Shauna Norton, ANP, LLC-Psychiatric Nurse Practitioner-16635 Centerfield Dr., #202-Eagle River, AK 99577

EVALUATION QUESTIONNAIRE

(This information becomes part of your confidential medical record)

Name: ________________________________DOB: ________________ Today's Date: _______________

Marital Status:_______________________ Occupation: ___________________________________

Work: Full time Part time Unemployed Retired

Education: Grade School High School Vocational College

Are you currently attending school: Yes No Full time Part time

Briefly describe the main reason for your visit today:

When did your symptoms first occur?

When do your symptoms occur? (when, where, in what situations)

What makes your symptoms better or worse?

Rate the intensity of your symptoms: 1 2 3 4 5 6 7 8 9 10

Less intense More intense

How are your symptoms affecting work, school, or activities of daily living (i.e., bathing, grooming, eating, etc.)?

PSYCHIATRIC HISTORY

Have you ever been diagnosed with a mental health condition? Yes No
If yes, please provide date(s), diagnosis, and symptoms:

Have you ever been hospitalized for psychiatric treatment? Yes No
If yes, list the hospital/treatment facility, diagnosis, and dates?

Have you ever participated in psychotherapy? Yes No
If yes, what was the reason for therapy?

Have you ever taken psychiatric medication(s)? Yes No
If yes, list any medication(s), dose and reason for taking:

Have you ever attempted or seriously considered suicide? Yes No
If yes, when:

Are you currently considering suicide? Yes No
If yes, do you have a plan? Yes No

Have you ever engaged in any self-harm behaviors? Yes No
If yes, are you currently engaging in self-harm behaviors? Yes No
If yes, what type of self-harm and how often?

MEDICAL INFORMATION

Primary Care Provider: ___________________________ Specialists: ______________________________

Men's or Women's Healthcare Provider: ____

Are you currently being treated for any medical condition(s)? Yes No

If yes, please list the condition and the treating provider:

Are you currently taking any medication(s), over the counter products, vitamins, or herbal supplements?

Yes No

If yes, please list here:

Medication Dose Reason for taking Prescriber

Do you have any allergies to any medication(s)? Yes No

If yes, please list the medication(s) and your reaction(s):

PAST HISTORY

Have you ever had any abnormal lab results? Yes No

If yes, please provide date, type of test done, and any treatment provided:

Have you ever been hospitalized for medical reasons? Yes No

If yes, please give dates and reason for hospitalization:

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Have you ever had any surgery? Yes No

If yes, please list the date(s) and the reason for the surgery:

Have you ever had a serious head injury or concussion? Yes No

If yes, please list the date(s) and type of injury:

Have you ever had a sleep study, EEG, brain CT scan or MRI? Yes No
If yes, please provide dates and results:

Have you ever been diagnosed with or treated for any developmental delays?
(speech, motor movements, social deficits) Yes No
If yes, please describe here:

Have you ever been diagnosed/treated for an STD? Yes No
If yes, please list diagnosis, treatment and/or outcome:

Women: Number of pregnancies: ___________ Birth Control: Yes No
Number of children: ______________ Hysterectomy: Yes No
Last menstrual period: ____________ Menopause: Yes No

FAMILY HISTORY - Please **circle** any family history of:

Depression Anxiety Bipolar Disorder ADHD Schizophrenia Eating Disorder

Substance Abuse Learning Disabilities Developmental Disorders

Psychiatric hospitalizations Suicide (including attempts) Jail or Prison

Hormonal Disorders (diabetes, thyroid, etc.) Heart or Lung problems (heart disease, COPD, asthma, etc.)

Blood Pressure Cholesterol Anemia Seizures Migraines

SOCIAL HISTORY

Have you experienced any significant trauma in your life? Yes No
(this may include things such as being bullied or being witness to a trauma)
If yes, please provide date(s) and type of trauma:

Have you ever been, or are you currently the victim of abuse or neglect? Yes No
(verbal, mental, emotional, physical, sexual, etc.)

Have you ever been involved in any legal proceedings? Yes No
If yes, please provide reason and outcome:

Have you ever been arrested or convicted of a crime? Yes No

If yes, please provide date(s) and charges:

SUBSTANCE USE

Do you currently smoke or chew tobacco? Yes No
If yes, how long have you smoked/chewed and how much do you smoke/chew per day?

If no, did you smoke or chew in the past? Yes No
If yes, when did you quit?

Do you currently drink alcohol? Yes No
If yes, how often do you drink alcohol and how much?

If no, did you consume alcohol in the past? Yes No
If yes, how much and when did you quit?

Do you currently use illegal substances or abuse prescription medication(s)? Yes No
If yes, please list them here:

If no, have you ever used/abused them in the past? Yes No
If yes, please list them here and the date you quit:

Have you ever received or been advised to receive substance abuse treatment? Yes No
If yes, where did you receive treatment and when?
What was the outcome of your treatment?

What is your primary goal for this visit? Therapy Medication Diagnosis
(If you wish, you may also describe your goals for treatment)

SHAUNA NORTON, ANP, LLC

Patient Information

Patient Name: ______________________________________ Date of Birth: ___________________ ◻ Male ◻ Female

Mailing Address: __________________________________ City: ____________________ State: ______ Zip: ____________

SS# ______________________Home Phone: ________________Cell Phone: ________________Work: _________________

May I leave a message on your Home Phone: Yes No May I leave a message on your Cell Phone: Yes No

Parent's Name (If patient is a minor): ______________________________ Contact Phone Number: _____________________

Spouse/Partner Name: ________________________________ Daytime Number: ____________________________________

Emergency Contact: ____________________________________ Best Contact Number: ______________________________

Primary Care Provider:_________________________________ Phone: ____

Responsible Party

Person Responsible for account: _______________________________ Relationship to patient: _________________________

Best Contact Number(s): ____

SS#: ______________________________ Date of Birth: __________________________

Insurance Information

PRIMARY Insurance Company: _________________________________Phone Number: _____________________________

ID#: _________________________________ Group#: ________________________________

Policy Holder's Name: _____________________________________ Relationship to patient: ____________________________

Policy Holder's DOB: ______________________ Policy Holder's SS#: _____________________________

SECONDARY Insurance Company: _________________________________Phone Number: _____________________________

ID#: _________________________________ Group#: ________________________________

Policy Holder's Name: _____________________________________ Relationship to patient: ____________________________

Policy Holder's DOB: ______________________ Policy Holder's SS#: _____________________________

I understand that I am fully responsible for any and all charges for services rendered to me by Shauna Norton, ANP. My insurance company will be billed as a courtesy to me, only if I provide insurance information to Shauna Norton, ANP. I am responsible to pay my portion of the bill at the time that services are rendered unless Worker's Compensation covers my claim. I hereby authorize payment by insurance directly to Shauna Norton, ANP. I further authorize release by Shauna Norton, ANP, to my insurance company, of any information necessary for payment of claims.

____ __________________________________

Signature Date

SHAUNA NORTON, ANP, LLC

Payment Policy

Insurance As a ***courtesy*** Shauna Norton, ANP, LLC will bill your primary and secondary insurance companies. We do not bill tertiary insurance. Upon request we will provide you with a detailed date of service billing that you may submit with your explanation of benefits to your tertiary insurance. Knowing your insurance benefits is ***your*** responsibility. Please contact your insurance company with any questions you may have regarding your coverage.

Co-payment and Deductible: ***All*** co-payments and deductibles must be paid at the time of service.

Non-covered Services: Be aware that some or all of the services you receive as part of your healthcare may not be covered by your insurance company and will become your responsibility. It is your responsibility to know your insurance coverage.

Proof of Insurance: All Patients must complete our patient information form before seeing the provider. We must obtain a copy of your driver's license and valid insurance card before we will bill your insurance company on your behalf. If you cannot provide a valid insurance card you will be responsible for paying for the cost of your visit at the time of your appointment.

Coverage Changes: If your insurance coverage changes, you must provide us with your new insurance information. Failure to provide accurate insurance information will result in the claim becoming patient responsibility.

Non-Payment: If your account is over 90 days past due you will be contacted by the billing service to make arrangements to pay your balance in full or to negotiate a payment plan. Please be aware that if the balance remains unpaid or a payment plan is not negotiated, we may refer your account to collections and you may be discharged from this practice.

Cancellation Policy: Your appointment time is reserved for you and you will be expected to pay for it unless you provide 24 hours advance notice except for an unavoidable emergency. Insurance does not cover the cost of missed appointments and you will be responsible for the full amount. If you miss three appointments without advance notice you may be discharged from the practice and need to seek treatment elsewhere.

Please let me know if you have any questions or concerns regarding the Payment Policy.

I have read and understand the payment policy and agree to abide by its guidelines.

______________________________________ ____________________

Signature of patient or responsible party **Date**

SHAUNA NORTON, ANP, LLC
16635 Centerfield Dr., #202, Eagle River, AK 99577
(877) 253-6065 fax

CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

SECTION A: CLIENT GIVING CONSENT

Name of Client:____
Parent or Guardian (if client is a minor)

SECTION B: Important Information – PLEASE READ THE FOLLOWING STATEMENTS CAREFULLY

Purpose of Consent: By signing this form, you will be giving your consent to my use and disclosure of your protected health care information. This information will be utilized solely for the rendering of mental health treatment and associated payment activities.
Notice of Privacy Practices: You have the right to read my Notice of Privacy Practices before deciding whether to sign this Consent. My Notice provides a description of the uses and disclosures I may make of your protected health information and of other important matters about your protected health information. A copy of my Notice of Privacy Practices is displayed in the office for your convenience. I encourage you to read it carefully before signing this Consent.
As circumstances may dictate, and within the limits of the law, I reserve the right to change my Privacy Practices. If changes are implemented, they will be posted for your review. Said changes may apply to your Health Care Information that was previously obtained. You may obtain a copy of my Notice of Privacy Practices, including any revisions of my Notice at any time by contacting me.
Right to Revoke: You have the right to revoke this Consent at any time by giving me written notice of revocation submitted to the address or fax number listed above. Please understand that revocation of this Consent will not affect any action taken in regards to this Consent before I received your revocation and that I may decline to treat or to continue treating you if you revoke this Consent.

I, __________________________________, have had full opportunity to read and consider the contents of this Consent and this office's Notice of Privacy Practices. I understand that by signing this Consent form, I am giving my consent to the use and disclosure of my protected health information to carry out treatment, payment activities and health care operations.

SIGNATURE: ____ **DATE**: __________________________

If this Consent is signed by a parent/guardian/personal representative on behalf of the client, complete the following:
Printed Name: ____________________________________Relationship to Client: _______________________________________

The **Notice of Privacy Practices** is posted in the waiting room. Please read it at your own discretion.
I acknowledge that I have, on behalf of myself/and or any minor or incapacitated dependents, read and understand the office's Notice of Privacy practices.
I authorize the release of pertinent clinical information for the purpose of communication with my other health care providers and/or referral to specialists deemed necessary to address health concerns.

__________YES, I authorize _________ NO, I decline

SIGNATURE OF PATIENT: ____ DATE: ______________

For Office Use Only

An attempt to obtain written acknowledgement of receipt of my Notice of Privacy Practices was made, however, acknowledgement could not be obtained because:
______________ Individual refused to sign
______________ Communication barriers prohibited obtaining the acknowledgement
______________ An emergency situation prevented me from obtaining the acknowledgement

Shauna Norton, ANP, LLC
16635 Centerfield Dr., Suite 202
Eagle River, Alaska 99577
(907) 782-4544 phone

First Appointment Checklist

1. Contact your health insurance company and/or Primary Care Provider/Family Physician to request a referral if one is needed prior to your first appointment
2. Print forms from website: http://www.shaunanorton.com/PatientForms.en.html
3. Complete forms
4. Bring completed forms and insurance card(s) with you to your appointment
5. Plan on a 1-1/2 to 2 hour visit for your first appointment

If you need to reschedule your first appointment please call 782-4544 at least 24 hours prior to your appointment