Rockwood Behavioral Health
801 W 5th Ave Suite 422
Spokane, WA 99204
Phone: 509-342-3480
Fax: 509-342-3481

Welcome to Rockwood Behavioral Health

On behalf of our staff, we would like to take this opportunity to welcome you to the Rockwood Behavioral Health Center. We are pleased that you have selected us and we look forward to your initial visit. Please read through this paperwork carefully, complete the forms, and bring them with you to your first appointment along with your insurance card, picture identification, and copay if your insurance requires one.

We ask that you arrive 15 minutes early for your first appointment. If you have not had time to complete the forms, please come at least 30 minutes early so that you can thoroughly complete them. We will not see you for an intake session without your paperwork being completed.

General Information

The therapeutic relationship is unique because it is highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how the relationship between provider and patient will work. Please read through the following information carefully and if you have further questions, you can discuss them with your provider or with our staff.

Sessions

The first intake session can last anywhere between 1-2 hours depending on which provider you are meeting with. During this time, your provider will gather necessary information to determine if we are able to address your needs within our short-term therapy model. **Please note that completing an intake appointment does not guarantee that we will be able to continue to see you for sessions and provide you services. If you are seeing a provider for a medication consult, be aware that our providers do not prescribe any medication at the first appointment**. If your provider determines during your intake session that you will benefit from longer-term care or more specialized services outside of our clinic, you will be provided with a list of handpicked referral resources that will suit your needs or concerns.

Duration of Provider and Patient Relationship

Our clinic works from a short-term model of counseling and therapy, typically seeing patients for 16-20 sessions. Your provider will have frequent conversations about your goals and progress. Your provider will discuss the expected duration and frequency of sessions based on your counseling goals and financial abilities. If you do not schedule additional sessions after a period of 90 days, we will assume you would like to discontinue care and we will remove you from our active caseload in effort to open availability or new patients.

Risks and Benefits

There are some risks and benefits involved in counseling. Risks may include remembering unpleasant events which can bring up strong emotions, or impact relationships with significant others. The benefits from counseling can include an improved ability to relate to others; a clearer understanding of self, values, and goals; increased productivity; and an ability to deal with everyday stress. Taking personal responsibility for working with these issues may lead to greater growth and sense of control over your life.

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Confidentiality and Patient Rights

The privacy of all communications between a provider and patient are protected by law. We can only release information about your treatment outside of Rockwood Clinic with your written permission, with a few exceptions. There are some situations where we are legally obligated to take action to protect others from harm, even if your provider must reveal information about your treatment. For example, if a child, elderly person, or disabled person is being abused, we are legally obligated to file a report with the appropriate state agency. If we believe that a patient is threatening serious bodily harm to another, we are required to take protective action. These actions may include notifying potential victims, contacting the police, or seeking hospitalization options for the patient. If a patient threatens to harm himself/herself, we may be obligated to seek hospitalization for him/her or contact family members who can provide protection. If a situation like this arises, your provider will make every effort to discuss it with you before taking action.

Our relationship with you will be professional and therapeutic. To preserve this relationship, we will not have a social or personal connection with you outside of the office. We will also not add you to any social media platforms. If anyone from our office sees you outside our clinic, we will not acknowledge you first. Your right to privacy and confidentiality is of the utmost importance to us and we do not want to jeopardize it. If you acknowledge our staff first outside of our clinic, we would be more than happy to speak with you briefly.

Contacting Your Provider

If you have questions or concerns, you may contact our front office staff at 509-342-3480 and they will be able to assist you. If you are experiencing an emergency and need immediate assistance, please call the Regional Crisis Line at 877-266-1818 or call 911 and head to your nearest emergency room. To ensure your confidentiality, we are prohibited from sending your health information through e-mail, text messages, or social media. You can contact your provider through MyChart for secure messaging. Our front office staff can help you sign up for MyChart if you need assistance.

Insurance and Copays

It is your responsibility as the patient to be aware of your insurance coverage, benefits, and what your copay amount may be. Please call your insurance company before your first visit. We recommend asking the following questions when you call:

- ☐ Do I have active coverage for mental health therapy?
- ☐ Do I have a copay for outpatient mental health therapy?
- ☐ Do I have any visit limits or need prior authorization?

Your insurance company requires us to collect your copay at the time of service. If you do not have insurance coverage and are a self-pay patient, the full balance of your visit is due at the time of service. Please come prepared to pay for copay or visit balance. For your convenience we accept cash, check, Visa, Mastercard, American Express, and Discover card.

Late Cancellation and No-Show Policy

We take treatment at our clinic seriously. The help you reach your goals and address your concerns, regular attendance of your appointments is crucial. Your scheduled session is reserved for you, and if missed your treatment is impacted. It also prevents up from offering that time to another patient in need. We understand that occasionally there are situations that will arise and prevent you from coming to your scheduled appointment. In these instances, we do require a 24- hour cancellation notice. If you cancel with less than 24-hours' notice, it is considered a late cancellation. Please read through our "No-Show and Late Cancellation Policy".

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What's a no-show? A no-show appointment is the term we use when patients do not arrive to their appointment and we have not received any communication that they were not going to attend.

What's a late cancellation? A late cancellation is when we receive a call from a patient to cancel an appointment, but it's within 24 hours of their scheduled appointment time.

What is the new policy? Patients with three no-shows or late cancellations in one year (starting January 1, 2020), are able call the front desk for same-day appointments instead of having regularly scheduled visits. We often have same-day openings available, so this may work better for your schedule!

But sometimes I don't have 24 hours' notice to cancel! We know that life happens and giving advanced notice isn't always possible! Each time you no-show or late-cancel, we will send you a letter, reminding you of this policy. After two letters, we ask that you and your provider revisit this policy, just to make sure we communicated clearly. After three letters, we will ask that you call our front desk when you are ready to schedule an appointment.

What can I do if I need to cancel an appointment? If you need to cancel an appointment, please call our front desk with at least 24 hours' notice. We are happy to work with you on rescheduling!

I still have questions! Our front desk team and administration are happy to help! You can call us, or chat with us on your way to or from an appointment. We understand new policies can be a challenge, so we are here to listen ☺

We are so grateful for patience, communication and time. Thank you for coming to our clinic!

Your signature below states that you have read through and understand the all information given to you on pages 1-3, and that you agree to its contents.

Patient/Guardian Signature

Date

Place Patient Label Here

Directions and Parking

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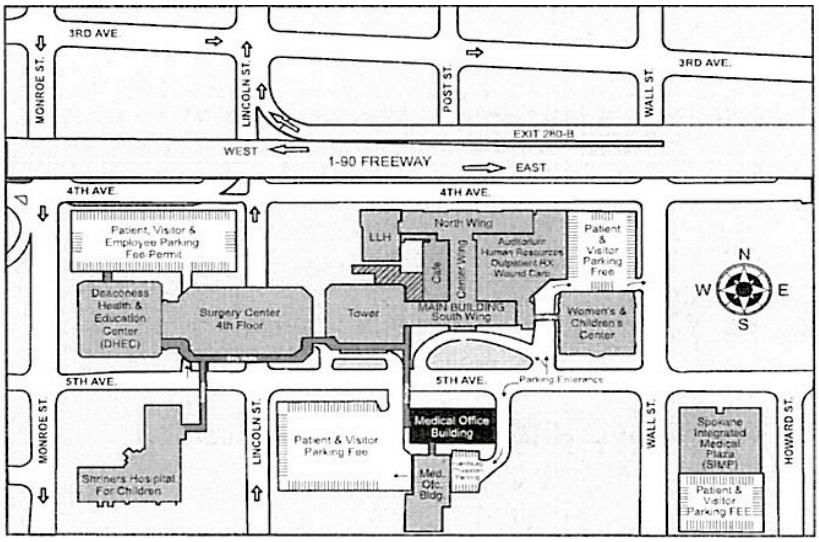

Location and Parking

The physical address for our clinic is 801 W. 5th Ave, Suite 422. We are located in the Deaconess Medical Building which is across the street from the Deaconess Emergency Room. The entrance to our parking lot is located on 5th Avenue. Please take a ticket and follow the ramp up to the parking lot**. Please note that parking is not validated. Please be prepared to pay $3.00 for parking.**

Directions

- ☐ **Westbound I-90:** Take exit 280-B (Lincoln Street). Turn right on 3rd Avenue. Turn right on Wall. Turn right on 5th Avenue. Head West on 5th Avenue to the Deaconess Medical Office Building at 801 W. 5th Avenue.
- ☐ **Eastbound I-90:** Take exit 280 (Maple/Lincoln). Turn right on Monroe. Turn Left on 5th Avenue. Head east on 5th to Deaconess.
- ☐ **Coming from the North on Monroe:** Take Monroe south to Fifth Avenue. Turn Left on Fifth Avenue. Head east on 5th to Deaconess Medical Office Building at 801 W. 5th Avenue.
- ☐ **Coming from the North on Division:** Go south on Division until it becomes Browne. Take Browne to 2nd Avenue and turn right. Take 2nd to Wall and turn left. Take Wall to 5th and turn right. Head west on 5th to Deaconess Medical Office Building at 801 W. 5th Avenue.
- ☐ **Coming from the South on Grand:** Go north on Grand until it becomes McClellan Street. Take McClellan to 8th Avenue and turn left. Take 8th until it becomes Washington Street. Take Washington to 5th and turn left. Head west on 5th to Deaconess Medical Office Building at 801 W. 5th Avenue.

PRESCRIPTION PROCEDURE

You must allow up to 72 hours (or three business days) for all prescription requests to be completed. **Please do not wait until you have taken your last dose to request a refill.** We do not keep any medication or samples on site. As a general rule, our prescribers require 2 visits to consult with you and assess your needs prior to prescribing medication. Please be aware prescriptions will not be given at your initial appointment.

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Refill procedures:

- ☐ You can electronically request refills can be requested through **MyChart**. Please speak with the front desk for help getting signed up.
- ☐ You can contact your pharmacy for all refill requests. The pharmacy will then request a refill from your provider.
- ☐ If your medication is a controlled substance, call and leave a detailed request at (509) 342-3480, option # 2. **Leave your full legal name, date of birth, requested medication and preferred pharmacy.**
- ☐ If you use a mail order pharmacy, regardless of what type of medication it is, you must call our office 2-3 weeks before you run out.
- ☐ If you have any questions or are having side effects please call our office at 509-342-3480

Please do not continually call after you have made your initial request unless 72 hours (or three business days) have passed and you have not heard from us.

If your child/dependent is the patient, please fill out **their information*

Patient History for _____
DOB: _____
Who is filling out this paperwork? _____

Who lives in your home with you?

Name	Age	Occupation/Grade	Relationship to you

Do you have children or adult children who live outside the home?

Name	Age	Occupation/Grade	Relationship to you

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Who lived in your home growing up?

Name	Relationship to you

- → Did your parent's divorce? ____No ____Yes when I was ____ years old
- → Were you abused or neglected as a child? ☐ No ☐ Yes How_____
- → Are you concerned that you are currently in an unsafe household? ☐ No ☐ Yes

Were any of the following problems for you or are they problems currently? Check all that apply.

Problem	Current Problem	Past Problem
Discipline problem in school		
Delinquency		
Running away from home		
Persistent lying		
Theft or vandalism		
Frequent initiation of fights		
Poor grades		
Other		

- → Have you ever been arrested? ☐ No ☐ Yes. When? _____ Why? _____
- → Have you ever been in jail? ☐ No ☐ Yes. When? _____ Why? _____
- → Do you currently have any legal problems? ☐ No ☐ Yes _____

Place Patient Label Here

☐ Anxiety ☐ ADHD ☐ Autism ☐ Behavioral Problems

☐ Bipolar Disorder ☐ Insomnia ☐ Medical Issues ☐ Pain

☐ Depression ☐ Eating Problem ☐ OCD ☐ Panic Attacks

☐ PTSD ☐ Stress ☐ Substance Abuse ☐ Bariatric Evaluation

☐ Other _____

- → Please briefly describe the reason that you are seeking help. _____ _
- → When did these problems begin? _____
- → Have you attempted suicide? ☐ No ☐ Yes When? _____
- → Have you wished you were dead or wished you could go to sleep and not wake up? ☐ No ☐ Yes

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- → Have you actually had thoughts about killing yourself? ☐ No ☐ Yes
- → Have you done anything, started to do anything, or prepared to do anything to end your life? ☐ No ☐ Yes
- → Are you having thoughts about hurting someone else? ☐ No ☐ Yes
- → Have you had mental health treatment before? ☐ No ☐ Yes
  With whom? _____ When? _____
- → Was previous treatment helpful? ☐ No ☐ Yes

Does anyone in your family have mental health, drug, or alcohol problems?

Name	Age	Mental Health Problem	Relationship to you

Medical Information

Please list all medical problems that you currently have.

Diagnosis	Treating Provider

- → Have you ever had a head injury? ☐ No ☐ Yes When? _____

Please list all mental health medication you currently take.

Medication	Dosage	Response

Please list all mental health medications taken in the past.

Medication	Dosage	Response

Please list ALL medications and supplements that you currently take.

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Medication	Dosage	Prescribing provider

→ Do you have any medication allergies or significant adverse reactions? ☐ No ☐ Yes to _____

Substance Use Information

→ Do you smoke, use an e-cigarette or chew tobacco? ☐ No ☐ Yes, _____ packs per day

Please indicate your history and current use of drugs.

Drug Name	Currently Using	Used in the past year	Ever used
Alcohol			
Marijuana			
Cocaine/Crack			
Ecstasy/Molly			
Heroin			
IV Drugs			
LSD			
Meth/Speed			
Prescriptions (abusive use)			
Other			

Patient Stress Questionnaire

Name: _____ Birthdate: _____ Date: _____

Over the last two weeks, how often have you been bothered by any of the following problems? Please circle your answer **and check the boxes that apply to you.**

	Not at all	Several days	More than half the days	Nearly every day
☐ Little interest or pleasure in doing things	0	1	2	3
☐ Feeling down, depressed, or hopeless	0	1	2	3

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☐ Trouble falling or staying asleep or ☐ Sleeping too much	0	1	2	3	
☐ Feeling tired or having little energy	0	1	2	3	
☐ Poor appetite or ☐ Overeating	0	1	2	3	
☐ Feeling bad about yourself or that you are a failure or you have let yourself or your family down	0	1	2	3	
☐ Trouble concentrating on things such as reading the newspaper or watching television	0	1	2	3	
☐ Thoughts that you would be better off dead or hurting yourself in some way	0	1	2	3	
	Add Columns				**Total**

Over the last two weeks, how often have you been bothered by any of the following problems? Please circle your answer **and check the boxes that apply to you.**

	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	
	Add Columns				Total

Are you currently in any physical pain?	No	Yes

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In your life, have you ever had any experience that was so frightening, horrible, or upsetting that ***in the past month you:***

1. Have had nightmares about it or thought about it when you did not want to?	No	Yes
2. Tried hard not to think about it or went out of your way to avoid situations that reminded you of it?	No	Yes
3. Were constantly on guard, watchful, or easily startled	No	Yes
4. Felt numb or detached from others, activities or your surroundings?	No	Yes

Drinking alcohol can affect your health. This is especially important if you take certain medications. We want to help you stay healthy and lower your risk for the problems that can be caused by drinking. These questions are about your drinking habits. We have listed the serving size of one drink below.

12 ounces of beer or wine cooler	1.5 ounces of 80 proof liquor	5 ounces of wine	4 ounces of brandy, liquor, or aperitif

Please circle your answer	**0**	**1**	**2**	**3**	**4**
How often do you have one drink containing alcohol?	Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times per week
How many drinks containing alcohol do you have on a typical day when you are drinking?	1 or 2	3 or 4	5 or 6	7 to 9	10 or more
How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
How often ***during the last year*** have you…					
…found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
…failed to do what was normally expected from you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
…needed a first drink in the morning to get yourself going after heavy drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

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…had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
…been unable to remember what happened the night before because you had been drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily

	0		2		4
Have you or someone else been injured as a result of your drinking?	No	Yes, but not in the last year	Yes during the last year		
Has a relative, friend, doctor or other health worker been concerned about your drinking or suggested you cut down?	No	Yes, but not in the last year	Yes, during the last year		
					Total:

Patient Problem Survey

How much are you distressed by:	Not at all	A little bit	Moderately	Quite a bit	Extremely
Crying easily					
Thoughts of ending your life					
Planning to end your life					
Blaming yourself or things					
Feeling depressed					
Loss of sexual interest or pleasure					
Change in appetite					
Feeling no interest in things					
Feeling hopeless about the future					
Feelings of worthlessness					
Feelings of guilt					
Change in sleep pattern					
History of hyperactivity					
Avoiding family, friends, and other social activities					
Fears about gaining weight or becoming fat					
Restring food to lose weight					
Vomiting or using laxatives to lose weight					
Impulsive behaviors					
Period of intense and/or excessive spending					
Periods of racing thoughts					
Repeated unpleasant thoughts that don't leave					

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Trouble remembering things					
Difficulty concentrating					
Difficulty making decisions					
Having to repeat the same actions such as checking, counting, or washing					
Trouble in your job					
Nervousness or shakiness inside					
Uncontrollable worrying					
Trembling					
Heart pounding or racing					
Episodes of terror or panic					
Feeling that something bad is going to happen					
Feeling fearful of specific situations					
Feeling afraid to leave your house					
Uncomfortable around new people/situations					
Feeling easily annoyed or irritated					
Temper outbursts that you could not control					
Having urges to beat, injure, or harm someone					
Feeling others are to blame for your troubles					
Feeling that you are watched or talked about by others					
The idea that someone else controls your thoughts					
How much are you distressed by:	**Not at all**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
Hearing voices that other people do not hear					
Other people being aware of your private thoughts					
Having thoughts that are not your own					
The idea that something serious is wrong with your body					
The idea that you should be punished for your sins					
Headaches					
Nausea or upset stomach					
Constipation or diarrhea					

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Mood Disorder Questionnaire

1. Has there ever been a period of time when you were not your usual self and…	YES	NO
…you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
…you were so irritable that you shouted at people or started fights or arguments?		
…you felt much more self-confident than usual?		
…you got much less sleep than usual and found that you didn't really miss it?		
…you were more talkative or spoke much faster than usual?		
…thoughts raced through your head or you couldn't slow your mind down?		
…you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
…you had more energy than usual?		
…you were much more active or did many more things than usual?		
…you were much more social or outgoing than usual, for example, you telephone friends in the middle of the night?		
…you were much more interested in sex than usual?		
…you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
…spending money got you or your family in trouble?		
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?		

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3. How much of a problem did any of these cause you—like being unable to work; having family, money or legal troubles; getting into arguments or fights?

☐ No problems
☐ Minor problem
☐ Moderate problem
☐ Serious problem

Place Patient Label Here

estionnaire

Many stressful life experiences are listed in the table below. In the left-hand column, answer "Yes" if you have had the experience or "No" if you have not. Then in the two columns on the right, rate how much the experience bothered you when it happened, and how much it bothers you now, using the 0-10 scare from "Not at All" to "Very Much".

Have You Had this Experience?		Description of Life Experience	How much did this experience bother you at the **Time it Happened?**	How much does this bother you **Now?**
Enter Yes or No		**While I was growing up, during the first 18 years of my life…**	0-Not at all to 10-Very much	0-Not at all to 10-very Much
	1	A parent or other adult in my home **often or very often…**swore at me, insulted me, put me down, or humiliated me. Or-acted in a way that made me afraid that I might be physically hurt.		
	2	A parent or other adult in my home **often or very often**…pushed, grabbed, slapped, spanked, choked or threw something at me. Or- ever, even just once, hit me so hard that I had marks or I was injured.		
	3	An adult or person at least 5 years older than me ever, even just once… touched or fondled me or had me touch their body in a sexual way. Or- attempted or actually had oral, anal or vaginal intercourse with me.		
	4	**I often or very often**… felt that no one in my family loved me or no one in my family thought I was important or special. Or- my family members didn't look out for each other, feel close to each other, or support each other.		
	5	**I often or very often** felt that… I did not have enough to eat, had to wear dirty clothes, and had no one to protect me. Or my parents were too drunk or high to take care of me or take me to the doctor if needed.		
	6	My parents were ever separated or divorced, even if they got back together.		
	7	My mother or stepmother **often or very often** was pushed, grabbed, slapped, or had something thrown at her. Or **sometimes, often, or very often** was kicked, bitten, hit with a fist, or hit with something hard. Or ever repeatedly hit at least a few minutes or threatened with a gun or knife.		

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	8	I lived with someone who was a problem drinker or alcoholic or used street drugs.		
	9	A parent of other adult in my home was depressed, or was mentally ill or attempted suicide.		
	10	A parent or other adult in my home went to prison.		

Place Patient Label Here