



## Wisconsin Nystrom Billing Policies and Consent for the Release of Records

Welcome to Nystrom & Associates (Nystrom) behavioral health treatment services in Wisconsin. We are honored you chose us for your care.

This document contains important information about our professional services and business policies. It also contains a summary of information about the health insurance portability and accountability act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your protected health information (PHI) for the purposes of treatment, payment, and healthcare operations. Although these documents are long and sometimes complex, it's very important that you do understand them.

Behavioral health treatment is a relationship between individuals that works in part because of clearly defined rights and responsibilities held by each person. As a participant in behavioral health treatment, you have certain rights and responsibilities that are important for you to understand. There are also legal limitations to those rights that you should be aware of. Your provider has corresponding rights and responsibilities. These rights and responsibilities are described in the following sections.

### **Goals of Mental Health Treatment / Psychotherapy and/or Substance Use Treatment**

There can be many goals for Mental Health treatment / Psychotherapy and/or Substance Use Treatment, some of these will be long-term goals such as improving the quality of your life, learning to live with mindfulness and self-actualization; other goals may be more immediate such as decrease in anxiety and depression symptoms, developing healthy relationships or change in behavior and /or decreasing/ending substance use.

Whatever your goals are for Mental Health treatment/Psychotherapy and/or Substance Use Treatment, they will be decided upon collaboratively by you and your provider. Your provider may make suggestions on how to reach that goal, but you decide where you want to go.

If you feel your treatment isn't helping you, please inform your provider, so that your treatment plan can be revised to meet your needs most effectively.

### **Risks/Benefits of Mental Health treatment/Psychotherapy and/or Substance Use Treatment.**

Mental Health treatment/Psychotherapy and/or Substance Use Treatment is an intensely personal process which can bring unpleasant memories or emotions to the surface. Choosing to not participate in treatment can result in worsening symptoms. There are no guarantees that Mental Health treatment/ Psychotherapy and/or Substance Use Treatment will work for you. Clients can sometimes make improvements only to go backwards after a time. Progress may happen slowly. Your treatment requires a very active effort on your part. To be successful, you will have to work on the things you and your provider discuss outside of sessions. There are many benefits to Mental Health treatment/ Psychotherapy and/or Substance Use Treatment. Treatment can help you develop coping skills, make behavioral changes, reduce symptoms of mental health disorders, improve the quality of your life, learn to manage anger, learn to live in the present and many other advantages.

### **Involuntary Discharge**

There are certain circumstances in which Nystrom can involuntarily discharge a patient from services. These circumstances include but are not limited to: abusing or selling prescription medications, obtaining similar medications from alternate providers, non-disclosure of regularly prescribed controlled medications, refusal to sign requested releases or attestation forms, threatening behavior towards staff or other patients, threatening litigation toward Nystrom or a Nystrom provider, and inability to pay for services (entering into collections process).

### **Appointments/Missed Appointments/Late Cancellation of Appointments**

Mental health treatment appointments can range in duration from 20 to 90 minutes depending on the type of service you are receiving. You and your provider will discuss the frequency and duration of appointments that will best meet your treatment needs/goals.

In addition, you are responsible for coming to your session on time; if you are late, your appointment will still need to end on time. This is to be respectful of your provider's time and other clients who may have scheduled sessions after your appointment time. If your provider is late, however, you will receive your full treatment time unless otherwise agreed upon by you and your provider.

Nystrom requires a 24-hour notice when cancelling an appointment. This will allow us to schedule the time for someone else. Please note: **IF YOU DO NOT ATTEND A SCHEDULED APPOINTMENT OR CANCEL WITH LESS THAN 24-HOUR NOTICE, YOU WILL BE CHARGED A FEE THAT CORRESPONDS TO THE SCHEDULED LENGTH OF YOUR SESSION.** Your insurance cannot be billed for missed appointments. At the discretion of Nystrom your services may be discontinued due to excessive failed appointments or late cancels.

### **Confidentiality**

Your provider is legally /ethically expected to keep personal information private. If you wish to have information released, you will be required to sign a **release of information form** before such information is released.

There are some limitations to confidentiality. Your provider may consult with a supervisor or other professional counselor to give you the best service. To ensure you are receiving the best care, your provider may speak to your external providers regarding your care. Minimal information will be shared without a release of information.

Providers are required by law to release information when the client poses a risk to themselves or others and in cases of abuse to children or vulnerable adults. For minors, this information will be provided to guardians as well. If your provider receives a court order or subpoena, he/she may be required to release some information. In such a case, your provider will consult with other professionals and limit the release to only what is necessary by law.

### **Attestation for Consent**

#### **Release of Information for Coordination of Care/Treatment, Operations, and/or Payment of Service**

By signing, you authorize Nystrom to disclose your behavioral health records to your primary care provider for the purpose of coordinating care for best treatment outcomes. This consent will remain in effect until you cancel it in writing to Nystrom. In addition, you authorize Nystrom to disclose your behavioral health records and substance use disorder (SUD) records to other Nystrom providers, including providers at Nystrom Residential Treatment LLC, Vantage Point, Life Works, Psychiatric Associates and Sandhill for purposes of treatment coordination and care.

By signing, I understand my mental health and/or substance use disorder records may be disclosed for treatment, payment, or operations. I understand my records may be re-disclosed as provided by regulations. I understand my substance use disorder records may not be re-disclosed for use in civil or criminal proceedings without expressed written consent or a valid court order.

### **Use of Electronic Signatures**

By signing, you understand that this becomes your electronic signature for the initial treatment plan and updated treatment plans. The provider will ask for your verbal consent after reviewing the forms with you.

**Do you have a legal guardian for healthcare decision making? If yes, your legal guardian must sign this document and provide guardianship paperwork prior to your appointment.**

### **Record Keeping**

Your provider will keep records of your therapy sessions and a treatment plan which includes goals for your counseling. These records are kept to ensure direction to your sessions and continuity of service. They will not be shared except with respect to the limits of confidentiality discussed in the confidentiality section.

Should you, the client, wish to have your records released, you are required to sign a **release of information**

which specifies what information is to be released and to whom.

For minors, there are some limitations to what we will and will not release to guardians, staying within the confidentiality parameters listed above.

**Release of Information forms are valid for the time indicated or up to 1 year after which a new release form must be signed for records to continue to be released.**

Records will be kept for at least seven years but maybe kept for longer. Records will be kept either electronically or in a paper file and stored in a locked cabinet.

### **Contacting Us**

Providers are not often immediately available by telephone. Providers do not answer phones when they are with clients or otherwise unavailable. At these times, you may contact our scheduling staff who can send a message to providers and your call will be returned as soon as possible or leave a message on our confidential voicemail. It may take up to 24 business hours for a return call for non-urgent matters.

If you feel you cannot wait for a return call or it is an emergency, go to your local hospital, call your local crisis line or call 911.

### **Rules for Engagement and Counseling.**

It is expected everyone will follow the rules at Nystrom. For the safety of everyone involved, not following the rules may be grounds for discharge from services.

The rules are as follows:

- Alcohol or drugs of any kind are not allowed to be consumed or shared with others on the premises.
- Coming to session under the influence of alcohol and drugs will not be tolerated.
- Sexual activity or any intimate physical contact between patients or staff on the premises is not allowed.
- Willful acts of aggression towards staff, other patients, or property cannot be condoned, and appropriate action to stop or curtail such behavior will be taken, including discharge from the program and/or pursuit of criminal charges.
- Dress may be casual, comfortable, and reasonably modest.
- Weapons of any kind are not allowed for clients and guests on the premises.

### **Consent to Mental Health Treatment/Psychotherapy services and/or Substance Use Treatment**

- I have been provided with the complete and accurate information and time to review the information or to seek additional information concerning the proposed treatment or services including:
  - The proposed care, treatment, or services.
  - The goals and potential benefits of the proposed care, treatment, or services.
  - The way the treatment is to be administered, and the services are to be provided.
  - The expected treatment side effects or risks of side effects which are a reasonable possibility: including side effects or risks of side effects from medication if applicable for the client.
  - Approximate duration and desired outcome of treatment recommended in the treatment plan.
  - Reasonable alternatives to the individual's proposed care, treatment, or services. The discussion encompasses risks and benefits related to the alternatives and the risk related to not receiving the proposed care, treatment, or services.
- I understand that I have the right to receive a copy of this completed informed consent document upon request.
- I give my consent to the proposed treatment/services. It is further understood that this consent shall remain in force for no longer than 1 year from the date noted below. It is further understood that in writing I may withdraw my consent to treatment at any time, but it is assumed that this consent continues unless I inform Nystrom otherwise.
- Your treatment with Nystrom is a partnership between you and the clinical staff in addressing the mental health, behavioral and or substance abuse problems that you are having. If there is a pattern of non-participation noted, there may be a disruption in services offered you and could be referred to another agency for services.
- I have been provided, both orally and in writing, an explanation of my rights in accordance with WI S. 51.61 (1) (a) and DHS 94.
- In addition, Nystrom's policies/procedures/expectations within this consent form have been discussed with me.

## **Billing Policies and Payments**

If you plan to submit your own claims to your insurance company, it is our policy that payment of the entire fee is due at the time of service. As a service to our patients, Nystrom & Associates (Nystrom) staff will submit your insurance claims. If you fail to provide active insurance information in a timely manner you will be held liable for this. Co-payments are due at the time of service. Deductibles and coinsurances will be billed to your account. In the event the undersigned is entitled to health insurance benefits of any type, insuring patient or any other party liable to the patient, their benefits are hereby assigned to this health care facility for application to the patient's account.

By signing, you authorize Nystrom to release information, including medical records, to your insurance company or the designee of your third-party payer (authorized agent) as may be necessary to determine benefits, process and pay health care claims, and perform quality of care reviews at Nystrom. Nystrom will submit charges to your insurance company whenever possible for services rendered. Payments will be applied to the oldest charge on your account. Charges are based on what occurs during your treatment with Nystrom. Charges associated with your appointment depend on your individual medical necessity and level of care, as determined by your treating provider.

Time billed for court appearances, court case review, report writing, letters, telephone consultation, and other charges excluded by insurance coverage are your responsibility. Charges vary based on time spent and type of service.

A service charge of 1.5% (18% annual rate), or the highest statutory amount allowed, whichever is higher, will be charged monthly on accounts past due 28 days. If payment from insurance is not received within 90 days, the account may be due and payable in full by the patient. An account 90 days past due will be subject to collection procedures and/or small claims court, and the patient agrees to be held responsible for the cost disbursement, including reasonable attorneys, collection, and court fees. Nystrom may use the information listed below to contact you regarding your account. There is a fee of \$30 for checks returned for insufficient funds.

## **Insurance Coverage**

Nystrom can make no guarantee that your insurance company will provide payment for services rendered. It is your responsibility to know what is and is not covered under your policy. You are responsible for the full amount of the charge, whether or not your insurance will cover any portion. If your insurance company requires preauthorization of services, you are responsible to inform us. Be aware that some insurance companies have an annual maximum benefit for outpatient mental health coverage.

## **Financially Responsible Party**

The parent or guardian who signs this agreement will be considered the responsible party and will receive all billing statements and letters. Any alternative financial arrangements, including court-ordered financial arrangements, must be worked out between the parents or guardian of the children outside of this agreement.

## **Unclaimed Refunds**

Please remember to read your invoices carefully and call us if you have any questions, especially if you believe there is a credit on your account. If Nystrom confirms that it owes you or your payer a credit refund, it will resolve that promptly. After 120 days, if a credit of less than \$25 remains on the account, and no credit refund has been requested it will be removed from the account. If Nystrom determines that it owes you a credit refund but cannot locate you, then Nystrom will file an Unclaimed Property Report with the State. The State publishes those Reports to alert the public that Nystrom owes you money that you have not yet claimed. The State typically publishes your name, your address, the amount unclaimed, and the identity of who owes you the money, which would be Nystrom and Associates

## **Communication from Nystrom about Your Care**

By signing, you authorize Nystrom to contact you via mailed correspondence, phone, text message, or email regarding your payment, treatment, and healthcare operations. Nystrom is not financially liable for any charges you incur from your service provider. By supplying your home phone number, mobile number, email address, and any other personal contact information, you authorize Nystrom and your healthcare provider, or a business associate of theirs, to contact you at any numbers or email addresses using an automatic telephone dialing system, using a pre-recorded voice or other third-party automated outreach and messaging system as well as to use your protected health information, or other personal or identifying information, during such contact for any administrative or health matter. You consent to the practice, your provider, or their business associate contacting you via unencrypted email and text messages. You also agree that they

may leave detailed messages on your voice mail, answering system, or with another individual, if you are unavailable at the number provided.

**Notice of Privacy Practices**

By signing, you acknowledge that Nystrom’s HIPAA Notice of Privacy Practices and Patient or Consumer Rights Handout, procedures for reporting alleged violations of patient’s rights and grievance procedures have been made available to you. This agreement may not be altered in any way. I have read and agree to the above and hereby guarantee payment of all charges for services with the financial arrangements of Nystrom.

**Your signature below indicates that you have read this agreement and agree to its terms.**

\_\_\_\_\_  
PRINTED FULL LEGAL NAME OF PATIENT

\_\_\_\_\_  
PATIENT DATE OF BIRTH

\_\_\_\_\_  
SIGNATURE OF PATIENT  
(age 14+ must sign)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
SIGNATURE OF LEGAL GUARDIAN  
(If you have a legal guardian, they must sign here)

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PRINTED NAME OF LEGAL GUARDIAN

\_\_\_\_\_  
PHONE NUMBER OF LEGAL GUARDIAN

\_\_\_\_\_  
ADDRESS OF LEGAL GUARDIAN

\_\_\_\_\_  
EMAIL ADDRESS OF PATIENT OR LEGAL GUARDIAN

\_\_\_\_\_  
EMERGENCY CONTACT

\_\_\_\_\_  
PHONE NUMBER OF EMERGENCY CONTACT



# NYSTROM & ASSOCIATES AUTHORIZATION TO RELEASE INFORMATION

*Please note that adult patients have the option to register for a FollowMyHealth account and can view their records there immediately, rather than going through the records request process.*

*Nystrom has partnered with Sharecare to fulfill your requests for records. If you would like Nystrom to send records, please utilize our online submission portal by visiting [www.nystromcounseling.com/medical-records](http://www.nystromcounseling.com/medical-records).*

PATIENT INFORMATION		
Patient Name	Date of Birth	
Address	Phone Number	
City	State	Zip Code

INITIAL ACTION
<input type="checkbox"/> Keep on File for Future Use <input type="checkbox"/> Request records from Agency/Name Listed Below

I AUTHORIZE NYSTROM & ASSOCIATES TO	<input type="checkbox"/> RELEASE INFORMATION TO: <input type="checkbox"/> RECEIVE INFORMATION FROM:
Agency/Name	Relationship to Patient
Phone Number	Fax Number
Address	City, State, Zip Code
Email	<input type="checkbox"/> This is my primary care provider.

INFORMATION TO BE RELEASED (CHECK APPROPRIATE BOX(ES)):	
<p><b><u>Only release Mental Health/Medical records checked below:</u></b></p> <p><input type="checkbox"/> Standard Release (Recent Intake Assessment, Last 3 Progress Notes, and Most Recent Treatment Plan)</p> <p><input type="checkbox"/> Most Recent Intake Assessment</p> <p><input type="checkbox"/> Last 3 Progress Notes</p> <p><input type="checkbox"/> Most Recent Treatment Plan</p> <p><input type="checkbox"/> Psychological Testing Interpretive Report</p> <p><input type="checkbox"/> Other (Specify Type) _____</p>	<p><b><u>Only release Substance Use Disorder (SUD) records checked below:</u></b></p> <p><input type="checkbox"/> Comprehensive Assessment/Update</p> <p><input type="checkbox"/> Letter of Recommendation</p> <p><input type="checkbox"/> Verification of Attendance Letter</p> <p><input type="checkbox"/> Progress Notes/Treatment Plan</p> <p><input type="checkbox"/> Transition/Discharge Summary</p> <p><input type="checkbox"/> Information Exchange for Family Involvement, Collateral, or Emergency Contact</p> <p><input type="checkbox"/> Other (Specify Type) _____</p>
<p><input type="checkbox"/> Or Any and All Mental Health/Medical Records Dated From: _____ to _____</p>	<p><input type="checkbox"/> Or Any and All SUD Records Dated From: _____ to _____</p>

**PURPOSE OF RELEASE (CHECK APPROPRIATE BOX(ES)):**

**The purpose of this release is for coordination of care or:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Personal Use/Review*               | <input type="checkbox"/> Family Involvement     | <input type="checkbox"/> Litigation/Legal*    |
| <input type="checkbox"/> Social Security Appeal/Disability* | <input type="checkbox"/> Collateral             | <input type="checkbox"/> Continuation of Care |
| <input type="checkbox"/> Insurance Payment/Claim*           | <input type="checkbox"/> Emergency Contact Only | <input type="checkbox"/> Other* _____         |

*\*Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 CFR § 164.542.*

**METHOD OF COMMUNICATION (CHECK APPROPRIATE BOX(ES)):**

**Electronic Methods:**

- |  |   |
|--|---|
| <input type="checkbox"/> Non-Secure Email (PDF)      | <input type="checkbox"/> Secure Email (PDF) |
| <input type="checkbox"/> CD (Password-Protected PDF) |   |

**Standard Methods:**

- |   |                                  |
|---|----------------------------------|
| <input type="checkbox"/> Phone/Email Conversation | <input type="checkbox"/> Pick Up |
| <input type="checkbox"/> Fax                      | <input type="checkbox"/> Mail    |

**NOTE:** Transmission of records via standard email is not a secure method of transmission. By choosing email, I understand that I risk my information being intercepted by an unauthorized individual.

I understand the following: a. I have a right to revoke this authorization in writing at any time, except to the extent information has been released according to this authorization. b. The information released in response to this authorization may be re-disclosed to other parties. Substance Use Disorder (SUD) records may not be re-disclosed to investigate or prosecute a patient. c. My SUD records are protected under the federal regulations governing confidentiality and SUD patient records, 42 CFR Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 CFR Parts 160, 164. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. e. Disclosure is only allowed with my authorization, except in limited circumstance as described in Nystrom Privacy Policy. f. I have the right to inspect and receive a copy of my treatment records that may be disclosed to others, as provided under applicable state and federal laws. This authorization shall be in force and effect until 1 year from the date of execution at which time this authorization expires. Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 CFR § 164.524.

**Patient/Legal Guardian Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Representative's Relationship to Patient (Parent, Guardian, etc.): \_\_\_\_\_

**NOTE:** If signed by someone other than the patient, we need written proof of authority.

If you are completing this release for a minor patient involved in Substance Use Disorder (SUD) treatment, the minor patient must also consent to the release of their protected health information by signing below.

**Minor Patient Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**DO NOT FORWARD TO ANOTHER PERSON OR AGENCY WITHOUT PATIENT CONSENT.**



## **Buprenorphine Treatment Agreement**

### **General Information about Risks and Treatment Options:**

Buprenorphine is a potent medication and dangerous when a person does not have a tolerance for opioids. When a person takes buprenorphine without taking opiates or buprenorphine regularly, death may be a result. Risk, including death, may occur from combining buprenorphine with alcohol and other drugs like opiates and benzodiazepines (such as Valium, Klonopin, Ativan, Xanax). There is no fixed time for being on buprenorphine and that the goal of treatment is for to stop using all illicit drugs and become successful in all aspects of my life.

### **Risks & Benefits**

1. The risks and benefits of buprenorphine treatment, as well as other treatment options (methadone, naltrexone, non-medication treatment options) have been explained to me.
2. I have been educated about the risks of overdose and death if I relapse on opioids. I understand that toddlers and adolescents have died from accidental exposure to buprenorphine. I have also been educated about the risks of fentanyl use and the potential for fentanyl occurring in illicit drugs.
3. I understand that I may experience opioid withdrawal symptoms when I stop taking buprenorphine.
4. If female, I have been educated on the following:
  - a. There is an increased chance of pregnancy when stopping illicit opioid use and starting buprenorphine treatment. I agree to discuss pregnancy prevention methods with my OB/GYN or PCP.
  - b. Neonatal abstinence syndrome (NAS) can occur when taking illicit opioids and that NAS is less severe, but can still occur, when pregnant women take methadone or buprenorphine as prescribed/dispensed in substance use disorder treatment.

### **Appointments:**

1. I understand I must be on time for appointments, including arriving before the scheduled appointment to allow time to collect and process the drug screen and complete paperwork. I understand that if I miss an appointment, medications will not be refilled until an appointment is scheduled and a drug screen has been submitted for review.
2. I understand that initially I will have weekly office visits and that the length between office visits will be increased at the discretion of my provider in consultation with me. I understand that I will be allotted 7 days of medication or enough medication to last until the next scheduled office visit. I understand my medication must last as prescribed.
3. I understand I may be required to default back to weekly visits if I have unexpected drugs in my drug screen sample, and that persistent drug use or arriving to the office intoxicated will result in a referral to a higher level of care.
4. I understand that random drug screening is a treatment requirement. If I do not provide a requested sample/refuse a drug screen, it will count as a positive drug test. I understand I must provide a requested sample by the close of business the next day. I understand that I can be called in for a pill or film count at any time. I understand I must bring my buprenorphine to my provider's office by 3:00 PM, within 1 business day of the request.
5. I understand that violence, threatening language, threatening behavior, or participation in any illegal activity will result in discharge from treatment. I agree to be respectful to my provider, office staff, and other patients at all times.

6. I understand that treatment of opioid use disorder involves more than just taking medication. I understand that I will be expected to participate in Nystrom & Associates, Ltd. Intensive Outpatient Program (IOP) and follow recommendations of my Substance Use Disorder (SUD) counselor as well. I agree to comply with my healthcare provider's recommendations for additional counseling and/or for help with other problems.

**Expectations:**

1. I will take the medication exactly as my healthcare provider prescribes. If I want to change my medication dose, I will speak with my healthcare provider first. Taking more medication than my healthcare provider prescribes is medication misuse. Snorting or injecting is also considered misuse. If this occurs I will be referred to a higher level care or change in medication based on my healthcare provider's evaluation.
2. I will keep my medication in a safe, secure place away from children (in a lockbox). *Describe where and how you will store your medication:* \_\_\_\_\_
3. I understand that if medication is lost, stolen or misplaced it may not be replaced.
4. I understand that it's illegal to give away or sell my medication; this is diversion. If this is suspected or occurs, I understand that my prescription for buprenorphine will no longer be provided and alternate medications or a higher level of care will be recommended.
5. I agree that I will keep my healthcare provider informed of all my prescribed or over-the-counter medication use (including herbs, vitamins or other supplements) along with any medical problems.
6. I agree not to obtain prescription controlled substances and/or medical marijuana. Controlled substances include opiates, benzodiazepines, stimulants, gabapentin and Lyrica. I will ask my health care provider before starting any new medication (prescribed or purchased over-the-counter) as failing to do so could jeopardize my participation buprenorphine treatment. I am aware that many CBD products have trace amounts of THC and can affect drug screen results. I will discuss with my provider if I am considering taking CBD products.
7. I understand that if I am going to have a medical procedure that will cause pain, I will let my health care provider know in advance so that my pain is adequately treated and the risk of relapse is reduced.
8. Other Specific items unique to my treatment include: \_\_\_\_\_

I have read and agree to the above statements. I attest that I will comply with the requirements outlined in this document as well as the treatment recommendations of my healthcare provider.

\_\_\_\_\_  
PRINTED NAME OF PATIENT

\_\_\_\_\_  
PATIENT DATE OF BIRTH

\_\_\_\_\_  
SIGNATURE OF PATIENT

\_\_\_\_\_  
DATE

\_\_\_\_\_  
PROVIDER SIGNATURE

# NYSTROM & ASSOCIATES

Psychiatric Consent and Agreement Form

Thank you for choosing us for your care, it is important for you to read each of the following statements carefully. If you have any questions about the items below, please discuss them with your new provider at your appointment.

## General:

- You are consenting to be evaluated and undergo possible medication treatment for your mental illness. Medication options will be discussed with you by your provider during your appointments. You may also be recommended to participate in other forms of mental health care treatment.
- Nystrom **does not offer** after-hours services. If you have a concern, please contact us using FollowMyHealth or by calling your clinic. During business hours, your message will first be triaged through our Psychiatry Triage Nurse Team.
- If you have an emergency, such as severe suicidal thoughts, thoughts to hurt someone else, or a severe drug reaction, you should call 911, 988 (for suicidal thoughts), go to your local urgent care, or go to the emergency room.
- Minors must have a Legal Guardian present at all appointments for treatment. If a guardian fails to attend the appointment, it will be cancelled and rescheduled. It is strongly recommended that an adult who is not their own legal guardian have their legal guardian present for all appointments.
- Release of Information is required for our providers to establish and provide ongoing care. Please complete a Release of Information for your Case Manager, any Substance Use Treatment Services, previous Psychiatric care including psychiatric hospitalization records. Medical records are vital to maintaining continuity of care and allow us to verify past/current medical and medication history.
- If you are disrespectful to any staff (including but not limited to yelling, foul language, bullying or harassing) or if you disrupt the care of other patients, we may end care with you.
- You may be asked to only use one pharmacy and your provider may talk with the pharmacist about your medications.
- You will be asked to participate in having vitals taken at a Nystrom location for monitoring purposes. This includes Height, Weight, Blood Pressure, and Pulse.
- You will be considered an inactive patient and unable to receive medication refills through Nystrom & Associates if you have not attended an appointment with your medication provider in a 12-month period.

## Medication Refill Requests:

- You should contact your pharmacy or use FollowMyHealth first for all medication refill requests.
- Refill authorizations can take up to 5 business days.
- Early Refills of Controlled medications will not be authorized.
- Refills of ADHD/Stimulant medication, controlled sleep medication, or benzodiazepine will not be issued outside of appointments.
- Your provider may not grant early refills for any reason (i.e. lost, stolen, damaged) for any controlled medication.

**Appointment Scheduling and Cancellations:**

- Patients are responsible for scheduling their next appointments to avoid running out of medications between office visits.
- Appointments canceled without a 24-hour notice may be assessed a fee.
- If you miss 3 appointments with your medication provider, we will end care with you. You will be ineligible to schedule ongoing care for 12 months following your discharge from care.
- Many of our providers work with medical or nursing students. You should inform your provider if you do not want a student participating in your appointments.
- Therapy appointments cannot be scheduled for the same day as psychiatric appointments.

**Forms/Letters:**

- Our providers require an appointment to complete any forms. Any forms needing completion should be dropped off at the front desk or uploaded to our website at [www.nystromcounseling.com](http://www.nystromcounseling.com). Your provider will review the forms and notify staff how long to schedule your forms appointment for. Any forms completed outside of an office visit will be assessed a fee, requiring prepayment.

**Laboratory & Psychological Testing:**

- Your provider will request you complete certain laboratory tests before initiating or continuing certain medications. Laboratory tests may include but are not limited to; saliva, hair follicle, urine, blood serum, electrocardiograms, psychological testing, genomic testing, etc.
  - Drug Screens, laboratory tests, and counts of remaining pills may be requested if you are taking controlled medications and must be completed within a 48-hour period.
- Laboratory testing is not available at all Nystrom locations. Laboratory testing fees are your responsibility. If your insurance plan will not cover the cost of laboratory, psychological, or other testing, you will be responsible for all costs incurred.

**Billing and Insurance:**

- A charge for psychotherapy in addition to a medication management billing code may appear on your billing statement. Psychotherapy is a standard psychotherapy add-on code that all Nystrom medication providers use to reflect psychotherapy services that occur in session. Psychotherapy is defined in Current Procedural Terminology (CPT) by the American Medical Association as “the attempt to alleviate the emotional disturbances, reverse or change maladaptive patterns of behavior and encourage personality growth and development” (2012).

**Controlled Substance Medications:**

- Patients are responsible for informing all other physicians of the controlled substance medication received through Nystrom & Associates. Likewise, patients will inform Nystrom & Associates medication provider of any other controlled substance medications received from another physician.
- Our providers may not prescribe standing doses of benzodiazepines with stimulant medications.
- Our providers must follow Nystrom & Associates prescribing and maximum dosing guidelines for controlled medications. If you are pregnant, have certain medical or psychiatric conditions, controlled medications may not be appropriate for you. If you are currently taking psychotropic medications, it is up to the clinical judgement of your new Nystrom & Associates Psychiatric Medication Management Provider whether they will continue them as they are currently prescribed.

- Our providers do not prescribe pain medication or medical cannabis. If you are taking narcotic pain medication, medical cannabis, have a history of substance abuse, or are not currently sober, our providers may not prescribe controlled medications to you. If you are taking medical cannabis, methadone, suboxone or other any other narcotic-based medications on an ongoing basis, controlled medications may be stopped while you are taking these other medications.
- If you sell, trade, share, fill early, or increase the dose of controlled medications on your own, these medications will be stopped and cannot be restarted during the duration of your care at Nystrom & Associates.
- Failure to notify your provider of any history of drug, alcohol, or prescription drug misuse may result in stopping any controlled medications.
- You can be found guilty of Driving Under the Influence (DUI) if taking these medications and driving.

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Printed Name of Patient

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Patients Date of Birth

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Printed Name of Legal Guardian

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Phone Number of Legal Guardian

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Signature of Patient or Legal Guardian

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Date



**THIS FORM HAS 2 SIDES. COMPLETE BOTH SIDES AND RETURN TO YOUR PROVIDER.**  
**PHQ-9 & GAD-7**

Today's Date: \_\_\_\_\_ Date of birth: \_\_\_\_/\_\_\_\_/\_\_\_\_

First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

**PHQ-9-Patient Health Questionnaire**

Over the <u>last 2 weeks</u> , on how many days 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 or 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 over eating	0	1	2	3
6. Feeling bad about yourself-or that you are 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	0	1	2	3
<b>Add the score for each column</b>		+	+	

<b>Total Score (add your column scores)</b>	
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**If you checked off any problems, how difficult have these 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 \_\_\_\_\_

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**THIS FORM HAS 2 SIDES. COMPLETE BOTH SIDES AND RETURN TO YOUR PROVIDER.  
PHQ-9 & GAD-7**

**GAD-7**

**Generalized Anxiety Disorder 7-item scale**

Over the last 2 weeks, on how many days 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's 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
<b>Add the score for each column</b>		<b>+</b>	<b>+</b>	

<b>Total Score (add your column scores)</b>	
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**If you checked off any problems, how difficult have these 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 \_\_\_\_\_

Source: Sptizer, RL, Kroenke K, Williams JBW, Loew B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006; 166:1092-1097

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**NYSTROM & ASSOCIATES**

**PSYCHIATRIC MEDICATION ADULT EVALUATION PACKET**

Today's Date: \_\_\_\_\_

**Identification:**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Nickname/Preferred Name: \_\_\_\_\_ Preferred Pronouns: \_\_\_\_\_

Preferred Pharmacy: \_\_\_\_\_

Emergency Contact/Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

**Current Providers:**

If anything below applies to the patient, it is requested that a release of information be placed on file.

**Legal Guardian:** appointed person for making medical decisions: \_\_\_\_\_

Phone: \_\_\_\_\_ Cell/Pager \_\_\_\_\_

**Medical/Primary Care Provider:** \_\_\_\_\_

Clinic: \_\_\_\_\_

Phone: \_\_\_\_\_ Date of last physical: \_\_\_\_\_

**Home Health Nurse or PCA:** \_\_\_\_\_

Company: \_\_\_\_\_ Phone: \_\_\_\_\_

**Psychologist/Therapist:** \_\_\_\_\_

Clinic: \_\_\_\_\_ Phone: \_\_\_\_\_

**County Social Worker/Case Manager:** \_\_\_\_\_

Phone: \_\_\_\_\_ Cell/Pager: \_\_\_\_\_

**Probation Officer:** \_\_\_\_\_

Phone: \_\_\_\_\_ Cell/Pager: \_\_\_\_\_

**Reason for Seeking Care**

I would like to discuss the following symptoms or concerns in my initial visit with my provider: \_\_\_\_\_

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Approximately when did these symptoms first begin? \_\_\_\_\_

Have these symptoms worsened recently? \_\_\_\_\_

How do these symptoms impair your ability to function, work, or relate to other people?

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Has anything happened in the last year or so that has been very stressful for you such as serious health problems in your home or a family member, death of a close friend or family member, work stress, loss of job, loss of home, financial problems, legal issues, physical or sexual assault?

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**Current Medications**

IF YOU ARE TAKING ANY PSYCHIATRIC MEDICATIONS, WE MUST HAVE A RELEASE OF INFORMATION FOR RECORDS FROM THE MOST RECENT PRESCRIBER (see page 5).

Please list ALL of your current medications and supplements in the table below:

MEDICATION	DOSE	NUMBER OF PILLS TAKEN			
		MORNING	NOON	AFTERNOON	BEDTIME
Example Medication (1 twice per day, 2 at night)	0.5MG	1	0	1	2

**Allergies**

Please list all medication allergies:

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### Medication History

Please check if you have EVER taken any of the following psychotropic medications:

<b>Depression and Anxiety Medications</b>			
<b>Medication</b>	<b>(X)</b>	<b>Medication</b>	<b>(X)</b>
Ascendin		Nardil/Phenelzine	
Anafranil/Clomipramine		Norpamin/Desipramine	
Auvelity		Pamelor/Nortriptyline	
Brintellix/Vortioxetine		Parnate/Tranlycypromine	
Brexanolone/Zulresso		Paxil/Paroxetine	
Celexa/Citalopram		Pristiq/Desvenlafaxine	
Cymbalta/Duloxetine		Prozac/Fluoxetine	
Cytomel		Remeron/Mirtazapine	
Desyrel/Trazodone		Sarafem/Fluoxetine	
ECT		Savella/Milnacipran	
Effexor/Venlafaxine		Serzone/Nefazodone	
Elavil/Amitriptyline		Sinequan/Doxepin	
Emsam/Selegiline		Surmontil/Trimipramine	
Esketamin/Spravato		TMS	
Fetzima/Levomilnacipran		Tofranil/Imipramine	
Ketamine		Viibryd/Vilazodone	
Lexapro/Escitalopram		Vivactil/Protriptyline	
Light Therapy		Wellbutrin/Bupropion	
Luvox/Fluvoxamine		Zoloft/Sertraline	
Marplan/Isocarboxazid			

<b>Mood Stabilizers and Anticonvulsant Medications</b>			
Depakote/Valproate		Neurontin/Gabapentin	
Keppra/Levetiracetam		Tegretol/Carbamazine	
Lithium/Eskalith/Lithiobid		Topomax/Topiramate	
Lamictal/Lamotrigine		Trileptal/Oxcarbazepine	
Symbax		Zonegran/Zonisamide	

<b>Alcohol/Opioid Abstinence Medications</b>			
Revia/Naltrexone		Methadone	
Antabuse/Disulfiram		Suboxone/Subutex/Buprenorphorphine	
Campral/Acamprosate			

<b>ADHD MEDICATIONS</b>			
<u>Please note:</u> you may be asked to have ADHD testing done with a psychologist before we can prescribe these medications. We may not prescribe these medications if you are taking narcotics, pain medications, methadone, or suboxone.			
Adderall/Amphetamine		Intuniv/Guanfacine	
Adderall XR/Amphetamine ER		Metadate/Methylphenidate	
Concerta/Methylphenidate ER		Methylin/Methylphenidate	
Daytrana/Methylphenidate patch		Quelbree/Viloxazine	
Desoxyn/Methamphetamine		Ritalin/Methylphenidate	
Dexedrine/Dextroamphetamine		Ritalin SR/Methylphenidate ER	
Dextrostat/Dextroamphetamine		Ritalin LA/Methylphenidate LA	
Focalin/Dexmethylphenidate		Strattera/Atomoxetine	
Focalin XR/Dexmethylphenidate ER		Vyvanse/Lisdexamfetamine	

<b>ANTIANSXIETY MEDICATIONS</b>			
<u>Please note:</u> we may not prescribe these medications if you are taking narcotic pain medications, methadone, suboxone, or ADHD medication.			
Atenolol		Librium/Chlordiazepoxide	
Ativan/Lorazepam		Serax/Oxazepam	
Buspar/Buspirone		Tranxene/Clorazepate	
Catapres/Clonidine		Valium/Diazepam	
Inderal/Propranolol		Vistaril/Hydroxyzine	
Klonopin/Clonazepam		Xanax/Alprazolam	

<b>Medications Used for Side Effects</b>			
Austedo/Deutetrabenzine		Inderal/Propranolol	
Artane/Trihexyphenidyl		Ingrezza/Valbenzaine	
Atenolol		Metformin	
Benadryl		Topamax/Topiramate	
Cogentin/Benzotropine			

<b>Sleep/ Wake Medications</b>			
Ambien/ Zolpidem		Nuvigil/Armodafinil	
Ambien CR/ Zolpidem		Periactin/Cyproheptadine	
Belsomra		Provigil/Modafinil	
Dalmane/Flurazepam		Restoril/Temazepam	
Dayvigo		Rozerem/Ramelteon	
Desyrel/Trazodone		Silenor/Doxepin	
Gabitril/Tiagabine		Sinequan/Doxepin	
Halcion/Triazolam		Sonata/Zaleplon	
Intermezzo		Xyrem/Sodium Oxybate	
Lunesta/Eszopicone			

<b>Antipsychotics</b>			
Abilify/Aripiprazole		Prolixin/Fluphenazine	
Clozaril/Clozapine		Rexulti/Brexpiprazole	
Fanapt/Iloperidol		Risperidol/Risperidone	
Haldol/Haloperidol		Saphris/Asenapine	
Invega/Paliperidone		Seroquel/Quetiapine	
Latuda/Lurasidone		Seroquel XR/Quetiapine XR	
Loxitane/Loxapine		Stelazine/Trifluoperazine	
Mellaril/Thioridazine		Thorazine/Chlorpromazine	
Moban/Molindone		Trilafon/Perphenazine	
Navane/Thiothixine		Vraylar/Cariprazole	
Nuplazid/ Primavanserin		Zyprexa/Olanzapine	

<b>Alzheimer's Disease Medications</b>			
Aduhelm/Aducanumab		Exelon/Rivastigmine	
Aricept/Donepezil		Namenda/Memantine	
Cognex/Tacrine			

<b>Herbal/Supplements</b>			
Ashwaganda		Melatonin	
B12		N- Acetylcysteine	
Lavella (Lavender Pill Form)		Omega 3 Fatty Acids	
Lithium Orotate		SAMe	
L-Methylfolate		St. Johns Wart	
L- Tryptophan		Vitamin D	
Magnesium		Others Tried	

### **Psychiatric History**

Check the types of Psychiatric treatments you have participated in, if applicable:

- Individual Therapy
- Group Therapy
- Couples Therapy
- Family Therapy
- Day Treatment
- DBT
- EMDR
- Biofeedback
- ECT: When? \_\_\_\_\_ Treatments: \_\_\_\_\_
- TMS
- VNS
- Psychiatric Hospitalization: When? \_\_\_\_\_
- Substance Use Disorder Treatment: When? \_\_\_\_\_
- Other: \_\_\_\_\_

Have you ever attempted suicide or engaged in self-injurious behavior?

- Yes
- No

If yes, when and by what means? (Overdose, cutting yourself, etc.)

Means:

Year:

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### Family History

Please complete the table below if you have any relatives with a history of mental illness and/or chemical dependency:

<b>Illness</b>	<b>Relationship to you</b> (e.g. mother, father, brother, sister, grandfather, cousin, aunt, etc.)
ADD/ADHD	
Alcoholism	
Anxiety, Panic Disorder, PTSD, OCD	
Bipolar Disorder	
Dementia	
Depression	
Drug Abuse	
Learning Disability or Low IQ	
Schizophrenia or Psychosis	
Suicide Attempts	

### Medical History

Please list all your physical medical illnesses/conditions (problems with your heart, lungs, liver, stomach, bowel, skin, joints, thyroid, etc. including if you are currently pregnant).

Condition: \_\_\_\_\_ Year Diagnosed: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Have you ever experienced any form of trauma/abuse?

- Yes
- No

Have you ever had any Legal History?

- Yes
- No

How often do you exercise? \_\_\_\_\_ times per week.

Have you ever had a seizure, or have you ever been diagnosed with epilepsy?

- Yes
- No

Are you or is there a chance you may be pregnant?

- Yes
- No

Have you ever had a period of unconsciousness (coma, knocked out, brain injury, concussion)?

- Yes
- No

If yes, please describe what happened and how long you were unconscious:

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**Surgical History**

Please list all surgeries you have had:

Surgical Procedure:

Year:

<hr/>	<hr/>
<hr/>	<hr/>
<hr/>	<hr/>

Additional Comments:

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### Substance Use History

Do you use ANY alcohol, or have you EVER used any drugs?

- Yes
- No

If yes, please complete the table below:

Drug	List the specific name of what you use(d).	Typical Amount Used	Date of Last Use	How Many Times Per Week or Month Do You Use?
<b>Alcohol</b>				
<b>Marijuana</b> Medical Cannabis, CBD, THC				
<b>Illicit Drugs</b> Methamphetamine, Crank, Heroin, Ecstasy, Speed				
<b>Prescription Drugs</b> <b>Pain Medications</b> (oxycodone, oxycontin, Percocet, codeine, Darvon, Vicodin) <b>Tranquilizers</b> (Xanax, Valium, Ativan, Klonopin) <b>Stimulants</b> (Ritalin, Adderall, Metadate, etc.)				

If you use ANY alcohol or drugs, please complete the table below:

STATEMENT	Yes	No
I feel the need to reduce my use of alcohol or drugs.		
People have complained to me about my use of alcohol or drugs.		
I feel guilty about my use of alcohol or drugs.		
I have used alcohol or drugs to help me get through the day.		

### Caffeine/Tobacco Use

How many caffeinated beverages do you have perday? \_\_\_\_\_

Do you use tobacco?

- Yes
- No

If yes, what type of tobacco do you use (chewing tobacco, cigarettes, etc.)? \_\_\_\_\_

How much per day? \_\_\_\_\_



## ADULT Health Screening Questionnaire

### Ages 18 and older

Date: \_\_\_\_\_

Clinician: \_\_\_\_\_

Name: \_\_\_\_\_

Birth date: \_\_\_\_\_

**Please answer the following questions to help our providers learn more about your nutrition and physical health.**

Do you skip breakfast, lunch or dinner?	Yes / No
Do you ever eat to the point where you feel uncomfortable or out of control?	Yes / No
<b>(CIRCLE THOSE THAT APPLY)</b> Do you have a history of, or are currently struggling with, an eating disorder, binge eating or emotional eating?	Yes / No
Do you have trouble sleeping?	Yes / No
Do you drink more than two servings of caffeine daily?	Yes / No
Do you have pre-diabetes or diabetes?	Yes / No
Do you have high cholesterol, high triglycerides or take medication for lowering cholesterol?	Yes / No
Do you have high blood pressure or take medication to lower blood pressure?	Yes / No
Have you lost or gained more than 10 pounds in the last 6 months? <b>(IF YES, CIRCLE ONE)</b>	Yes / No
Have you experienced unintentional weight loss or weight gain? <b>(IF YES, CIRCLE ONE)</b>	Yes / No
During a normal week, how often are you physically active? _____ minutes per day _____ days per week	
On a scale of 1-10, how ready are you to be more physically active? _____ (10=extremely motivated; 1=no motivation at all)	
<b>(CIRCLE THOSE THAT APPLY)</b> Do you have any problems with swallowing, chewing, diarrhea, or constipation?	Yes / No
Do you follow any special diet? If yes, what type of diet? _____	Yes / No
Do you have any food allergies/intolerances/sensitivities? If yes, what foods? _____	Yes / No
Do you experience significant pain on a regular basis? <i>Examples: migraines, Fibromyalgia, Irritable Bowel Syndrome, etc.</i>	Yes / No
Do you have enough food to eat?	Yes / No
During a normal meal, is half the food on your plate fruits and vegetables?	Yes / No
On a scale of 1-10, how ready are you to eat more fruits and vegetables? _____ (10=extremely motivated; 1=no motivation at all)	
Do you eat protein with every meal?	Yes / No
Do you drink 8 or more glasses of water a day?	Yes / No
What concerns, if any, do you have with your eating habits? _____ _____	
Do you smoke cigarettes?	Yes / No
On a scale of 1-10, how ready are you to quit smoking cigarettes? _____ (10=extremely motivated; 1=no motivation at all)	