VICKI PAULUS, MN ARNP CS

7600 NE 41ST Street, Suite 310
Vancouver, WA 98662
(360) 571-2050

PATIENT REGISTRATION

TODAY'S DATE: _____

PLEASE PRINT!

PATIENT:

NAME | BIRTHDATE | SOCIAL SECURITY #

STREET ADDRESS | CITY | STATE | ZIP | HOME PHONE

EMPLOYER | EMPLOYER ADDRESS | WORK PHONE | CELL PHONE

OCCUPATION | SEX: M/F | MARITAL STATUS: M D W S | NAME OF SPOUSE

YOUR PHYSICIAN NAME | PHONE | ADDRESS | HOW LONG?

NEAREST FRIEND OR RELATIVE | PHONE | ADDRESS | HOW LONG?

SPOUSE:

NAME | BIRTHDATE | SOCIAL SECURITY #

STREET ADDRESS | CITY | STATE | ZIP | HOME PHONE

EMPLOYER | EMPLOYER ADDRESS | WORK PHONE | CELL PHONE

IF PATIENT IS A MINOR, PLEASE COMPLETE THE FOLLOWING:

NAME OF PERSON RESPONSIBLE FOR THE BILL | RELATIONSHIP TO PATIENT

STREET ADDRESS | CITY | STATE | ZIP | HOME PHONE

EMPLOYER | EMPLOYER ADDRESS | WORK PHONE | CELL PHONE

OCCUPATION | SOCIAL SECURITY # | BIRTHDATE | EMERGENCY PHONE

INSURANCE:

PRIMARY COVERAGE INSURANCE COMPANY

NAME OF POLICY HOLDER / RELATIONSHIP

POLICY/GROUP# | SOCIAL SECURITY #

CLAIM ADDRESS | SUBSCRIBER DATE OF BIRTH

SECONDARY COVERAGE INSURANCE COMPANY

NAME OF POLICY HOLDER / RELATIONSHIP

POLICY/GROUP# | SOCIAL SECURITY #

CLAIM ADDRESS | SUBSCRIBER DATE OF BIRTH

PLEASE READ: I understand that I am responsible for my account balance and agree to pay my balance when due. I understand that you may file my insurance as a courtesy to me. I understand that my insurance coverage is an agreement between myself and my insurance company, and that you are not responsible for my insurance reimbursement.

INSURANCE BENEFIT ASSIGNMENT: I assign any and all insurance benefits be paid directly to Vicki Paulus, MN, ARNP, CS.

I authorize Vicki Paulus, MN ARNP, CS to render psychiatric treatment to me, and agree to adhere to treatment guidelines as designated.

PATIENT SIGNATURE | DATE | IF PATIENT IS A MINOR, SIGNATURE OF PARENT OR GUARDIAN

VICKI PAULUS MN, ARNP, CS

Treatment Agreement

I am committed to providing you with the best possible care. In order to achieve this goal, I need your assistance and understanding of my policies.

Payment is due at the time services are rendered, unless other arrangements have been approved, in advance. Your insurance is a contract between you and your insurance company. As a courtesy, I am happy to send your claim to your insurance company for you if you provide me with the proper information. I am not a party to your insurance contract and you are responsible for your entire account balance. Not all services are covered by your insurance contract. It is your responsibility to verify your plan benefits.

Please notify me if you have any changes in your address, phone number, or insurance coverage.

Charges will be made for missed appointments and for appointments cancelled without 24 (twenty-four) hour advanced notice, unless it is a verifiable emergency.

Termination of treatment is usually a mutually agreed upon ending of the therapeutic relationship, but some circumstances may result in premature termination or closing of your case. These circumstances may include:

- Three (3) missed appointments or late cancellations
- More than three (3) cancelled appointments in a six (6) month period
- No office appointments scheduled in three (3) consecutive months
- Undisclosed substance use, including use of prescribed controlled substances
- Physical threat to provider or staff, non-compliance with treatment guidelines
- No payment received on your balance over sixty (60) days

Fee Schedule

Initial Evaluation (1 hour)	$375.00
Medication Management and Psychotherapy (1/2 hour)	$135.00 and up
Missed or late cancelled appointments	$100.00
Letters and other paperwork services	$35.00 and up

As a patient, I hereby authorize Vicki Paulus MN, ARNP, CS to release to the insurance company all information that it may request, concerning my medical treatment. I understand and agree that, regardless of my insurance status, I am ultimately responsible for the balance of my account for any professional services rendered. I have read all the information on this form and have been given the opportunity to ask questions.

Patient signature:_____ Date:_____

Staff Witness:_____ Date:_____

7600 NE 41st Street, Suite 310 • Vancouver, WA • 98662
Phone: (360) 571-2050 • Fax (360) 253-3196

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Staff Witness:_____ Date:_____

7600 NE 41st Street, Suite 310 • Vancouver, WA • 98662
Phone: (360) 571-2050 • Fax (360) 253-3196

VICKI D. PAULUS, MN, ARNP, CS
7600 NE 41st Street, Suite 310 Vancouver, WA 98662 (360) 571-2050

Treatment Guidelines

Patient selection:

- Adults 18 years of age and over (with specific exceptions regarding adolescents)
- Psychiatric disorders including mood and anxiety disorders
- Complex or acute disturbances requiring more extensive services are excluded
- Active chemical dependency is excluded from service

Treatment:

- Individual
- Outpatient
- Medication management
- Mutually acceptable treatment goals

Environment:

- Safe
- Comfortable
- Courteous
- Quiet

We expect the professionals, staff, and patients to behave with mutual respect to preserve this environment. Violent, threatening, or loud behavior is not acceptable. Patients who cannot comply with this requirement are not appropriate for service.

Availability:

Treatment occurs within your scheduled office appointment. Patients selected for treatment are relatively healthy and independent. Patients are expected to rarely require service from this office outside their sessions. My business hours are Monday, Tuesday and Wednesday 8 a.m. to 5 p.m. An answering machine will take your message after hours and I will return your call on the following business day. During my absence cross-coverage is coordinated by this office.

Emergencies:

Occasionally medical emergencies occur. I choose not to handle emergencies through this office. For this reason all patients are expected to have a primary care physician for medical emergency treatment. Southwest Washington Medical Center and other emergency services are available 24 hours per day. If you have a life-threatening emergency, please contact one of these services.

_____ _____

Patient Signature Today's Date

PATIENT COPY

VICKI D. PAULUS, MN, ARNP, CS
7600 NE 41st Street, Suite 310 Vancouver, WA 98662 (360) 571-2050

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_____ _____

Patient Signature Today's Date

VICKI PAULUS, MN, ARNP, CS

(360) 571-2050 7600 NE 41st Street, Suite 310 Vancouver, WA 98662

PATIENT HISTORY FORM

Please fill out this form with as much detail as possible. The information will help with your situation.

Name: _____ Date: _____

Who referred you to our office?

What problem made you decide to come in for help?

How and when would you say the problem started?

Have you been treated for this or another emotional problem before? When, where, and how?

Have blood relatives been treated (or do you feel they should be treated) for any of the following?: (please circle)

Depression
Bipolar Disorder (Manic Depression)
Obsessive Compulsive Disorder
Drug or Alcohol Problem
Attention Deficit Disorder
Schizophrenia
Panic Disorder
"Nervous Breakdown"
"Bad Nerves"

Explain:

_____
_____
_____
_____
_____

Who is your primary care physician?

Where is your primary care physician located?

Do you know of any birth trauma, or did your mother use alcohol or drugs during pregnancy with you? Any other problems during pregnancy?

What is your intake per day/week/month of:

Alcoholic beverages
Caffeine beverages
Tobacco
Other drugs

Please list your medications and doses (including vitamins, hormones, natural, and over the counter remedies):

Please tell us about your:

Parents: Ages? Involvement in your life now?

Brothers and sisters: Ages? Involvement in your life now?

Life growing up in your family:

Relationships:

Current social supports, friends, church, etc.?

Intimate relationships (when/what outcomes?)

Children (names, ages, sexes)

Any current legal or financial problems?

Education:

Jobs: (what type, how long?)

Hobbies and special interests:

Is religion or spirituality important in your life? In what way?

Other comments?

DO YOU HAVE OR HAVE YOU EVER HAD:

Y N Hospitalization for illness or surgery
Y N An allergic reaction
Any reaction to
Y N aspirin
Y N penicillin
Y N erythromycin
Y N tetracycline
Y N codeine
Y N sedatives or sleeping pills (barbiturates)
Y N any other medication
Y N Hepatitis
Y N Jaundice (yellow skin and eyes)
Y N Arthritis
Y N Venereal disease/Herpes
Y N Rheumatic fever
Y N Scarlet fever
Y N Anemia or other blood disorders
Y N Prolonged bleeding from a small cut
Y N Kidney disease
Y N Diabetes
Y N Stomach or duodenal ulcer
Y N Liver disease
Y N Tuberculosis
Y N Emphysema
Y N Thyroid or parathyroid disorders
Y N Heart trouble
Y N Heart murmur
Y N Arteriosclerosis
Y N High blood pressure
Y N Low blood pressure
Y N Excessively swollen ankles
Y N A stroke
Y N Shortness of breath on mild exertion
Y N Chest pains on mild exertion
Y N Hives, skin rash, hay fever
Y N Asthma
Y N Emotional problems or tension
Y N Psychiatric treatment
Y N A tumor or abnormal growth
Y N Radiation treatment by cobalt, radium
Y N Glaucoma
Y N Contact lenses
Y N Prostate disorders
Y N Tested positive for HIV or AIDS

ARE YOU:

Y N Presently being treated for any illness
Y N Taking any meds now or over the past year
Y N Any change in your health over the last year
Y N Aware of any recent weight change
Y N Often thirsty
Y N Urinating more than 6 times a day
Y N Often exhausted and fatigued
Y N Subject to frequent headaches
Y N A heavy smoker (2 or more pkgs. per day)
Y N Generally a nervous person
Y N Often unhappy or depressed

IF FEMALE ARE YOU NOW:

Y N Pregnant
Y N Taking birth control pills or other hormones
Y N Experiencing menopause ("change of life")
Y N Post menopause

Please explain fully any YES answer above:

_____
_____
_____
_____
_____
_____
_____

Do any of these ailments run in your family? Yes/No If yes, which ones?

_____
_____
_____

PLEASE INFORM US IF YOUR HEALTH CHANGES IN ANY WAY

PATIENT SIGNATURE: _____ DATE: _____

VICKI PAULUS, MN, ARNP, CS

(360) 571-2050 7600 NE 41st Street, Suite 310 Vancouver, WA 98662

ASSIGNMENT OF INSURANCE BENEFITS:

Insurance: _____

Subscriber: _____

Patient: _____

Insurance: _____

Patient: _____

I hereby assign my benefits to be paid directly to Vicki Paulus, MN, ARNP, CS for her services rendered. I authorize use of my signature on all my insurance claim submissions, whether manual or electronic. I further authorize release of my medical records to and from my current insurance company/companies and primary care physician, as needed for my treatment and care and insurance payment.

PATIENT SIGNATURE: _____ DATE: _____

BURNS ANXIETY INVENTORY*

Indicate how much each of the following physical symptoms have been bothering you in the past several days.

	NOT AT ALL	SOMEWHAT	MODERATELY	A LOT
1. Skipping, racing, or pounding of the heart	0	1	2	3
2. Pain, pressure, or tightness in the chest	0	1	2	3
3. Tingling or numbness in the toes or fingers	0	1	2	3
4. Butterflies or discomfort in the stomach	0	1	2	3
5. Constipation or diarrhea	0	1	2	3
6. Restlessness or jumpiness	0	1	2	3
7. Tight, tense muscles	0	1	2	3
8. Sweating not brought on by heat	0	1	2	3
9. A lump in the throat	0	1	2	3
10. Trembling or shaking	0	1	2	3
11. Rubbery or "jelly" legs	0	1	2	3
12. Feeling dizzy, lightheaded or off balance	0	1	2	3
13. Choking or smothering sensations	0	1	2	3
14. Headaches or pains in the neck or back	0	1	2	3
15. Hot flashes or cold chills	0	1	2	3
16. Feeling tired, weak, or easily exhausted	0	1	2	3

BURNS DEPRESSION CHECKLIST*

Indicate how much each of the following symptoms have been bothering you in the past several days.

	NOT AT ALL	SOMEWHAT	MODERATELY	A LOT
1. **Sadness:** Have you been feeling sad or down in the dumps?	0	1	2	3
2. **Discouragement::** Does the future look bleak or hopeless?	0	1	2	3
3. **Low self-esteem**: Do you feel worthless or think of yourself as inferior?	0	1	2	3
4. **Inferiority**: Do you feel inadequate or inferior to others?	0	1	2	3
5. **Guilt:** Do you get self critical and blame yourself?	0	1	2	3
6. **Indecisiveness:** Is it hard to make decisions?	0	1	2	3
7. **Irritability and frustration:** Have you been feeling angry or resentful?	0	1	2	3
8. **Loss of interest in life:** Have you lost interest in your career, hobbies, families, or friends?	0	1	2	3
9. **Loss of motivation:** Do you feel overwhelmed and have to push yourself hard to do things?	0	1	2	3
10. **Poor self image:** Do you think you're looking old or unattractive?	0	1	2	3
11. **Appetite changes:** Have you lost your appetite? Or, do you overeat compulsively?	0	1	2	3
12. **Sleep changes:** Is it hard to get a good night's sleep? Are you tired and sleeping too much?	0	1	2	3
13. **Loss of libido:** Have you lost your interest in sex?	0	1	2	3
14. **Hypochondriasis:** Do you worry a lot about your health?	0	1	2	3
15. **Suicidal impulses:** Do you think life is not worth living or think you'd be better off dead? *Anyone with suicidal urges should seek immediate help from a mental health professional.*	0	1	2	3

Vicki Paulus, MN, ARNP, CS
7600 NE 41st Street, Suite 310
Vancouver, WA 98662

phone (360) 571-2050
fax (360) 253-3196

Consent to Use or Disclose Clinical Information

I authorize Vicki Paulus, MN, ARNP, CS to use and disclose the health care information for the purpose of ***Treatment*** (such as coordinating your care with your primary physician or other health care professionals), ***Payment*** (such as billing your insurance company and determining eligibility of your health benefits) and routine ***Health Care Operations*** (such as scheduling appointments or calling to remind you of an appointment).

This consent form is being provided to you with an attached ***Notice of Privacy Practices.*** Please review this ***Notice of Privacy Practices*** for additional information about the uses and disclosures of protected health care information described in this Consent prior to signing this Consent.

A summary of the ***Notice of Privacy Practices*** will be posted in my office indicating the effective date of the current copy of this document. As more fully explained in the Notice of Privacy Practices, you have the right to request restrictions on how your health care information may be used for treatment, payment, and routine health care operations. You also have the right to request a review of your records or to amend your records; this is more fully explained in the Notice of Privacy Practices.

Please verify that you received the ***Notice of Privacy Practices*** by initialing here: _____

I understand that I have the right to revoke this Consent, provided that I do so in writing, except to the extent that this office has already used or disclosed information prior to my decision to revoke consent.

_____ _____
Signature of Client Date

_____ _____
Signature of legal guardian (if client is a minor) Date

_____
Relationship to client (if client is a minor)

Vicki Paulus, MN, ARNP, CS
7600 NE 41st Street, Suite 310
Vancouver, WA 98662
phone (360) 253-6425
fax (360) 253-3196

Notice of Privacy Practices

This document describes how clinical and health care information may be used and disclosed and how you can get access to this information. Please review it carefully. This notice describes the privacy policies followed by this office and any practitioner who might provide "on-call" coverage for me, and applies to the information I have about your health and the services you receive from this office. If you have any questions or requests concerning this notice, please contact me.

I am required by current federal law, effective April 14, 2003, under The Health Insurance Portability and Accountability Act of 1996 (HIPAA) to give you this notice. It will tell you about the ways in which I may use and disclose protected health information about you and describe your rights and my obligations regarding the uses and disclosure of that information.

How I May Use and Disclose Protected Health Information (PHI)

By State law and the ethics of the mental health profession, I must have your written and signed consent to use and disclose health care information for the following purposes:
For Treatment: I may disclose health care information in order to provide better clinical services, i.e.; discussing your case with your primary physician or another practitioner for consultation purposes.
For Payment: I may use and disclose health information so that services may be billed and paid by you, your insurance company or a third party. It is my policy to release only demographics, diagnosis, date and type of service when I bill third party payers. If more information is required by a payer, I will request your written consent for that disclosure.
For Routine Health Care Operations: I may use health information about you in order to run my practice, i.e., appointment reminders. I may contact you as a reminder that you have an appointment. Please notify me if you do not wish to be contacted for appointment reminders, or if there are restrictions you want to make about such contacts.

You may revoke your Consent at any time by giving written notice. Your revocation will be effective when I receive it, but will not apply to any uses and disclosures that occurred prior to that time.

If you are receiving substance abuse treatment, federal and state law require your written Authorization each time I release information. The Authorization will specify who is to receive the information, the purpose of the release of information, and a time period after which the Authorization will terminate. You may modify or revoke an authorization at any time.

Special Situations
I may use or disclose health information about you without your permission for the following purposes, subject to all applicable legal requirements and limitations:
To Avert a Serious Threat to Health or Safety: Based on professional judgment, I may use and disclose information when necessary to prevent a serious threat to your health or safety or the health or safety of the public or another person.
Required by law: Based on professional judgment I may disclose health care information about you when required by federal, state or local law.
Lawsuits and Disputes: If you are involved in a lawsuit, I may disclose health information in response to a court order or subpoena, and I will use my professional judgment about the information to be disclosed.
Law Enforcement: I may release health information if required to do so in response to a court order, subpoena, warrant, summons, or similar process, subject to all applicable legal requirements.
Family and Friends: In situations where you might not be capable of giving authorization, because you are not present or due to your incapacity or medical emergency, I may determine that a disclosure to your family member or friend is in your best interest. In that situation, I will disclose only information relevant to the person's involvement in your care.

Additional disclosures are permitted under HIPAA regulation. These will not be made without your authorization and consent. Once information leaves my office and becomes part of any data resource beyond my control, HIPAA permits disclosure in the following circumstances:
Research: Health information about you may be used for research projects that are subject to a special approval process. You may be asked for your permission, if the researcher will have access to your name, address, or other information that reveals who you are.
Military, National Security, and Intelligence: If you are a member of the armed forces, or part of the national security or intelligence communities, military command or other government authorities may require the release of health information about you. HIPAA also permits the release of information about foreign military personnel to the appropriate foreign military authority.

Workers Compensation: Health information may be released for workers compensation or similar programs. These programs provide benefits for work-related injuries.
Public Health Risks: Health information may be released in order to prevent or control disease, injury or disability; report births, deaths, suspected abuse or neglect, non-accidental injury, reactions to medications or problems with products.
Health Oversight Activities: Health information may be disclosed to a health oversight agency for audits, investigations, inspections, or licensing purposes. These disclosures may be necessary for certain state and federal agencies to monitor the health care system, government programs, and compliance with civil rights laws.
Information Not Personally Identifiable: Health information may be disclosed in a way that does not personally identify you or reveal who you are.

Other Uses and Disclosures of Health Information
This office will not disclose your health information for any purpose other than those identified in the previous sections without your specific written Authorization. You may also revoke your Authorization in writing, at any time. If you revoke your Authorization, I will not disclose any further information, but I cannot take back any disclosures already made with your permission. A separate written authorization is required for the release of information regarding HIV or substance abuse treatment. In order to disclose these types of records, I will provide a separate written release that complies with the law governing HIV or substance abuse records.

Your Rights Regarding Protected Health Information
Right to Review Records: You have the right to review your clinical, medical and billing records. You must submit a written request to me, the designated privacy officer, in order to inspect your health information. If you request a copy of the records, I may charge a fee for the costs of copying and/or mailing the records. I may deny your request to inspect, review or copy records in certain limited circumstances, such as when I believe exposure to this information may be detrimental to your mental health. If you are denied access to your health information, you may ask that the denial be reviewed. If such a review is required by law, I will select a licensed mental health care professional to review your request and my denial. The person who conducts this review will not be the person who denied the request, and I will comply with the outcome of the review. You do not have the right to review or copy private psychotherapy notes or information compiled in anticipation or, or for use in, a civil, criminal, or administrative proceeding.
Right to Amend: If you believe the health records about you are incomplete or incorrect, you may ask me to amend the information. You have the right to request an amendment when the information is kept by this office. To request an amendment, you must submit a clear statement of the requested amendment to the designated privacy contact. I may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, I may deny your request if you ask to amend information that:
- I did not create.
- Is not part of the health information that I keep.
- You would not be permitted to review, inspect, or copy.
- Is accurate and complete.

Right to an Accounting of Disclosures: You have the right to request an "accounting of disclosures". This is a list of the disclosures I have made of clinical information about you for purposes other than treatment, payment, and routine health care operations. To obtain this list, you must submit your request in writing. Your request must state a time period, which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). I may charge you for the costs associated with providing the list. I will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.
Right to Request Restrictions: You have the right to request a restriction or limitation on the health care information disclosed about you for treatment, payment or health care operations. You have the right to request limits on disclosures, such as asking that I not call you at your office, or that I not communicate with family members.
Right to Request Confidential Communications: You have the right to request that I communicate with you about clinical matters in a confidential ways, such as asking that I only contact you at home.
Right to a Paper Copy of this Notice: You have the right to a paper copy of this privacy notice. Even if you have agreed to receive it electronically, you are entitled to a paper copy.

Changes to this Notice
I reserve the right to change this privacy notice, and to make the revised notice effective for any medical or clinical information I receive in the future. I will post a summary of the current privacy notice, including its effectiveness date, in my office. You are always entitled to a copy of the notice currently in effect.

Complaints
If you believe your privacy rights have been violated, you may file a complaint with the Secretary of the Department of Health and Human Services.

One Park Place

7600 NE 41st Street, Suite 310
Vancouver, WA 98662
Telephone: (360) 253-6425
Fax: (360) 253-3196

Margret Anderson, LCSW
Kathleen Bruhn, Ph.D.
Tracy Clason, ARNP
Carla Crockford, ARNP
Harry Dudley, Psy.D.
Megan Dye, ARNP
Shelley Geil, ARNP
Judy Hedrich Kozicki, ARNP
Jack Litman, Ph.D.
Jacqueline Moore, ARNP
Vicki Paulus, ARNP
Walter Spafford, LCSW
Jaime Vazquez, M.D.

From I-5 (either direction) take the **Orchards, SR 500 Exit (Exit 2)**. Go approximately 4 miles **east on SR 500,** then take the **Andresen Exit**. Go **LEFT (north) on Andresen**. After going under the overpass (see below)*

From I-205 coming from the SOUTH take **EXIT 30C (Orchards, Vancouver, SR 500)**. **Bear LEFT** on the exit so you end up on **SR 500**, heading **west towards Vancouver**, not Orchards. After passing Vancouver Mall, take the **Andresen exit**; and turn **RIGHT (north) on Andresen** (see below).*

From I-205 coming from the NORTH take **Exit 30 (Orchards, Vancouver, SR 500)**. **Bear RIGHT onto SR 500**, heading **west towards Vancouver**.
After passing Vancouver Mall, take the **Andresen exit**; and turn **RIGHT (north) on Andresen** (see below).*

***From Andresen Road,** turn **RIGHT (east) onto NE 40th Street**, which is clearly marked with a traffic light (US Bank and Comcast Cable are on the corners). **The road will curve left and change into 72nd Avenue**. Take the FIRST **RIGHT onto NE 41st Street**. We are in the **fourth building on the left side**. A marker at the street says "**One Park Place**". The awning at the front entrance says "One Park Place" and "7600". We are on the third floor in **Suite 310**.

*****

Parking: Use any available space (except "disabled"). Several one-hour "Visitor" spaces are available in the front of the building. There is also plenty of parking on the top level of the parking structure immediately to the west, behind "Two Park Place". (Enter the lot on the west side of that building).

TO I-5