Lynn Hutchins
Psychiatric Group

NEW PATIENT FORMS CHECKLIST

Please make sure that all information is included as your initial assessment WILL NOT be scheduled until we have ALL information.

- Health History
- GAD-7 Assessment
- PHQ-9 Assessment
- Adult ADHD Assessment
- Patient Information, *completed and signed*
- Acknowledgement of Receipt of "Notice of Privacy Practices" and Patient Fees/Appointment Attendance, *completed and signed*
- Insurance Information and Insurance Authorization, *completed and signed*
- Authorization Form, *completed and signed*
- Controlled Substance Agreement, *completed and signed*
- Release of Information, *completed and signed (Please list any past or current medical providers.)*
- Copy of State Issued ID
- Copy of the Front and Back on Current Insurance Card

Lynn Hutchins Psychiatric Group
Health History

Name:_____ Date:_____

Indicate (Y) for yes and (N) for no for the following:
Have you recently had:

Fever ____	Weight Loss ____	Blurred Vision ____
Sore Throat ____	Sinus Problems ____	Chest Pain ____
Palpitations ____	Shortness of Breath ____	Wheezing ____
Asthma ____	Diarrhea ____	Abdominal Pain ____
Urinary Problems ____	Sexually Transmitted Disease ____	Weakness ____
Diabetes ____	Bleeding ____	Bruising ____
Muscle Pain ____	Heat-Cold Intolerance ____	Seizures ____
Dizziness ____	Depression ____	Anxiety ____
Rash ____		

What is the reason/medical problem for your visit? _____

_____

_____

How long have you had the problem? _____

Does anything cause the problem or make it worse? _____

_____

What medication do you take now? _____

_____

_____

Do you have any pain? _____Rate the pain 1-10 _____

_____
Signature of Patient

Name: Date:

DOB:

GAD-7

Over the last 2 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. Feeling nervous, anxious or on edge	0 ○	1 ○	2 ○	3 ○
2. Not being able to stop or control worrying	0 ○	1 ○	2 ○	3 ○
3. Worrying too much about different things	0 ○	1 ○	2 ○	3 ○
4. Trouble relaxing	0 ○	1 ○	2 ○	3 ○
5. Being so restless that it is hard to sit still	0 ○	1 ○	2 ○	3 ○
6. Becoming easily annoyed or irritable	0 ○	1 ○	2 ○	3 ○
7. Feeling afraid as if something awful might happen	0 ○	1 ○	2 ○	3 ○

(For office coding: Total Score ☐ + ☐ + ☐ = ☐ **)**

DOB: 12

The Patient Health Questionnaire (PHQ-9)

Patient Name Date

Over the past 2 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 asleep, 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're 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 have noticed. 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 in some way	0 ○	1 ○	2 ○	3 ○

Column Totals ☐ + ☐ + ☐

Add Totals Together ☐

10. If you checked off any problems, how difficult have those 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

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

DOB .

Patient		Today's Date	

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. Please give this completed checklist to your healthcare professional to discuss during today's appointment

	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

Lynn Hutchins
Psychiatric Group

POLICIES AND PROCEDURES

PLEASE READ CAREFULLY AND COMPLETE

We welcome you to Lynn Hutchins Psychiatric Nurse Practitioner, PLLC. We prepared the following information so that you may have a clear understanding of our policies and procedures concerning fees, insurance, and confidentiality. We look forward to working with you and getting to know you! It is our goal to provide the best mental health care, as well as making your visits here pleasant, courteous, and as efficient as possible.

Please treat the staff at the office respectfully at all times. If you are disrespectful to staff or disrupt the care of other patients your treatment will be stopped.

Office Hours: Our normal business hours are Monday through Thursday, 8:00 am to 5:00 pm. We are closed for lunch from noon until 1:00 pm. Our Facebook page, website, or our voicemail are the best ways to stay updated on closings due to holidays, vacation, or inclement weather. It is important to make sure you have enough medicine to prevent running out when the office is closed. **Please note that the office is always closed for a week during the July 4th holiday and December 24-January 1. Please contact our office at least one week prior to closing to make sure you have enough medication to last during these periods of time.**

Appointments: Due to the sensitivity of our practice, some appointments may take extra time that was not anticipated at time of scheduling. We ask that you please be considerate of the care that we provide to those patients and the special time that we dedicate to them, as we all would want to be treated by our physicians with the same attentiveness. Taking this into consideration, please allow an extra 30-45 minutes past your scheduled appointment.

Please be on time for all scheduled appointments. If you are more than 10 minutes late for your appointment, you may have to reschedule.

If you are unable to keep an appointment, please call our office immediately**. A Missed Appointment Fee will be charged if you have failed to contact our office at least 1 business day prior to your appointment to cancel or reschedule.** Our business days are Monday-Thursday, 8:00 am- 5:00 pm. (i.e.: If you have a Wednesday appointment, you must contact our office before 5:00 pm on Tuesday. If you have a Monday appointment, you must contact our office before 5:00 pm on Thursday.)

Prescription Refills: Refills are only given during office hours, Monday-Thursday, 8:00-5:00. Allow at least 2 business days for all prescription refills. For all controlled substances, prescriptions will be sent for a 30-day supply to a local pharmacy only. Please call the office if a refill is needed on any medications before you run out.

Communication: You may contact our office during office hours with questions, concerns, or prescription refill requests by calling 252-281-5044 or by emailing us at contact@lynnhutchinspsych.com. All efforts will be made to respond within 1 business day. **In the case of a psychiatric emergency after hours or on weekends,** please call 911 for transport to your nearest emergency room. **NO REFILLS WILL BE GIVEN AFTER HOURS OR**

ON WEEKENDS. For non-emergency issues, we ask that you call during regular office hours; otherwise, there may be a $35.00 charge billed to you.

Confidentiality: Any confidential information you disclose to us during treatment, or any other confidential information we may obtain, shall be held in confidence unless you permit us to disclose such information in writing or where we are required to disclose such information by law.

Medical Records, Medical Forms, Letter Fees: All requests for records, forms and letters may take up to 30 days to complete. The completion of forms and letters is a courtesy. To cover the costs incurred in searching, handling and copying records for these requests, which is due prior to receiving the requested documents, a fee for each request shall be:

Medical Records

- Minimum of $10.00 or:
- $0.75 per page for the first 25 pages of medical records
- $0.50 per page for pages 26-100 of medical records
- $0.25 per page for excess of 100 pages of medical records

Medical/Disability Forms

- A minimum of $25.00 or
- $10.00 per page for forms containing more than 3 pages excluding pages to be completed by the patient

Letters (other than appointment confirmation)

- Minimum of $10.00

Payment: As a courtesy to you, Lynn Hutchins Psychiatric will file office visits with your insurance company. **Payment is due BEFORE your appointment**. Please bring your current insurance card to all appointments. We accept payments by cash, check, credit, debit card, or Apple Pay. If you do not have your insurance card or full payment, your appointment will be rescheduled. If you have an outstanding balance, all appointments will be cancelled, and refills will not be given until the balance is paid in full.

If a check is returned due to insufficient funds, a processing charge of $25.00 will be charged to your account for the returned check.

You are ultimately responsible for all charges incurred for your treatment or the treatment of those for whom you are responsible. If for any reason your insurance company, or other third-party payer, does not promptly reimburse Lynn Hutchins Psychiatric for services, you are responsible for those charges.

By being a patient of Lynn Hutchins Psychiatric, you are agreeing to the disclosure of confidential information where such disclosure is necessary to obtain certification, authorization, or payment for your treatment, or where we are required to disclose information by the terms of our contract with your insurer or managed care company. You are also expressly authorizing your provider to pursue appeals and grievances with insurers or managed care companies when those appeals are necessary to obtain payment for one of your insurance claims or when your provider believes an appeal of denial of care by your insurer is appropriate or necessary.

I understand I may lose my right to treatment in this office if I break any part of the Practice policies and agreements

Patient Information

Last Name: _____ **First Name:** _____ **Middle Initial:** ___

Refer to Patient as (if name is different than above):_____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date of Birth: _____ **Gender:** (Circle one) M F Other: _____

Marital Status: € Single € Married € Other: _____ **Spouse Name:** _____

School/ Employer_____**Grade**_____

Race (Optional): € American Indian or Alaska Native € Asian € Black or African American € White

€ Native Hawaiian or Other Pacific Islander € Other: _____

Ethnicity (Optional): € Hispanic/Latino € Not Hispanic/Latino **Preferred Language:** _____

Home Phone: _____ **Work Phone:** _____ **Cell Phone:** _____

Preferred Phone: (Circle one) Home Work Cell **May we leave a message:** (Circle one) Yes No

Preferred Method for Appointment Reminders: (Circle one) Phone Text Email

SSN: _____ **Email Address:** _____

Emergency Contact: _____ **Phone:** _____ **Relationship:** _____

Responsible Party Information (If Not Patient)

Last Name: _____ **First Name:** _____ **Middle Initial:** ___

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Date of Birth: _____**SSN:** _____ **Relationship to Patient:** _____

Other Information

Pharmacy Name: _____ **City:** _____ **State:** _____**Phone:** _____

Primary Care Physician Name: _____ **Phone:** _____

Therapist: _____ **Phone:** _____

ALL CO-PAYS AND DEDUCTIBLES ARE DUE AT THE TIME OF SERVICE.

Patient or Responsible Party Printed Name: _____

Patient or Responsible Party Signature: _____ **Date:** _____

Witness: _____

Lynn Hutchins Psychiatric Nurse Practitioner, PLLC

ACKNOWLEDGEMENT OF RECEIPT OF "NOTICE OF PRIVACY PRACTICES":

I, _____, acknowledge that I have received Lynn Hutchins Psychiatric
Patient Name Printed
Nurse Practitioner, PLLC the "Notice of Privacy Practices" at my request and have had adequate opportunity to read and review the document.

CONSENT TO TREATMENT: I, _____, agree to receive treatment
Patient Name Printed
from Lynn Hutchins Psychiatric Nurse Practitioner, PLLC. I agree to use only one provider for all psychiatric medications. I understand that I can withdraw this consent to treatment at any time. A withdrawal of consent will be done in writing and will include the reason for withdrawal.

CONSENT TO TELEHEALTH TREATMENT (WHEN APPLICABLE): I, _____,
Patient Name Printed
authorize Lynn Hutchins Psychiatric Nurse Practitioner, PLLC to use the telehealth practice platform for telecommunication for evaluating, testing and diagnosing my medical condition. I understand that technical difficulties may occur before or during the telehealth session and my appointment may not be started or ended as intended.

CONSENT FOR EXTERNAL PRESCRIPTION CHECK: I, _____, grant
Patient Name Printed
permission to Lynn Hutchins Psychiatric Nurse Practitioner, PLLC to view when and where I am filling my prescriptions from external sources to verify compliance with our controlled substance agreement.

PATIENT FEES/APPOINTMENT ATTENDANCE: I, _____, agree to
Patient Name Printed
the following fee/attendance policy. I agree to pay according to the guidelines. I am aware that when I make an appointment, that time is especially made for me. Our goal is that all patients are seen in a timely manner; therefore, the following will be followed:

Cancellation/Reschedule (**with** -1 Business Day Notice)	No Charge
Cancellation/Reschedule (**without** -1 Business Day Notice)	$75.00
Missed Appointment	$75.00
More Than 10 minutes late for appointment	Must Reschedule

(If you repeatedly are more than 10 minutes late for appointments, you will be charged the missed appointment fee.)

Insurance does not pay for Cancelled or Missed Appointments. The above fees will be an out of pocket expense for you as an individual. Our business days are Monday-Thursday. If you have an appointment scheduled for Monday, you must call before closing on Thursday to cancel or reschedule to avoid a charge.

PAYMENT: I, _____, agree to pay for my appointment before
Patient Name Printed
being seen. I am aware that I am responsible for any balance not paid by my insurance. If I have an outstanding balance, I understand that no refills will be given or appointments will be scheduled until satisfactory arrangements have been made.

Patient or Responsible Party Printed Name: _____

Patient or Responsible Party Signature: _____ **Date:** _____

Witness: _____

Lynn Hutchins Psychiatric Nurse Practitioner, PLLC

PLEASE READ CAREFULLY AND COMPLETE

COPY OF CARD ON FILE or complete the following and provide a copy of the card as soon as possible.

NAME ON INSURANCE CARD: _____

INSURANCE COMPANY: _____

INSURANCE COMPANY PHONE: _____ EMPLOYER PLAN: € YES € NO

If name on insurance card is someone other than the patient, please complete the following:

INSURED PARTY NAME: _____

INSURED PARTY ADDRESS: _____ CITY: _____ STATE: _____ZIP: _____

INSURED PARTY PHONE: _____ INSURED PARTY DATE OF BIRTH: _____

INSURED PARTY SOCIAL SECURITY NUMBER: _____

Do you have any additional insurance coverage? (Circle one) Yes No

COPY OF CARD ON FILE or complete the following and provide a copy of the card as soon as possible.

NAME ON INSURANCE CARD: _____

INSURANCE COMPANY: _____

INSURANCE COMPANY PHONE: _____ EMPLOYER PLAN: € YES € NO

INSURANCE AUTHORIZATION

IN ORDER TO FILE YOUR INSURANCE FOR YOU, WE REQUIRE THAT YOU INITIAL EACH ITEM AND SIGN BELOW

_____ I understand that I am responsible for my bill.

_____ I authorize use of this form on all my insurance claims.

_____ I authorized release of information to all my insurance carriers.

_____ I authorize my provider to act as my agent in helping me obtain payment from my insurance.

_____ I authorize payment directly to my provider, and hereby assign my right to reimbursement for services rendered to Lynn Hutchins Psychiatric, P.L.L.C. If insurance payment is made directly to me, I am responsible for paying the amount paid by insurance in addition to my payment.

_____ I permit a copy of this authorization to be used in place of the original.

Patient or Responsible Party Printed Name: _____

Patient or Responsible Party Signature: _____ **Date:** _____

Witness: _____

Lynn Hutchins Psychiatric Nurse Practitioner, PLLC Release Authorization Form

I, _____, authorize Lynn Hutchins Psychiatric to release health
Patient Name Printed
information to the following individuals. I understand that I have the right to rescind this authorization at any time by notifying Lynn Hutchins Psychiatric in writing.

Name: _____ Relationship to Patient: _____

€ Appointment information _____ (initial)

€ Protected Health Information _____ (initial)

Name: _____ Relationship to Patient: _____

€ Appointment information _____ (initial)

€ Protected Health Information _____ (initial)

I authorize the exchange of protected health information between Lynn Hutchins Psychiatric and the following:

Primary Care or Referring Provider:

Name: _____ Organization: _____

Address: _____

Office Phone: _____ Fax Number: _____

Therapist:

Name: _____ Organization: _____

Address: _____

Office Phone: _____ Fax Number: _____

Other:

Name: _____ Organization: _____

Address: _____

Office Phone: _____ Fax Number: _____

AUTHORIZATION TO MAIL, CALL, TEXT, OR EMAIL

I understand the privacy risks of mail, phone calls, texts, and email. I authorize Lynn Hutchins Psychiatric to mail, call, text or email me with communications concerning my healthcare, including but not limited to things such as appointment reminders, referrals, laboratory results, or financial information regarding my services, including insurance claims. (This includes voicemail.) I understand that I have the right to rescind this authorization at any time by notifying Lynn Hutchins Psychiatric in writing.

Patient or Responsible Party Printed Name: _____

Patient or Responsible Party Signature: _____ **Date:** _____

Witness: _____

Lynn Hutchins Psychiatric Group

Controlled Substance Patient Agreement

Controlled substance medications, such as benzodiazepines, stimulants, hypnotics, and sedatives, are useful but have a high potential for misuse and abuse. The use of these medications is controlled and monitored by local, state, and federal agencies.

PLEASE INITIAL EACH ITEM

_____I agree to keep my schedule appointments, adhere to the payment policy outlined by the practice, and conduct myself in a courteous manner to all staff and other patients. If I need to cancel my appointment, I will do so with a minimum of 24 business hours before the appointment.

_____I am responsible for keeping track of the amount of medication and will plan ahead for refills in a timely manner, so I will not run out of my medication. I understand that these types of medications will only be refilled during regular business hours and require at least 2 business days' notice for all refill requests.

_____I will take my medication as instructed and prescribed and will not exceed the maximum prescribed dose. I understand my medication dosage may need to be increased or decreased depending upon my condition. I will not adjust my medication myself and understand if I need more medication due to a worsening of my condition, I must see my provider to be re-evaluated before my medication will be increased.

_____I understand that most prescriptions are written for a 30-day supply. If I use my medication up sooner than prescribed, lose my prescription or medication, or if my medication is stolen, I understand my provider will not refill my medication until it is time for a scheduled refill.

_____I will inform my prescriber of all other medicines that I take and let them know of any new medications prescribed. I will not get any other medicines that can be addictive such as benzodiazepines, stimulants, or opioid pain medicines without telling my prescriber at this practice before I fill that prescription.

_____I will obtain all controlled substances from one in-state pharmacy. Should I need to change my pharmacy, I will inform my provider at the earliest possible time. Once a prescription is sent to the pharmacy, I will fill it at that pharmacy. (Exceptions are made if the pharmacy is out of stock.)

_____I agree to give a blood, saliva, and/or urine sample, if asked, to test for drug use. No prescriptions will be given until the results are received and reviewed.

_____I will inform my provider of any current or past substance abuse problem. I agree to abstain from problematic alcohol usage, opioids, marijuana, cocaine, and other medical/non-medical addictive substances.

_____I have never been involved in the illegal sale, possession, or transportation of controlled substances. I understand that the giving and/or sale of my prescription medication to any other person is illegal and WILL result in the immediate dismissal from this practice as well as being reported to law enforcement officers.

_____I am aware that my provider has access to and will be reviewing my patterns of filling prescriptions through the available prescription monitoring programs.

_____I take full responsibility for the consequences of driving a motor vehicle, operation of machinery or doing any other activity in which alertness, reflexes, coordination and/or judgement are necessary.

_____I am not pregnant. Should I become pregnant, I agree to notify my provider immediately and accept the risk to my baby and myself if I should use these medications while pregnant.

I understand that I may lose my right to treatment in this office if I break any part of this agreement.

Patient Name: _____ Date of Birth: _____

Signature: _____ Date: _____

Witness: _____

Release of Information
Lynn Hutchins Psychiatric Group
4612 Nash St N, Wilson, NC 27896
PO Box 8342, Wilson NC, 27893
Phone: 252 281-5044 Fax: 252-558-0242

**Authorization for Use or Disclosure of Protected Health Information
(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization
I authorize _____ (healthcare provider) to use and disclose the protected health information described below to Lynn Hutchins Psychiatric Group (individual seeking the information).

2. Effective Period
This authorization for release of information covers the period of healthcare from:
a. ☐ _____ to _____.
OR
b. ☒ all past, present, and future periods.

3. Extent of Authorization
a. ☒ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDs, and treatment of alcohol or drug abuse).
OR
b. ☐ I authorize the release of my complete health record with the exception of the following information:
- ☐ Mental health records
- ☐ Communicable diseases (including HIV and AIDS)
- ☐ Alcohol/drug abuse treatment
- ☐ Other (please specify): _____

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until discharge from practice (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

_____ DOB____/____/____
Patient Name

_____
Signature of patient or legal representative

_____
Date