Peak Performance
Psychiatry & Counseling

Name: _____ Date of birth_____

Address: _____

City, State, ZIP_____

Phone: _____ ☐

Email: _____ ☐

Please check which way you would like us to contact you (phone or email).

What is the main reason you have scheduled an appointment today?

List any significant health problems:

List any medications you take:

List any medication allergies you have:

Please tell us about any other mental health treatment you have had:

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PAYMENT POLICY

Thank you for the opportunity to serve you. At Peak Performance Psychiatry & Counseling, PLLC we are committed to helping you achieve your highest goals in life.

We require payment of your portion of the bill before leaving the office. This usually includes co-pays, co-insurance and deductibles. We will bill your insurance company for the remainder.

We accept checks, credit and debit cards.

APPOINTMENTS and CANCELLATIONS

We will be happy to schedule your next appointment before you leave the clinic. If you would like a reminder call or email 24 hours prior to the appointment, please tell Linda as you check-out.

If you need to cancel an appointment, please call us at **509.315.4142** at least 24 hours in advance so that we can schedule someone else in your place. A habit of no-shows or last-minute cancellations could result in termination of our agreement to provide further services. We do understand, though, that last-minute family emergencies are sometimes unavoidable.

EMERGENCY POLICY

We do not provide 24-hour emergency care. If you ever feel you are experiencing a **mental health or medical emergency, please call 911** immediately. If you feel that you are safe enough to travel, you may have someone take you to Providence Sacred Heart Hospital, 101 West 8th Ave., Spokane, WA 99204. You will be assessed in the emergency room to see if admission to the inpatient psychiatric unit is necessary.

CLINIC PRIVACY POLICY

Please review the attached HIPAA privacy policy. We will be happy to answer any questions that you have.

I have read and understand the clinic's policies.

Signature_____ Date_____

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THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.

January 2013

1. Uses and Disclosures: Peak Performance Psychiatry & Counseling, PLLC is permitted by law to disclose the minimum necessary personal health information of each patient to carry out treatment, payment and health care operations of the clinic. For treatment purposes, such disclosures may be made to physicians and other health care providers as necessary to effectuate the appropriate treatment and care of patients. Personal health information may be disclosed to the government or other third party payers for the purpose of obtaining payment for services provided. Peak Performance may also use personal health information to carry out the clinic's day to day operations such as scheduling, quality review and appointment reminders. A complete list of other examples of disclosures is available upon request.

2. Required Disclosures: We may release medical information if ordered to do so by a law enforcement official in response to a court order, subpoena, warrant, summons or similar process. We may also disclose protected health information if we, in good faith, believe that the disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public.

3. Privacy Compliance: In accordance with the privacy regulations promulgated under the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164 (the "Privacy Regulations"), Peak Performance has adopted privacy policies regarding usage of patients' personal health information. The clinic is committed to enforcing the Privacy Regulations and all other laws and regulations regarding patients' right to privacy. Except for the "Required Disclosures", Peak Performance will not disclose any patient's personal health information for any purpose aside from payment, treatment and health care operations without a patient's authorized consent to such disclosure. Upon request for such authorization, patient shall have the right to refuse and/or revoke any disclosure of patient's personal health information.

4. Additional Information: For additional information regarding the clinic's privacy policy or for a copy of our 3-page privacy policy, please contact our business office. The clinic reserves the right to change this Notice to reflect changes in the "Privacy Regulations" and to make the revised and changed notice effective for medical information that the clinic already has about you, as well as any information the clinic receives in the future. We will post a copy of the current notice in the clinic. The notice will contain the effective date.

The following signature acknowledges that I have received a copy of this Notice concerning the use and disclosure of protected health information as defined by the Privacy Regulations.

Signature: _____ Printed name:_____