# Amber Kostial, MD
# Psychiatrist

*360.255.2505 Ext. 110*

Dear _____,

I look forward to meeting you at our first appointment:

**Date:** _____ **Time:** _____

**Your appointment will be at 801 Samish Way, Bellingham, WA 98229**

**PLEASE CHECK IN AT THE RECEPTION WINDOW AT YOUR FIRST APPOINTMENT**

**Enclosed you will find:**

- **Directions**
- **Intake form** – Please fully complete both sides.
- **Notice of Privacy Practices** – Please read this form and keep it for your records (required by Federal law).

Thank you for carefully reading and completing these forms. Please bring them with you to our first appointment, as well as your insurance card(s) and picture id.

If, after reading these forms, you decide against keeping your appointment, I ask that you contact me as soon as possible and no later than 48 hours prior to our scheduled appointment time.

Otherwise, I will see you at our first appointment. Directions to my office are on the back of this letter.

Sincerely,

Amber Kostial, MD

Directions are as follows:

From I-5 North

1. Take the Samish Way exit, EXIT 252, toward W Wash University.
2. Turn sharp right onto Samish Way.
3. 801 Samish Way is on the left just past Ridgemont Way.

From I-5 South

1. Take the Samish Way exit, EXIT #252.
2. At traffic light, turn left onto So. Samish Way, crossing back over I-5 freeway.
3. Then right turn at the next traffic light onto Samish Way.
4. 801 Samish Way is on the left just past Ridgemont Way.

# AMBER KOSTIAL MD
# CLIENT INTAKE FORM

PLEASE FILL OUT BOTH SIDES COMPLETELY.

Patient Name: _____ Social Security #: _____

Mailing Address: _____

City/State/Zip_____

Picture ID Copied ☐ Verified ☐

Home Phone #_____ Work Phone #_____ Cell Phone # _____
*OK to leave message? YES/NO* *YES/NO* *YES/NO*

Date of Birth: _____ Referred by: _____

Sex: FEMALE / MALE / _____ Primary Care Physician: _____

Employer / School_____ Position/Grade_____

Employer Address_____

Emergency contact_____ Phone # _____

If visit is related to auto accident: Date of Accident: _____ State: _____

**PRIMARY INSURANCE**

Insurance Co.: _____

Policy ID Number: _____
(*this may be a social security #)*

Group Number: _____

Policy Holder's Name:
_____

Relationship to you: _____

Policy Holder date of birth: _____

**SECONDARY INSURANCE**

Insurance Co.: _____

Policy ID Number: _____
*(this may be a social security #)*

Group Number: _____

Policy Holder's Name:
_____

Relationship to you: _____

Policy Holder date of birth: _____

**AUTHORIZATION TO RELEASE INFORMATION, ASSIGNMENT OF INSURANCE BENEFITS / CONTRACT**

*I hereby authorize Amber Kostial MD to release to my insurance companies any medical information necessary to assist in the processing of my insurance claim. My signature also authorizes any insurance benefits to be paid on my behalf directly to Amber Kostial MD. I acknowledge that I have read or been offered the enclosed Notice of Privacy Practices. I certify that all the above information is correct and I have read and will subscribe to the payment policy on my practitioner's disclosure form.*

_____ _____
Signature Date

# AMBER KOSTIAL MD INTAKE INFORMATION

## PERSONAL INFORMATION

Where were you born/raised? _____

Highest Educational Level Completed (circle): 8 9 10 11 12 13 14 15 16 17 18 19+

## FAMILY SITUATION

RELATIONSHIP STATUS: single involved engaged cohabitating
married separated divorced widowed

MARRIAGES, SIGNIFICANT RELATIONSHIPS, AND CHILDREN:

| Partner/Spouse | Beginning Year | Ending Year | Names/ages of children from relationship | Where/with whom do they live? |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |

Others living in your home, ages, relationship: _____

_____

Your sources of social/emotional support (family, friends, spiritual community, etc.):

_____

_____

Current sources of income (circle all that apply)

Employment Retirement Disability Family Savings/Investments Other: _____

EMPLOYMENT: (circle all that apply)

Full time Part Time Current Occupation: _____

Retired Disabled Student Homemaker Unemployed

Past Occupations: _____

Are you currently practicing a religion / faith system? _____

If so, are there any religious/faith beliefs that you think are important that I know about for the purpose of our work together? _____

What, if any, religious / faith traditions were important in your upbringing? _____

_____

# MEDICAL HISTORY

LIST ALL PREVIOUS AND CURRENT ***PSYCHIATRIC*** MEDICATIONS:

| Drug Name | Dosage | Times/Day | Approximate start/end date | Results (Benefits, side effects) |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

ALL ***OTHER*** CURRENT MEDICATIONS (Including vitamins, herbal supplements and over-the-counter drugs):

| Medication | Dosage | For What Purpose? | Date Started |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

Please list all current health care providers: _____

_____

_____

Current medical (non-psychiatric) illnesses, problems, issues. Please be as complete as possible:

_____

_____

_____

Previous medical illnesses, problems, and surgeries (include dates):

_____

_____

_____

Allergies to medicines/foods/environmental exposures: _____

_____

Alcohol/Drug/Tobacco/Caffeine use:

Past: _____

Present: _____

## MENTAL HEALTH HISTORY

Have you had mental health problems in the past (please explain)? _____

_____

Do you have any prior mental health

diagnoses?_____

_____

Have you sought treatment for this or other mental health problems? If so, what treatment have you had?

Was it helpful? _____

_____

Were you ever hospitalized for psychiatric reasons? If so, when, where and why?

_____

---

Have any of your relatives had problems with their mental health? If so, please describe: _____

_____

## GOALS FOR THERAPY/EVALUATION

What would you like to see happen as a result of your work here? _____

_____

_____

_____

_____ _____

Signed (Patient signature) Date

# *SECTION BELOW IS FOR OFFICE USE ONLY.*

## CLINICIAN'S NOTES (for office use only)

Clinician Name: _____

| Date | DX code | Diagnosis | Clinician signature |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Vital Information about Your Mental Health Insurance**

As your provider, my office will file a claim with your insurance company to help you receive any mental health insurance benefits to which you are entitled. Benefit plans can vary from company to company and can even change within the same company over time. Thus, it is important for you to investigate benefits by calling your insurance company *before your first scheduled visit*. Insurance companies often base the amounts that they will pay toward your treatment on restricted fee schedules related to premium payments and geographical location. In other words, your insurance plan will pay me a set allowed amount for each visit, regardless of what my customary fee may be. There may be set limitations in terms of a maximum number of visits to a mental health provider per calendar year. Deductibles and co-payments are typically built into most plans and state law strictly regulates their required payment. Both my office, and you as the policy beneficiary, can be prosecuted if deductibles and co-payments are not collected. Your Employee Benefits Director can usually help you become familiar with your plan and its' restrictions, and my office will do our best to help you with maximizing your benefits.

My responsibilities to you include:

1. Complete your insurance claim forms and submit them to your carrier.
2. Accept any direct payment from your carrier and keep track of balances.
3. Notify you with a monthly billing statement of any remaining balances that may be your responsibility to pay.
4. My office will help to facilitate claims payment, but we do not have the ability to make your plan pay.

Your responsibilities to my office include:

1. To know your benefits.
2. To provide my office with up-to-date and necessary information concerning your insurance coverage so that we may correctly file a claim at the time of your first visit and at any time changes to your insurance coverage occur.
3. To pay any account balance promptly, including but not limited to, copays, co-insurance, and deductibles not paid by insurance. *Balances not paid by you in a timely manner may be referred to an outside collections company*.
4. Some insurance companies pay their benefits to subscribers rather than the provider. If you are paid by your insurance company for any benefits, we ask that you notify the office so that we can make necessary adjustments and correctly bill you for the amount due.

Thank you for choosing my office to provide your care. Please sign this form below acknowledging the responsibilities listed above. My office will keep one copy in your chart and will give you one copy for your own records.

_____ _____

Patient or Insured's Signature Date

# Notice of Privacy Practices Regarding Protected Health Information

***To our clients:*** *We are required to give this notice to you under the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA). This notice describes how psychological/ medical information about you may be used and disclosed, and how you can get access to this information. Please review it carefully.*

**I. Uses and Disclosures for Treatment, Payment, and Health Care Operations**

Your ***Protected Health Information (PHI)*** is any information about your past, present, or future physical or mental health conditions or treatment, or any other information that could identify you.

By signing this form, you are giving consent for us to disclose your PHI to other Pacific Harbor Psychology, Psychiatry and Psychotherapy therapists and/or other outside entities for the following purposes:

- ***Treatment:*** providing, coordinating, or managing your health care and other services related to your health care. An example would be when your therapist consults with another health care provider, such as your family physician.

- ***Payment*****:** obtaining reimbursement for your healthcare. Examples include when we disclose your PHI to your health insurer to obtain payment for your health care, or to determine your insurance eligibility or coverage.

- ***Health Care Operations*****:** activities that relate to the performance and operation of our practice. Examples are quality assessment and improvement activities, business-related matters such as audits and administrative services, and clinical peer review.

**II. Uses and Disclosures Requiring Authorization**

Outside of routine treatment, payment, and health care operations, we will not release your PHI unless you sign an ***Authorization Form*** authorizing that specific disclosure.

We would also need to obtain your authorization before releasing your Psychotherapy Notes—notes your therapist has made about your conversations during a private, group, joint, or family counseling session, which may be kept separate from the rest of your medical record. These notes are given a greater degree of protection than other PHI.

We do not release your private health information for marketing or as part of a sale of information. (In situations where that do happen, your authorization would be required.)

You may revoke all such authorizations (of PHI and/or Psychotherapy Notes) at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1) we have already released information based on that authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

**III. Uses and Disclosures with Neither Consent nor Authorization**

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If your therapist has reasonable cause to believe that a child has been abused or neglected, she/he is required by law to report it to the proper law enforcement authorities.

- **Adult and Domestic Abuse:** If your therapist has reasonable cause to believe that a vulnerable adult has been abandoned, abused, financially exploited, sexually or physically assaulted or neglected, she/he must immediately report it to the appropriate authorities.
- **Health Oversight:** If the State Department of Health subpoenas your therapist or your PHI as part of its investigations, hearings, or proceedings relating to the discipline, issuance, or denial of licensure to therapists, she/he must comply. This could include disclosing your relevant mental health information.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding, we will release information only with the written authorization of you/your legal representative, or a subpoena of which you have been notified, or a court order. (This does not apply when you are being evaluated for a third party or for the court.)

- **Serious Threat to Health or Safety:** We may disclose your mental health information to any person without authorization if we reasonably believe that disclosure will avoid or minimize imminent danger to your health or safety, or the health or safety of any other individual.

- **Worker's Compensation:** If we are treating you under a worker's compensation claim, we must make all mental health information in our possession that is relevant to the injury available to your employer, your representative, and the Department of Labor and Industries upon their request.

**IV. Patient's Rights**

- ***Right to Request Restrictions:*** You have the right to request restrictions on specific uses and/or disclosures of your PHI. However, we are not required to agree to a restriction you request.

- ***Right to Receive Confidential Communications by Alternative Means at Alternative Locations:*** You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations (for example, only calling you at work).

- ***Right to Inspect and Copy:*** You have the right to inspect and/or obtain a copy of PHI and Psychotherapy Notes in our mental health and billing records. We may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed.

- ***Right to Amend:*** You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request if we believe the original information is accurate.

- ***Right to an Accounting of Disclosures:*** You have the right to receive a list of the disclosures that our office has made of your PHI. Some exceptions do apply.

- ***Right to opt out of receiving fundraising communications.***

- ***Right to restrict disclosure*** of your private health information to a health plan when you have paid out of pocket, privately, for the health service.

- ***Right to be notified*** if there has been a breach of your protected health information.

**V. Therapist's Duties**

- We are required by law to maintain the privacy of your PHI and to provide you with this Notice of our legal duties and privacy practices with respect to PHI.

- We reserve the right to change the privacy policies and practices described in this Notice. Unless we notify you by mail of changes, we are required to abide by the terms in this Notice.

**VI. Complaints**

If you have a complaint about the way we have handled your privacy rights, you may contact our Privacy Officer, 801 Samish Way, Bellingham, WA 98229, 360-255-2505 x100.

You may also send a written complaint to the Secretary of the U.S. Dept. of Health and Human Services. 200 Independence Avenue, S.W., Washington, DC 20201 (877) 696-6775.