for the amendment.
5. **Right to Receive an Accounting of Disclosures:** You may obtain an accounting of certain disclosures of PHI made about you in the last six years.
6. **Right to Receive Notification of a Breach:** You will be notified if a breach of your unsecured PHI is discovered.

OFFICE POLICIES - Continued

My Practice's Duties: I am required to maintain the privacy of your information and inform you of any changes. I must abide by the terms of this Notice.
Changes to This Notice: I reserve the right to revise or change this notice. Revised notices will be posted in the waiting room with the effective date.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be submitted or verified in writing. You have specific rights under the Privacy Rule. You will not be penalized for filing a complaint.

PRIVACY OFFICER
For privacy questions, you may contact Stacia Welch, Chief of Operations, at 360-773-6340, via email at stacia.w@pacpx.com, or by mail to "Privacy Officer," 1499 SE Tech Center Place, Suite 190, Vancouver, WA 98686.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE
I am required to provide you with a copy of this Notice and document your receipt. Please fill out an Acknowledgement of Receipt of Notice of Privacy after receiving this Notice. (See Below.) Acknowledgement of Receipt of Notice of Privacy Practices In order to comply with HIPAA standards, each practice must obtain a signed acknowledgment that each direct treatment patient has received its Notice of Privacy Practices or must document a good faith effort to provide the Notice and receive a written acknowledgment of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or health care operations. I have received a copy of the Notice of Privacy Practices from: PACIFIC PHOENIX GROUP PLLC. By signing this form you agree and acknowledge you received your HIPAA standards via this form.

Behavioral Agreement

This Behavioral Agreement ("Agreement") is entered into between Pacific Phoenix Group, DBA TMS Services of Vancouver (referred to as "the Office") and the patient or individual receiving services ("Patient") to establish guidelines for appropriate behavior within the psychiatric office. It is essential to create a safe and respectful environment for all individuals involved. By signing this Agreement, the Patient acknowledges their understanding and acceptance of the following terms:

1.**Respectful and Professional Conduct:**

A. The Patient agrees to treat all Office staff, including healthcare providers, administrative personnel, and fellow patients, with respect, courtesy, and professionalism at all times.
B. The Patient shall refrain from engaging in any form of harassment, intimidation, bullying, verbal abuse, or discriminatory behavior towards others within the Office premises. This includes but is not limited to foul language, verbal, physical, or written forms of harassment.
C. The Patient agrees to communicate with the Office staff in a respectful manner, maintaining appropriate boundaries and refraining from using offensive language or engaging in aggressive behavior.

OFFICE POLICIES - Continued

2. **Harassment and Inappropriate Behavior:**
   A. The Office has a zero-tolerance policy for harassment and inappropriate behavior. The Patient understands that any act of harassment, including but not limited to sexual harassment, verbal abuse, threats, or unwanted advances, is strictly prohibited.
   B. The Patient shall not engage in any form of behavior that causes discomfort, distress, or harm to others within the Office premises. This includes actions such as spreading rumors, gossiping, or engaging in any form of cyberbullying.
   C. The Patient agrees to follow the instructions and guidelines provided by the Office staff regarding appropriate behavior and professional conduct during appointments or while on the Office premises.

3. **Aggressiveness and Violence:**
   A. The Office maintains a safe environment for all patients and staff members. The Patient shall not engage in any violent, aggressive, or threatening behavior towards any individual within the Office premises.
   B. The Patient understands that any act of physical aggression, including but not limited to physical assault, property damage, or threats of violence, will result in immediate dismissal from the Office. Such behavior will not be tolerated under any circumstances.
   C. Weapons are prohibited from being in the office as we are a weapons-free zone. Weapons can include but are not limited to firearms, knives, pepper spray, and anything intended to harm or used for combat.

4. **Harassing Calls or Communication:**
   A. The Patient acknowledges that any form of harassing calls, messages, or communication directed towards the Office staff, including healthcare providers and administrative personnel, is strictly prohibited.
   B. The Patient agrees not to engage in any form of communication that is intended to harass, intimidate, or cause distress to any individual associated with the Office. This includes phone calls, emails, text messages, social media messages, or any other means of communication.

5. **Automatic Dismissal:**

The Office reserves the right to dismiss the Patient from its services immediately and without prior warning if the Patient engages in any behavior outlined above, including harassment, inappropriate behavior, aggressiveness, or engaging in harassing calls or communication. Dismissal from the Office will result in the termination of the therapeutic relationship, and the Patient will no longer be able to receive services or prescriptions from the Office.

INFORMED CONSENT FOR TELEMEDICINE SERVICES INTRODUCTION

Telemedicine involves the use of electronic communications to enable healthcare providers at different locations to share individual patient medical information for the purpose of improving patient care.

EXPECTED BENEFITS

1. Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults with healthcare practitioners at distant/other sites.
2. More efficient medical evaluation and management.
3. Obtaining expertise of a distant specialist.

POSSIBLE RISKS

As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to:

1. In rare cases, information transmitted may not be sufficient (e.g., poor resolution of images) to allow for appropriate medical decision-making by the physician and consultant(s).
2. Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment.
3. In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information
4. In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reactions or other judgment errors.

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent.
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment.
3. I understand that I have the right to inspect all information obtained and recorded in the course of a telemedicine interaction and may receive copies of this information for a reasonable fee.
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time.
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform Pacpx PLLC of electronic interactions regarding my care that I may have with other healthcare providers.
7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of Washington or Oregon and will be present in the state of Washington or Oregon during all telehealth encounters.

PATIENT CONSENT TO THE USE OF TELEMEDICINE

I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care. I understand a copy of this form will be available for me to print. I hereby authorize Pacpx PLLC to use telemedicine in the course of my diagnosis and treatment. Email Communication While we mainly require all messages to be sent via our Tebra EMR system, on occasion email is used.

Email: Risks of Using Email
The physician offers patients the opportunity to communicate by email. Transmitting patient information poses several risks of which the patient should be aware. The patient should not agree to communicate with the physician via email without understanding and accepting these risks. The risks include, but are not limited to, the following:

1. The privacy and security of email communication cannot be guaranteed.
2. Employers and online services may have a legal right to inspect and keep emails that pass through their system.
3. Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender or to ensure that only the recipient can read the email once it has been sent.
4. Emails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
5. Email can be forwarded, intercepted, circulated, stored, or even changed without the knowledge or permission of the physician or the patient.
6. Email senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients.
7. Email is indelible. Even after the sender and recipient have deleted their copies of the email, backup copies may exist on a computer or in cyberspace.
8. Use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties.
9. Email can be used as evidence in court.

OFFICE POLICIES - Continued

The physician uses encryption software as a security mechanism for email communications.

The Patient:

1. Agrees to and will comply with the use of encryption software.
2. Chooses not to use encryption software when communicating with the physician, with the full understanding that this increases the risk of violation of the patient's privacy.

Conditions of Using Email

The physician will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, the physician cannot guarantee the security and confidentiality of email communication. Thus, patients must consent to the use of email for patient information. Consent to the use of email includes agreement with the following conditions:

1. Emails to or from the patient concerning diagnosis or treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.
2. The physician may forward emails internally to the physician's staff and to those involved, as necessary, for diagnosis, treatment, reimbursement, healthcare operations, and other handling. The physician will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
3. Although the physician will endeavor to read and respond promptly to an email from the patient, the physician cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, the patient should not use email for medical emergencies or other time-sensitive matters.
4. Email communication is not an appropriate substitute for clinical examinations. The patient is responsible for scheduling appointments where warranted.
5. If the patient's email requires or invites a response from the physician and the patient has not received a response within a reasonable time period, it is the patient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
6. The patient should not use email for communication regarding sensitive medical information, such as sexually transmitted diseases, AIDS/HIV, mental health, developmental disability, or substance abuse. Similarly, the physician will not discuss such matters over email.
7. The patient is responsible for informing the physician of any types of information the patient does not want to be sent by email, in addition to those set out in the bullet above. Such information that the patient does not want communicated over email includes: [Patients can add to or modify this list at any time by notifying the physician in writing.]
8. The physician is not responsible for information loss due to technical failures associated with the patient's email software or internet service provider.

Instructions for Communication by Email
To communicate by email, the patient shall:

1. Limit or avoid using an employer's or other third party's computer.
2. Inform the physician of any changes in the patient's email address.
3. Review the email to make sure it is clear and that all relevant information is provided before sending to the physician.
4. Inform the physician when the patient receives an email from the physician.
5. Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding computer passwords.
6. Withdraw consent only by email or written communication to the physician.
7. Should the patient require immediate assistance, or if the patient's condition appears serious or rapidly worsens, the patient should not rely on email. Rather, the patient should call the physician's office for consultation or an appointment, visit the physician's office, or take other measures as appropriate.

By signing this document (by paper or electronically), I, the patient, have read, understand, and agree to the terms above. I also understand that failure to comply with the above policies may result in being discharged as a patient from Pacific Phoenix TMS.

I have read and fully understand the above:

Patient Signature: Date:

Physician-patient email communication template consent form

Physician information

Name: Providers of Pacific Phoenix Group PLLC

Address: 1499 SE Tech Center Place, Suite 190, Vancouver, WA 98683

Email: SEE PATIENT PORTAL FOR EMAIL ADDRESS

Risks of using email

The physician offers patients the opportunity to communicate by email. Transmitting patient information poses several risks of which the patient should be aware. The patient should not agree to communicate with the physician via email without understanding and accepting these risks. The risks include, but are not limited to, the following:

- The privacy and security of email communication cannot be guaranteed.
- Employers and online services may have a legal right to inspect and keep emails that pass through their system.
- Email is easier to falsify than handwritten or signed hard copies. In addition, it is impossible to verify the true identity of the sender, or to ensure that only the recipient can read the email once it has been sent.
- Emails can introduce viruses into a computer system, and potentially damage or disrupt the computer.
- Email can be forwarded, intercepted, circulated, stored or even changed without the knowledge or permission of the physician or the patient. Email senders can easily misaddress an email, resulting in it being sent to many unintended and unknown recipients.
- Email is indelible. Even after the sender and recipient have deleted their copies of the email, back-up copies may exist on a computer or in cyberspace.
- Use of email to discuss sensitive information can increase the risk of such information being disclosed to third parties.
- Email can be used as evidence in court.
- The physician uses encryption software as a security mechanism for email communications.

The patient:

- Agrees to and will comply with the use of encryption software.
- Chooses not to use encryption software when communicating with the physician, with the full understanding that this increases the risk of violation of the patient's privacy.

Conditions of using email

The physician will use reasonable means to protect the security and confidentiality of email information sent and received. However, because of the risks outlined above, the physician cannot guarantee the security and confidentiality of email communication. Thus, patients must consent to the use of email for patient information. Consent to the use of email includes agreement with the following conditions:

- Emails to or from the patient concerning diagnosis or treatment may be printed in full and made part of the patient's medical record. Because they are part of the medical record, other individuals authorized to access the medical record, such as staff and billing personnel, will have access to those emails.
- The physician may forward emails internally to the physician's staff and to those involved, as necessary, for diagnosis, treatment, reimbursement, healthcare operations, and other handling. The physician will not, however, forward emails to independent third parties without the patient's prior written consent, except as authorized or required by law.
- Although the physician will endeavour to read and respond promptly to an email from the patient, the physician cannot guarantee that any particular email will be read and responded to within any particular period of time. Thus, the patient should not use email for medical emergencies or other time-sensitive matters.

- Email communication is not an appropriate substitute for clinical examinations. The patient is responsible for following up on the physician's email and for scheduling appointments where warranted.
- If the patient's email requires or invites a response from the physician and the patient has not received a response within a reasonable time period it is the patient's responsibility to follow up to determine whether the intended recipient received the email and when the recipient will respond.
- The patient should not use email for communication regarding sensitive medical information, such as sexually transmitted disease, AIDS/HIV, mental health, developmental disability, or substance abuse. Similarly, the physician will not discuss such matters over email.
- The patient is responsible for informing the physician of any types of information the patient does not want to be sent by email, in addition to those set out in the bullet above. Such information that the patient does not want communicated over email includes:

The patient can add to or modify this list at any time by notifying the physician in writing.

- The physician is not responsible for information loss due to technical failures associated with the patient's email software or internet service provider

Instructions for communication by email

To communicate by email, the patient shall:

- Limit or avoid using an employer's or other third party's computer.
- Inform the physician of any changes in the patient's email address.
- Include in the email: the category of the communication in the email's subject line, for routing purposes (e.g., 'prescription renewal'); and the name of the patient in the body of the email.
- Review the email to make sure it is clear and that all relevant information is provided before sending to the physician.
- Inform the physician when the patient receives an email from the physician.
- Take precautions to preserve the confidentiality of emails, such as using screen savers and safeguarding computer passwords.
- Withdraw consent only by email or written communication to the physician.
- Should the patient require immediate assistance, or if the patient's condition appears serious or rapidly worsens, the patient should not rely on email. Rather, the patient should call the physician's office for consultation or an appointment, visit the physician's office or take other measures as appropriate.

Patient acknowledgment and agreement

I acknowledge that I have read and fully understand this consent form. I understand the risks associated with the communication of email between the physician and me, and consent to the conditions outlined herein, as well as any other instructions that the physician may impose to communicate with patients by email. I acknowledge the physician's right to, upon the provision of written notice, withdraw the option of communicating through email. Any questions I may have had were answered.

Patient name:

Patient address: _____

Patient email: _____

_____

Patient signature _____ Date _____

Witness signature _____ Date

PACIFIC PHOENIX PSYCHIATRY & TMS

Vancouver: 1499 SE Tech Center Place, Suite 190, Vancouver, WA 98683
Salmon Creek: 2501 NE 134th St, Suite 104, Vancouver, WA 98686
Lakewood: 8524 Steilacoom Blvd SW, Suite 102B, Lakewood WA 98498 Phone:
360-828-7802 | Fax: 360-326-2606 | https://www.pacpx.com

Notice of Privacy Practices and Policies, effective Oct, 1st, 2016

AS REQUIRED BY FEDERAL LEGISLATION, THIS NOTICE DESCRIBES HOW HEALTH CARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This notice applies to all of the paper and electronic records of your care maintained by Elia Gonzalez-Rodriguez, MD, whether created by Dr. Gonzalez-Rodriguez, office personnel or records acquired from outside resources such as other clinicians involved in your care and laboratory reports.

I. **Uses and Disclosures of Protected Health Information (PHI)**

A. Permissible Uses and Disclosures without your written authorization.

The following categories describe ways that I use and share your confidential information. Confidential information includes Protected Health Information ("PHI" - information that could be used to identify you). Not every use or disclosure in a category is listed. However, all of the ways I am permitted to use and disclose information will fall within one of the categories.

1. ROUTINE SITUATIONS

For Treatment. I may use and disclose PHI in order to provide treatment to you. For example, I may use PHI to diagnose and provide counseling service to you. In addition, I may disclose PHI to other health care providers involved in your treatment to coordinate care to the extent they need to know the information.

For Payment. I may use and disclose PHI so that the treatment and services you receive at the practice may be billed and payment may be collected from you, an insurance company or a third party – including a collection agency if necessary. For example, I may give your health plan information about services you received at the practice so your health plan will reimburse you for the services. I may also tell your health plan about a treatment you are going to receive to obtain prior approval or to determine whether your plan will cover the treatment.

For Health Care Operations. I may use and share PHI for administrative functions necessary to run my practice and promote quality care. For example, I may use your information or combine it with other patient information to review the effectiveness of my treatment and services, to evaluate my performance in caring for you, or to make decisions about additional services my practice should offer. Wherever it is practical, I may remove information that identifies you.

I may share information with business associates who provide services necessary to run my practice, such as transcription companies or billing services in the future (none currently). I will contractually bind these third parties to protect your information as I would. Also, I may permit your health plan or other providers to review records that contain information about you to assist them in improving the quality of service provided to you.

Communicating with You and Others Involved in Your Care. My practice may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you. In certain situations, I may share information about you with a friend or family member of yours who is involved in your care or payment for your care unless you have requested that such disclosures not occur and I have agreed. Information disclosed will be directly relevant to such person's involvement with your care or payment related to your care. Whenever possible, this person will be identified by you. However, in emergencies or other situations in which you are unable to indicate your preference, I may need to share information about you with other individuals or organizations to coordinate your care or notify your family.

2. SPECIAL SITUATIONS

As Required By Law: I will disclose information about you when required to do so by federal, state or local law. For example, I may release information about you in response to a valid subpoena or for communicable disease reporting.

(1) Health Oversight Activities: including audits, investigations, inspections, and licensure.

(2) For Judicial or Administrative Proceedings: in response to a court order or other lawful processes.

(3) To Avert Serious Threat to your Health or Safety or the health or safety of others

(4) Public Health Risks: including but not limited to:

To prevent or control disease, injury or disability;

To report child abuse or neglect; To report adult and domestic abuse;

To report reactions to medications or problems with products;
To notify people of recalls of products they may be using;

To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition;
To notify the appropriate government authority if we believe a patient has been the victim of abuse, neglect or domestic violence.

(5) Law Enforcement: In response to a court order, subpoena, warrant, summons or similar process;

To identify or locate a suspect, fugitive, material witness, or missing person;
If you are suspected to be a victim of a crime, generally with your permission;

About a death we believe may be the result of criminal conduct;

About criminal conduct at the hospital; and,
In emergency circumstances, to report a crime; the location of the crime or victims; or the identity, description or location of the person who committed the crime.

(6) Worker's Compensation: If you file a worker's compensation

(7) In the event of Medical Emergency

(8) In the event of the client's death or disability, information may be released if the client's personal representative or the beneficiary of an insurance policy on the client's life signs a release authorizing disclosure.

B. Uses and DISCLOSURES THAT REQUIRE your written AUTHORIZATION

Uses and disclosures other than those described in Section IA above will be made only you're your written authorization. For example, you will need to sign an authorization form before we can send PHI to a school or your attorney. You may revoke any such authorization in writing at any time.

Psychotherapy notes are handled separately under HIPAA and have additional protections. Specifically, the regulations state that in most instances a practice must obtain an authorization for any use or disclosure of psychotherapy notes. No authorization is needed to carry out treatment, payment, or health care operations and the uses listed in routine situations. All other circumstances require a valid authorization from you for use and disclosure.

II. YOUR RIGHTS AS A PATIENT

A. Right to request restrictions on certain uses and disclosures. You have the right to request a restriction or limitation on the use and sharing of information about you for treatment, payment, orhealth care operations. You must request any such restriction in writing. I am not required to agree to any such restriction you may request.

B. Right to receive confidential communications. You have the right to request tha my staff or I communicate with you in a certain way or at a certain location. For example, you can ask that we only contact you at work or at a post office box. To request confidential communications, you must make your request in writing.

C. Right to inspect and obtain copies. You have the right to review and obtain copies of information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. To inspect and copy information that may be used to make decisions about you, you must submit your request in writing. You may be charged a fee for the costs of copying, mailing or other supplies associated with your request. Under limited circumstances, I may deny access to your records if I believe the information may be harmful to you or someone else. You have the right to appeal any denials. The appeal will be reviewed by a qualified individual other than myself. I will comply with the outcome of the review.

D. Right to amend confidential information. Ifyou feel that the information I have about you is incorrect or incomplete, you may ask me to amend the information. Your request must be in writing submitted to me, and it must explain why the information should be amended. I may deny your request under certain circumstances.

E. Right to receive an accounting of disclosures of confidential information. Upon request, you may obtain an accounting of certain disclosures of PHI made about you in the last six years, subject to certain restrictions and limitations.

F. Right to receive notification of a breach. We are required to notify you if I discover a breach of your unsecured PHI, according to requirements under federal law.

MY PRACTICE'S DUTIES

In addition to your rights as a patient, my practice has duties to protect your confidential information and inform you of changes to protection measures. I am required by law to maintain the privacy of confidential information and provide you with notice of my legal duties and privacy practices with respect to such information. I am required to abide by the terms of this Notice currently in effect.

CHANGES TO THIS NOTICE

I reserve the right to revise or change provisions on this notice. I will make the new Notice provisions effective for all confidential information I maintain. If I change this Notice, I will post the revised notice in the waiting room. The Notice will contain the effective date on the top of first page.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with me or with the Secretary of the Department of Health and Human Services. All complaints must be submitted or verified in writing. You have specific rights under the Privacy Rule. You will not be penalized for filing a complaint.

PRIVACY OFFICER

I am the privacy officer for my practice. You may contact me with questions or comments at 360-828-7802 or by mail to Elia Gonzalez-Rodriguez, MD, 1499 SE Tech center Pl, suite 190. Vancouver, WA 98683.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

I am required to provide you with a copy of this Notice and document your receipt. Please fill out an Acknowledgement of Receipt of Notice of Privacy after receiving this Notice.
(See Below.)

Acknowledgement of Receipt of Notice of Privacy Practices

In order to comply with HIPAA standards each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or health care operations.

I have received a copy of the Notice of Privacy Practices from: **PACIFIC PHOENIX GROUP PLLC**

Patient Signature: _____ Date: _____

Patient Name : _____

PHQ9

Patient Name	Date



Over the last two weeks, how often have you been bothered by any of the following problems?	Not at all	Several Days	More than half the days	Nearly every day
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself - or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could notice. Or the opposite - being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead, or of hurting yourself	0	1	2	3
add columns:				

total: _____

If you have checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Mood Disorder Questionnaire (MDQ)

Name: _____ **Date:** _____

Instructions: Check the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1.Has there ever been a period of time when you were not your usual self and...		
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	○	○
...you were so irritable that you shouted at people or started fights or arguments?	○	○
...you felt much more self-confident than usual?	○	○
...you got much less sleep than usual and found you didn't really miss it?	○	○
...you were much more talkative or spoke faster than usual?	○	○
...thoughts raced through your head or you couldn't slow your mind down?	○	○
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	○	○
...you had much more energy than usual?	○	○
...you were much more active or did many more things than usual?	○	○
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	○	○
...you were much more interested in sex than usual?	○	○
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	○	○
...spending money got you or your family in trouble?	○	○
2.If you checked YES to more than one of the above, have several of these ever happened during the same period of time? *Please check 1 response only.*	○	○
3.How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting intoarguments or fights? *Please check 1 response only.* ○ No problem ○ Minor problem ○ Moderate problem ○ Serious problem		
4.Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	○	○
5.Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	○	○

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through apersonal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.*2000;157:1873-1875.

This instrument is designed for screening purposes only and is not to be used as a diagnostic tool.

How to Use

The questionnaire takes less than 5 minutes to complete. Patients simply check the yes or no boxes in response to thequestions. The last question pertains to the patient's level of functional impairment. The physician, nurse, or medicalstaff assistant then scores the completed questionnaire.

How to Score

Further medical assessment for bipolar disorder is clearly warranted if patient:

- Answers *Yes* to 7 or more of the events in question #1

AND

- Answers *Yes* to question #2

AND

- Answers or *Moderate problem or Serious problem* to question #3



Name:

GAD-7 Anxiety

Date:

Over the last two weeks, how often have you been bothered by the following problems?	0 Not at all	1 Several days	2 More than half the days	3 Nearly every day
1. Feeling nervous, anxious, or on edge				
2. Not being able to stop or control worrying				
3. Worrying too much about different things				
4. Trouble relaxing				
5. Being so restless that it is hard to sit still				
6. Becoming easily annoyed or irritable				
7. Feeling afraid, as if something awful might happen				

Column totals _____ + _____ + _____ + _____ = *Total score* _____

If you checked any problems, how difficult have they made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu. PRIME-MD® is a trademark of Pfizer Inc. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of "not at all," "several days," "more than half the days," and "nearly every day."

GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

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Name:

Date:

Beck's Depression Inventory

This depression inventory can be self-scored. The scoring scale is at the end of the questionnaire.

1.
0 I do not feel sad.
1 I feel sad
2 I am sad all the time and I can't snap out of it.
3 I am so sad and unhappy that I can't stand it.

2.
0 I am not particularly discouraged about the future.
1 I feel discouraged about the future.
2 I feel I have nothing to look forward to.
3 I feel the future is hopeless and that things cannot improve.

3.
0 I do not feel like a failure.
1 I feel I have failed more than the average person.
2 As I look back on my life, all I can see is a lot of failures.
3 I feel I am a complete failure as a person.

4.
0 I get as much satisfaction out of things as I used to.
1 I don't enjoy things the way I used to.
2 I don't get real satisfaction out of anything anymore.
3 I am dissatisfied or bored with everything.

5.
0 I don't feel particularly guilty
1 I feel guilty a good part of the time.
2 I feel quite guilty most of the time.
3 I feel guilty all of the time.

6.
0 I don't feel I am being punished.
1 I feel I may be punished.
2 I expect to be punished.
3 I feel I am being punished.

7.
0 I don't feel disappointed in myself.
1 I am disappointed in myself.
2 I am disgusted with myself.
3 I hate myself.

8.
0 I don't feel I am any worse than anybody else.
1 I am critical of myself for my weaknesses or mistakes.
2 I blame myself all the time for my faults.
3 I blame myself for everything bad that happens.

9.
0 I don't have any thoughts of killing myself.
1 I have thoughts of killing myself, but I would not carry them out.
2 I would like to kill myself.
3 I would kill myself if I had the chance.

10.
0 I don't cry any more than usual.
1 I cry more now than I used to.
2 I cry all the time now.
3 I used to be able to cry, but now I can't cry even though I want to.
11.
0 I am no more irritated by things than I ever was.
1 I am slightly more irritated now than usual.
2 I am quite annoyed or irritated a good deal of the time.
3 I feel irritated all the time.
12.
0 I have not lost interest in other people.
1 I am less interested in other people than I used to be.
2 I have lost most of my interest in other people.
3 I have lost all of my interest in other people.
13.
0 I make decisions about as well as I ever could.
1 I put off making decisions more than I used to.
2 I have greater difficulty in making decisions more than I used to.
3 I can't make decisions at all anymore.
14.
0 I don't feel that I look any worse than I used to.
1 I am worried that I am looking old or unattractive.
2 I feel there are permanent changes in my appearance that make me look unattractive
3 I believe that I look ugly.
15.
0 I can work about as well as before.
1 It takes an extra effort to get started at doing something.
2 I have to push myself very hard to do anything.
3 I can't do any work at all.
16.
0 I can sleep as well as usual.
1 I don't sleep as well as I used to.
2 I wake up 1-2 hours earlier than usual and find it hard to get back to sleep.
3 I wake up several hours earlier than I used to and cannot get back to sleep.
17.
0 I don't get more tired than usual.
1 I get tired more easily than I used to.
2 I get tired from doing almost anything.
3 I am too tired to do anything.
18.
0 My appetite is no worse than usual.
1 My appetite is not as good as it used to be.
2 My appetite is much worse now.
3 I have no appetite at all anymore.
19.
0 I haven't lost much weight, if any, lately.
1 I have lost more than five pounds.
2 I have lost more than ten pounds.
3 I have lost more than fifteen pounds.

20.
0 I am no more worried about my health than usual.
1 I am worried about physical problems like aches, pains, upset stomach, or constipation.
2 I am very worried about physical problems and it's hard to think of much else.
3 I am so worried about my physical problems that I cannot think of anything else.
21.
0 I have not noticed any recent change in my interest in sex.
1 I am less interested in sex than I used to be.
2 I have almost no interest in sex.
3 I have lost interest in sex completely.

INTERPRETING THE BECK DEPRESSION INVENTORY

Now that you have completed the questionnaire, add up the score for each of the twenty-one questions by counting the number to the right of each question you marked. The highest possible total for the whole test would be sixty-three. This would mean you circled number three on all twenty-one questions. Since the lowest possible score for each question is zero, the lowest possible score for the test would be zero. This would mean you circles zero on each question. You can evaluate your depression according to the Table below.

Total Score_____

Levels of Depression

1-10_____These ups and downs are considered normal
11-16_____ Mild mood disturbance
17-20_____Borderline clinical depression
21-30_____Moderate depression
31-40_____Severe depression
over 40_____Extreme depression

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PCL-5 with Criterion A

Instructions: This questionnaire asks about problems you may have had after a very stressful experience involving actual or threatened death, serious injury, or sexual violence. It could be something that happened to you directly, something you witnessed, or something you learned happened to a close family member or close friend. Some examples are a serious accident; fire; disaster such as a hurricane, tornado, or earthquake; physical or sexual attack or abuse; war; homicide; or suicide.

First, please answer a few questions about your worst event, which for this questionnaire means the event that currently bothers you the most. This could be one of the examples above or some other very stressful experience. Also, it could be a single event (for example, a car crash) or multiple similar events (for example, multiple stressful events in a war-zone or repeated sexual abuse).

Briefly identify the worst event (if you feel comfortable doing so):

How long ago did it happen? _____ (please estimate if you are not sure)

Did it involve actual or threatened death, serious injury, or sexual violence?

☐ Yes
☐ No

How did you experience it?

_____ It happened to me directly
_____ I witnessed it
_____ I learned about it happening to a close family member or close friend
_____ I was repeatedly exposed to details about it as part of my job (for example, paramedic, police, military, or other first responder)
_____ Other, please describe

If the event involved the death of a close family member or close friend, was it due to some kind of accident or violence, or was it due to natural causes?

☐ Accident or violence
☐ Natural causes
☐ Not applicable (the event did not involve the death of a close family member or close friend)

PCL-5

Pacific Phoenix Psychiatry & TMS

Name: _____

Date: _____

Instructions: Below is a list of problems that people sometimes have in response to a very stressful experience. Keeping your worst event in mind, please read each problem carefully and then select one of the numbers to the right to indicate how much you have been bothered by that problem **in the past month.**

Your worst event: _____

In the past month, how much were you bothered by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
1. Repeated, disturbing, and unwanted memories of the stressful experience?	O	O	O	O	O
2. Repeated, disturbing dreams of the stressful experience?	O	O	O	O	O
3. Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?	O	O	O	O	O
4. Feeling very upset when something reminded you of the stressful experience?	O	O	O	O	O
5. Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?	O	O	O	O	O
6. Avoiding memories, thoughts, or feelings related to the stressful experience?	O	O	O	O	O
7. Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?	O	O	O	O	O
8. Trouble remembering important parts of the stressful experience?	O	O	O	O	O
9. Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?	O	O	O	O	O
10. Blaming yourself or someone else for the stressful experience or what happened after it?	O	O	O	O	O
11. Having strong negative feelings such as fear, horror, anger, guilt, or shame?	O	O	O	O	O
12. Loss of interest in activities that you used to enjoy?	O	O	O	O	O
13. Feeling distant or cut off from other people?	O	O	O	O	O
14. Trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?	O	O	O	O	O
15. Irritable behavior, angry outbursts, or acting aggressively?	O	O	O	O	O
16. Taking too many risks or doing things that could cause you harm?	O	O	O	O	O
17. Being "superalert" or watchful or on guard?	O	O	O	O	O
18. Feeling jumpy or easily startled?	O	O	O	O	O
19. Having difficulty concentrating?	O	O	O	O	O
20. Trouble falling or staying asleep?	O	O	O	O	O

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months.	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

How old were you when these problems first began to occur?_____

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Description:
The Symptom Checklist is an instrument consisting of the eighteen DSM-IV TR criteria. Six of the eighteen questions were found to be the most predictive of symptoms consistent with ADHD. These six questions are the basis for the ASRS v1.1 Screener and are also Part A of the Symptom Checklist. Part B of the Symptom Checklist contains the remaining twelve questions.

Scoring and Interpretation:
If four or more marks appear in the darkly shaded boxes within Part A then the patient has symptoms highly consistent with ADHD in adults and further investigation is warranted. The frequency scores on Part B provide additional cues and can serve as further probes into the patient's symptoms. Pay particular attention to marks appearing in the dark shaded boxes. The frequency-based response is more sensitive with certain questions. No total score or diagnostic likelihood is utilized for the twelve questions. It has been found that the six questions in Part A are the most predictive of the disorder and are best for use as a screening instrument.

References:

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