Telemedicine & Practice Intake Form

The Psychiatry Group PLLC

5904 N Division St, Spokane, WA 99208

Phone: 844-495-4357

Fax: 844-584-3428

Intake:

Thank you for scheduling your appointment with The Psychiatry Group. We work with injured workers and help with diagnosis and treatment of psychiatric conditions to enable them to return to work safely and promptly.

We understand that your time is valuable. While this packet is lengthy, it will help your treatment team to understand your condition better and respond to queries from your treatment team members, Department of Labor and Industries and other authorized parties. This packet would require approximately 30 minutes of your time. If you do not understand a question, please ask your doctor on the day of your appointment. Please complete as much of this form as you can prior to the appointment.

This packet must be completed and returned before your appointment. Failure to do so may result in your appointment being rescheduled to the next available slot.

Please pay close attention to the policies including confidentiality. In certain situations, we are required to release medical information to third parties. If you have any questions, please ask us before your appointment. Your medical providers at The Psychiatry Group can answer some of your questions as well.

Your treatment team will include the doctor doing initial assessment and other psychiatrists, nurse practitioners and physician assistants. In many cases, your follow up care will be through a certified physician assistant or nurse practitioner. Our medical office staff will assist you with your questions and concerns. All of our treatment is provided remotely through a HIPAA compliant secure video system.

We look forward to working with you to help you achieve your goals.

Patient Information

Name: _____

Address: _____
City, State, ZIP: _____
Primary Phone: _____
Alternative Phone: _____
Email Address: _____

Date of Birth (MM/DD/YYYY): _____
Claim Number (if applicable): _____
Date of Injury (if work-related): _____
Employer (if work-related): _____
Claim Manager: _____
Legal Representative (if applicable): _____

Emergency contact: _____
Name: _____
Phone number: _____
Relationship: _____

Language Requested:

English

Spanish

Russian

Ukranian

Farsi

Other :_____

Preferred Interpreter: _____

Insurance Provider (select all that apply):

- Washington State Labor & Industries
- Self-Insured, Self-Administered
- Third-Party Insurer
- California Workers' Compensation
- Idaho SIF
- Other (specify): _____

Mobile SMS Appointment Reminder Consent:
By providing my mobile number, I consent to receive automated SMS appointment reminders and notices from The Psychiatry Group PLLC. Message and data rates may apply. I understand I can opt out at any time by replying **STOP**.
☐ I consent to SMS reminders as described above.

Location Confirmation (Telemedicine):
☐ I agree to inform the office at each appointment if I am outside of Washington state. If you are outside of Washington, our staff will attempt to find a provider who is licensed in the location you are in.

Reason for seeing your doctor:

Injury details:

Allergies:

Medications:

Accepted diagnoses on the claim, if applicable:

Medical Conditions:

Family history of psychiatric illness:

Education:

Previous employments:

Prior work injury claims, reprimands and terminations:

Military history:

Legal history:

Psychiatric history:

Psychiatric history prior to this work injury:

Psychiatric treatment after the work injury:

Previous psychiatric hospitalizations:

Previous psychiatric medications:

Prior self-harm or suicide attempts:

Traumatic experiences, abuse violence and trauma before or after the injury:

Substance use : Check all that apply
Alcohol

Cannabis

LSD/MDMA

Amphetamines/Cocaine

Nicotine vapes or cigarettes

Others

Statement of Patient Financial Responsibility

I understand that I am financially responsible for all charges for services rendered by The Psychiatry Group PLLC. As a courtesy, the practice will verify my coverage and bill my insurer. However, I am ultimately responsible for any deductible, co-payment, co-insurance, and any amounts not covered by my insurer.

I agree to pay any balances not covered by insurance and understand that if my insurer denies coverage, or if I continue beyond approved benefits, I am responsible for full payment. Payments are expected at the time services are rendered.

Patient Signature: _____ Date: _____
Guarantor Signature (if different): _____ Date: _____

Co-Pay Policy

Some health plans require a co-pay for services. Co-pays are due at each visit.

Patient/Guarantor Signature: _____ Date: _____

Consent for Treatment & Release of Information

I authorize The Psychiatry Group PLLC and its staff to perform assessment and treatment procedures deemed necessary. I also authorize release of information from my records to appropriate agencies for treatment, payment, or healthcare operations, as allowed by law.

Patient/Guarantor Signature: _____ Date: _____

Cancellation / No-Show Policy

Appointments missed without 24-hour notice, or excessive cancellations (2 no-shows in a row, 3 total no-shows, or 4 cancellations), may result in discharge from care. Written notification via certified mail will be provided before discharge.

Patient/Guarantor Signature: _____ Date: _____

Self-Pay / Motor Vehicle Insurance (PIP)

Self-Pay: ☐ I do not have health insurance and agree to pay in full at each visit.
PIP: ☐ I request claims be submitted to my motor vehicle carrier and understand I am responsible for balances if PIP exhausts or denies.

Patient/Guarantor Signature: _____ Date: _____

Telemedicine Informed Consent

1. I understand that telemedicine involves electronic communication of my health information and that federal (HIPAA) and state privacy laws (including those where I am located) apply.

2. I must be physically present in a state where my provider is licensed; I will inform the office of my location prior to each telemedicine session.

3. Telemedicine may not be appropriate for emergencies or crisis situations; if I am in crisis, I will seek in-person or emergency care.

4. I have the right to withdraw consent at any time without affecting my future care.

5. I may inspect and receive copies of information obtained during telemedicine interactions for a reasonable fee.

Initials: _____

Patient Signature: _____ Date: _____
If signed by proxy, relationship to patient: _____
Witness Signature: _____ Date: _____
Patient Initialed Copy Offered: ☐ Yes ☐ No

Notice of Privacy Practices Acknowledgment

I acknowledge receipt of the Notice of Privacy Practices, which describes how my medical information may be used and disclosed, and my rights under HIPAA.

Patient/Guarantor Signature: _____ Date: _____

Authorization to Disclose Protected Health Information

Patient Name: _____ DOB: _____ Claim/SSN: _____

I authorize The Psychiatry Group PLLC and its designees to ☐ Disclose / ☐ Receive my PHI to/from:
Name/Organization: _____
Fax: _____ Address: _____
Purpose: ☐ Continuation of Care ☐ Payment ☐ Insurance Review ☐ Other: _____

Information to be disclosed (check all that apply):
☐ Counseling/Psychiatric Services (attendance, diagnosis, treatment summary)
☐ Treatment Plans & Notes ☐ Lab/X-ray Reports ☐ Immunization Records
☐ Other: _____

I understand my records may include sensitive information (mental health, substance use, HIV/AIDS). My initial indicates I permit disclosure of the following:
☐ Alcohol/Drug Abuse ☐ Mental Health ☐ HIV/AIDS ☐ Sexual Assault

This authorization is valid for _____ days or one year from the date signed. I may revoke this authorization in writing except to the extent information has already been released.

Patient/Authorized Signature: _____ Date: _____
Witness Signature: _____ Date: _____

Provider Contact & Privacy Officer:
The Psychiatry Group PLLC, 5904 N Division St, Spokane, WA 99208

Email: info@psychiatrygroup.com