

**Adult Behavioral Health Clinic**  
University of Utah Hospital and Clinics  
**Clinic Policies – July 1, 2011**

Dear Patients,

Thank you for your interest in being seen at the University of Utah Adult Behavioral Health Clinic. We are pleased that we are able to offer high quality care to the individuals that choose our clinic. Our attending physicians are highly trained in the field of Psychiatry, and are also part of the University of Utah Medical Group. Please take a moment to review this information before completing the packet. The information covered in this packet will allow our physicians to provide the best possible evaluation at your first visit.

**Setting an Appointment**

Once you have received this packet, reviewed the information, and completed the Patient Information and Financial Responsibility statements, please return the forms to our Clinic. Having these forms will allow the physician to review your history and current symptoms prior to your first visit. These appointments usually last an hour. Our physicians may provide medication management, psychotherapy, and consultations when requested by other physicians.

**Fees and Services**

The Adult Behavioral Health Clinic serves participants in the UNI Behavioral Health Network (BHN) and a few other insurances. We will let you know who we are contracted with when we call to schedule your appointment. If you are a participant in the UNI BHN, or an insurance where we are contracted the co-pay will be collected at each visit.

For other individuals, the Clinic is a self-pay clinic. If you are a self-pay patient, this means that the **full** payment for service is due at check-in for each visit. The initial evaluation requires a credit card deposit for the full value of the assessment. This will be applied at the time of the assessment. Your clinician will supply you with a *superbill*, which is a form that can be submitted to medical insurance companies for reimbursement. Although our doctors are not listed on medical insurance "Preferred Provider Lists," the majority of medical insurance plans provide for "Out Of Network" benefits. (Please note that our clinicians *may* be listed as providers on your insurance. However, this is most likely coverage for inpatient care. Please check with your insurance company to verify your coverage.) If your insurance company does not provide for "Out of Network" benefits, you will be liable for the total bill. **Our physicians and staff will NOT complete insurance forms or call insurance companies for authorization of visits.**

Our fee schedules are based upon the level of training; however, all of our physicians provide excellent care.

- **Attendings:** MDs who have completed Adult Psychiatry Residency. All are board eligible or board certified in Adult Psychiatry.
- **Residents:** Senior level trainees, completing an Adult Psychiatry Residency, working under the supervision of an attending and, in some cases, a psychologist.

Type of Provider	Initial Evaluation (90801)	Medication Management 30 min. appt. (90805)	Therapy (1 hour) (90806)	Transfer of Care (90807)	Psychology Testing (96101)	Speech Pathologist (1 hour) (92507)	2 <sup>nd</sup> Opinion/Case Review (based on hourly rate) (99244)
Resident	\$200	\$60	\$50	\$100			\$150
Psychiatrist	\$300	\$110	\$160	\$180			\$250
<b>Other Services</b>						\$95	
Report requests							*Billed/hour based on specialty
Letter requests							\$25
Mailing Prescriptions		<b>*Please bring Self Addressed Stamped Envelopes</b>					

### Missed Appointments

For each visit after the initial evaluation, a reminder card will be mailed of the scheduled date and time. Missed appointments or appointments not cancelled prior to 48 hours before the scheduled time will be charged the full fee for the scheduled service. This also applies to diagnostic evaluations (first visits). This fee will automatically be charged by the University of Utah Hospital if a “no show” occurs. We understand that there are special circumstances that cannot be avoided (emergencies, severe weather, etc.) and such events will be taken into account.

### Release of Information

The Release of Medical Information (paper with blue edge) is an extremely important document included with this packet. This allows any previous physicians or treatment facilities to send us a copy of your past medical records. These medical records are an essential part in obtaining an accurate history of your illness and its treatment. Most physicians and treatment facilities are more than willing to provide these records. We recommend calling the physician or treatment facility to request a release of information. In addition, we have found it helpful if you contact the physician or treatment facility approximately a week before the appointment to verify that the records have been sent.

**Prescription Requests**

**Our Clinic requires 2 business days' notice for any prescription refills.** In addition, regular clinical visits are necessary to continue medication refills, as directed by the physician. We are happy to fill 90-day mail order prescriptions. However, by Utah Law, we *cannot offer this service for any controlled substance (e.g. stimulants).*

**After Hours/Weekends**

If it becomes necessary to contact a physician for crisis counseling or for other emergencies, the University Neuropsychiatric Institute (UNI) is staffed at all times to assist you. The doctor on call can be contacted through the hospital operator at (801)583-2500.

**Complaints**

Any complaints or difficulties regarding the Clinic procedures, physicians, or staff, should be addressed to Josette Dorius, BSN, MPH (Service Director), at 587-3108.

If you have any questions, please feel free to contact the clinic at 585-1212.

**We look forward to seeing you at the Adult Behavioral Health Clinic.**

**650 Komas Drive, Suite 208  
Salt Lake City, Utah 84108**

**Phone: (801) 585-1212  
Fax: (801) 585-9096**

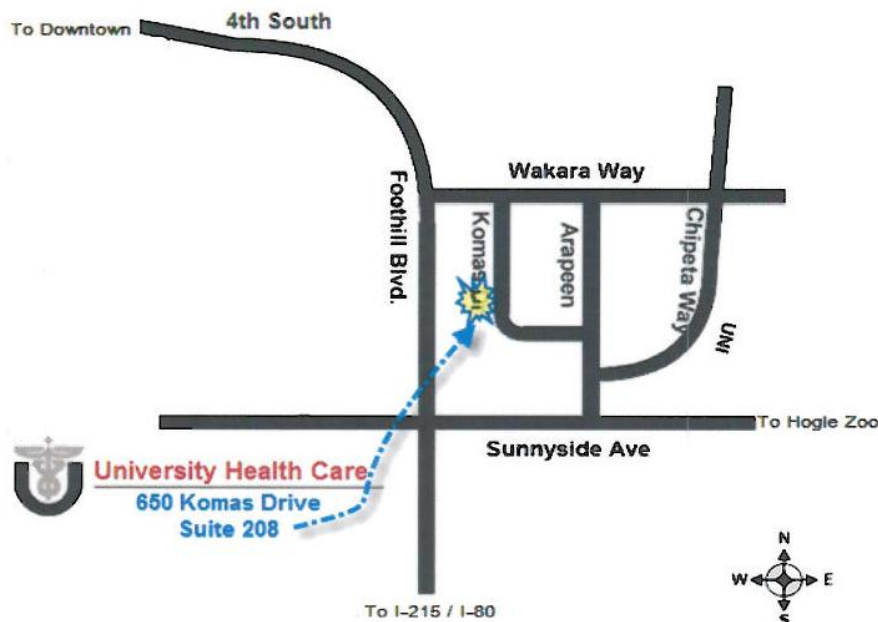
# University Health Care

Child and Adolescent /  
Adult Behavioral Health Clinics  
**650 Komasa Drive, Suite 208**

801-585-1212

### End Directions

Parking lot is in back (west) of building  
Enter from the West side of the building  
Take Elevator or stairs to 2nd floor  
Suite 208 is on the south end of the long hallway



Utah Transit Authority (UTA) have bus routes that come to the east side of our building, including 3, 455, 473. For more information, go to the UTA web site at [www.utabus.com](http://www.utabus.com)

### Estimated Driving Times:

From Sandy via I 215 to Foothill: 40 minutes

From Draper via I 15 to I215 to Foothill: 40 minutes

From West Jordan via 7800 South to I15 to I215 to Foothill: 45 minutes

From Magna via Highway 201 to I80 to Foothill: 40 minutes

**GIVE YOURSELF EXTRA TIME IF DRIVING IN THE MORNING: TRAFFIC IS VERY HEAVY!!**

**ADULT BEHAVIORAL HEALTH CLINIC  
UNIVERSITY OF UTAH HOSPITAL AND CLINICS**

<u>Last Name</u>	<u>First</u>	<u>Middle</u>	<u>Birth Date</u>	<u>Sex</u>	<u>Social Security Number</u>
<u>Home Address</u>	<u>Street</u>	<u>City</u>	<u>State</u>	<u>Zip</u>	<u>Home Phone</u>
<u>Name of Patient's Employer</u>	<u>Complete Address</u>			<u>Work Phone</u>	
<u>Cell number</u>					
<u>Do you currently have a family member being seen in the Child Adolescent or Adult Behavioral Health Clinic? Y or N</u>					
<u>If so, what practitioner(s) are they seeing?</u>					
<u>E-Mail Address</u>			<u>Preferred Method of Contact</u>		

**Emergency Contact Information**

<u>Name of Emergency Contact</u>	<u>Relationship</u>	<u>Phone</u>		
<u>Address</u>	<u>Street</u>	<u>City</u>	<u>State</u>	<u>Zip</u>

I have read and understand the enclosed clinic policies. The Adult Behavioral Health Clinic is a self-pay clinic. Payment in full is due at the time of service. A bill will be provided so that you may submit it to insurance for reimbursement. For participants in the UNI Behavioral Health Network, a co-payment will be required at the time of service. If a co-payment or service fee is not submitted on the day of service, a 10% fee will be assessed.

Signed: \_\_\_\_\_

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

**FINANCE CHARGE**

I understand that the services received today and in the future will be my responsibility. All charges not paid in full after 60 days will incur interest at the rate of 1.5% per month (18% annum) or a repeat billing charge of \$3.00, whichever is greater. I agree to pay a \$15.00 service fee for any check returned unpaid by my bank. In the event any balance due is not paid I agree to pay all costs of collection, including but not limited to collection fees, attorney fees and court costs.

Signed: \_\_\_\_\_

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

**UNIVERSITY OF UTAH HOSPITALS AND CLINICS  
OUTPATIENT CONDITIONAL AGREEMENT**

**1. TREATMENT CONSENT:**

The patient consents to treatment with the University of Utah Hospital and Clinics which includes University Hospitals and Clinics and School of Medicine Departments. Treatment may include x-ray examinations, laboratory procedures, anesthesia, medical treatment, and surgical treatment.

**2. RELEASE OF INFORMATION:**

The Hospital and Clinics may disclose all or any part of the patient's record, as part of the treatment, to the physician, and other providers concerned with the patient's care.

The Hospital and Clinics may also disclose the patient's records to any person, Social Security Administration, insurance or benefit payor, health care service plan, or worker's compensation carrier, which is or may be liable for all or any portion of the hospital's or treating physician's charges to the extent necessary to determine liability for payment and to obtain reimbursement. Further release will be governed by the Utah Government Records Access and Management Act, Section 63-2-101 et. Seq., U.C.A., 1953 as amended.

**3. ASSIGNMENT OF BENEFITS:**

The patient assigns all benefits to the Hospital and Clinics for the full amount of charges due and all rights to claims, and causes of actions, the proceeds of any insurance coverages, third party liabilities, worker's compensation, governmental agency or disability benefits, and all settlements, judgments or verdicts in favor of the patient, and the Hospital and Clinics is given a lien in like amount. I certify that the information given by me, the undersigned, is accurate to the best of my knowledge including information for applying for payments under Title XVIII or Title XIX benefits.

**4. FINANCIAL RESPONSIBILITY:**

I understand that I am financially responsible for charges not covered by my third party payors.

I agree to be financially responsible for all Hospital and Clinics charges in accordance with the regular rates and terms. If payment of all charges is not made when due (upon initial billing), I agree to pay all costs of collection for amounts due, including collection fees, attorney's fees and costs of court. All delinquent accounts may bear interest at the legal statutory rate.

**5. APPLICATION OF THE UTAH GOVERNMENT IMMUNITY ACT:**

I understand that all claims against the University of Utah Hospital and Clinics employees, including but not limited to physicians, nurses, technicians, and students, are subject to the provisions of the Utah Governmental Immunity Act, Section 63-30-1, et. seq., U.C.A., 1953 as amended, which act controls all procedures and limitations with respect to any claim of liability or malpractice.

**I HEREBY ACKNOWLEDGE THAT I HAVE READ THE AGREEMENT AND AS THE PATIENT, OR THE PERSON AUTHORIZED TO SIGN ON THE PATIENT'S BEHALF TO EXECUTE THIS DOCUMENT, ACCEPT THE TERMS AND CONDITIONS SET FORTH.**

\_\_\_\_\_  
**NAME OF PATIENT (PLEASE PRINT)**

\_\_\_\_\_  
**DATE**

\_\_\_\_\_  
**SIGNATURE OF PATIENT OR REP.**

\_\_\_\_\_  
**RELATIONSHIP**

## PERSONAL HISTORY QUESTIONNAIRE

By completing this questionnaire, you will help make your evaluation as thorough as possible in the initial visit, increasing the chance that treatment can begin immediately. If there is a question that you cannot or do not wish to answer, just leave it blank.

This questionnaire will become part of your permanent medical record. Your answers will be kept confidential. However, if you consent now or in the future to the release of your records to another party (for example, an insurance company), a copy of your completed questionnaire may be released along with other relevant information.

### GENERAL INFORMATION

Name: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Age: \_\_\_\_ Sex: M F Occupation: \_\_\_\_\_

Marital status: single/married/separated/divorced/widowed

Spouse's Name: \_\_\_\_\_

Who referred you to see me? \_\_\_\_\_

### CURRENT PROBLEMS

Describe the problem(s) for which you are seeking help:

---

---

Why have you chosen to seek help now? \_\_\_\_\_

---

When did your problem(s) begin? \_\_\_\_\_

What might be causing these problems? \_\_\_\_\_

---

List any health care providers you have seen for your problem(s):

<u>Name</u>	<u>Treatment</u>	<u>Dates</u>	<u>Helpful / Not</u>	
_____	Medication <input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	Counseling <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Both <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
_____	Medication <input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	Counseling <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Both <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
_____	Medication <input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	Counseling <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Both <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
_____	Medication <input type="checkbox"/>	_____	<input type="checkbox"/>	<input type="checkbox"/>
	Counseling <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>
	Both <input type="checkbox"/>		<input type="checkbox"/>	<input type="checkbox"/>

List any medications you have taken including **dose** and **frequency** of use for your problem(s):

<u>Medication</u>	<u>Highest Dose</u>	<u>Dates</u>	<u>Results</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

List any hospitalizations for psychological problems:

<u>Hospital</u>	<u>Doctor's Name</u>	<u>Dates</u>	<u>Helpful / Not</u>	
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	_____	<input type="checkbox"/>	<input type="checkbox"/>

Have you ever attempted suicide? No  Yes

If yes, complete the following:

<u>Date</u>	<u>How did you attempt it?</u>	<u>What happened?</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

Have you ever thought about hurting someone else?

No  Yes

## SYMPTOM CHECKLIST

Please indicate how much trouble you have had with each of the following symptoms in the past one month:

SYMPTOM	Not at all	A little	A great deal	Extremely
Feeling sad				
Feeling irritable				
Feeling unworthy or a failure				
Feeling guilty				
Loss of interest in most things				
Loss of pleasure in most things				
Difficulty concentrating				
Difficulty making decisions				
Feeling tired or low in energy				
Loss of appetite				
Loss of weight				
Increase in appetite				
Increase in weight				
Difficulty falling asleep at night				
Waking up during the night				
Waking up too early in the morning				
Sleeping more than usual				
Felling that there is no hope				
Thoughts of death or suicide				
Feeling anxious				
Worrying				
Feeling tense				
Restlessness				
Headaches or other aches or pains				
Heart beating quickly or strongly without reason				
Chest pains				
Difficulty breathing, or Feeling unable to get enough air				
Attacks of panic				
Washing your hands over and over				
Irrational fears of certain objects or situations				
Thoughts that distress you that you cannot get rid of				
Checking things repeatedly				
Strange ideas or experiences which other people do not have				
Feeling that someone is giving you a hard time or trying to hurt you				
Hearing things others cannot hear				
Seeing things others cannot see				

**FAMILY HISTORY**

Father

Is your father still living? No  Yes

If yes, what is his age? \_\_\_\_\_

What is/was his occupation? \_\_\_\_\_

Current living situation (where, with whom)?

\_\_\_\_\_

Describe your father's

Personality \_\_\_\_\_

Attitude toward you \_\_\_\_\_

Relationship with you when you were a child

\_\_\_\_\_

Relationship with you now

\_\_\_\_\_

If deceased, Age at his death: \_\_\_\_\_

Cause of death: \_\_\_\_\_

Mother

Is your mother still living? No  Yes

If yes, what is her age? \_\_\_\_\_

What is/was her occupation? \_\_\_\_\_

Current living situation (where, with whom)?

\_\_\_\_\_

Describe your mother's

Personality \_\_\_\_\_

Attitude toward you \_\_\_\_\_

Relationship with you when you were a child

\_\_\_\_\_

Relationship with you now

\_\_\_\_\_

If deceased, Age at her death: \_\_\_\_\_

Cause of death: \_\_\_\_\_

If your parents divorced, how old were you? \_\_\_\_\_

Brothers and Sisters

List your brothers and sisters, including yourself, from the oldest to the youngest:

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Relationship</u>	
			Close	Distant
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>

Does any member of your family (including aunts, uncles, grandparents) suffer from depression, anxiety, alcoholism, other substance abuse problems, or any other emotional or mental disorder?  
No  Yes

Has any relative attempted suicide? No  Yes

If you answered Yes to either of the last two questions, please give details:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**SOCIAL HISTORY**

Where were you born and raised? \_\_\_\_\_

What was your family's financial status growing up?

Below average  Average  Above average

What are your current sources of income?

Salary  Self-employed  Retirement  Disability

Do you have current financial stresses? No  Yes

What is your current religious preference? \_\_\_\_\_

Is spirituality important in your life? No  Yes

**DEVELOPMENTAL HISTORY**

Are you aware of any difficulties in completing developmental tasks while growing up—such as walking, talking, or toilet training? No  Yes

Check any of the following that occurred during your childhood or adolescence:

- Family problems
- Afraid to go to school
- Short attention span
- Hyperactivity
- Anorexia/bulimia
- Truancy
- Ran away from home
- Legal problems
- Alcohol or other drug abuse

Were you abused growing up?

Not at all  Emotionally  Physically  Sexually

Please list any other traumatic events you have suffered:

---



---

Did you make and keep friends easily? No  Yes

If no, what problems did you have? \_\_\_\_\_

Did you date during high school? No  Yes

List your interests (clubs, hobbies, etc.) during your teens:

---

**EDUCATIONAL/OCCUPATIONAL HISTORY**

How were your grades in school? \_\_\_\_\_

Did you graduate from high school? No  Yes

List any degrees earned beyond high school:

Degree	Major	School	Year
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Have you served in the military? No  Yes

List the jobs you've held since completing your education:

---

---

---

How long have you had your current job? \_\_\_\_\_

Does your current job satisfy you? No  Yes

If you answered No, please explain: \_\_\_\_\_

---

### LEGAL HISTORY

Any legal problems past or present? No  Yes

If you answered Yes, please explain: \_\_\_\_\_

### INTERPERSONAL HISTORY

	1 <sup>st</sup> marriage or relationship	2nd marriage or relationship	3rd marriage or relationship	4th marriage or relationship
Partner's 1 <sup>st</sup> name				
Your age when married				
Length of relationship				
Reason it ended				
Number of children				

Current partner:

Name \_\_\_\_\_ Age \_\_\_\_\_

Occupation \_\_\_\_\_

Personality \_\_\_\_\_

In what areas are you compatible? \_\_\_\_\_

In what areas are you incompatible? \_\_\_\_\_

List your children, from oldest to youngest:

<u>Name</u>	<u>Age</u>	<u>Sex</u>	<u>Relationship</u>	
			Close	Distant
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>
_____	_____	___	<input type="checkbox"/>	<input type="checkbox"/>

Do any of your children present special problems?

No  Yes

If you answered Yes, please explain: \_\_\_\_\_

\_\_\_\_\_

Who provides emotional support for you? \_\_\_\_\_

How comfortable are you in social situations?

very comfortable  relatively comfortable  relatively uncomfortable  very anxious

### **SEXUAL HISTORY**

At what age did you become sexually active ? \_\_\_\_\_

Are you sexually active currently? No  Yes

If you answered Yes, are you using any form of contraception? No  Yes

Is your current sex life satisfactory? No  Yes

**MEDICAL HISTORY**

How tall are you? \_\_\_\_\_

How much do you weigh? \_\_\_\_\_

Check any of the following problems you have or have had:

- Asthma       Bladder problems       Cancer
- Chronic pain                       Diabetes       Epilepsy
- Gastrointestinal problems       Glaucoma       Headaches
- Heart disease                       High blood pressure
- Infections       Kidney disease       Liver disease
- Neurological problems       Prostate problems
- Thyroid disease

(For Women Only:)

- Menstrual irregularities       Premenstrual syndrome
- Postpartum depression       Menopause

If you checked any of the above items, please give details:

---



---



---

Describe any significant injuries you have suffered:

---



---

Have you ever had a concussion (been knocked out)?

No  Yes  If Yes, describe: \_\_\_\_\_

List any surgeries you have had:

Type	Date
_____	_____
_____	_____
_____	_____
_____	_____

List **ALL** current **medication(s)** and **dosage(s)** you are currently taking (including birth control pills, over-the-counter drugs, and herbal remedies):

---

---

---

---

---

List any allergies:

---

---

List any doctors that you see regularly and their specialty:

---

---

---

When was your last complete physical exam? \_\_\_\_\_

**HABITS**

Do you drink coffee, tea, or colas? No  Yes

If Yes, how much each day? \_\_\_\_\_

Do you smoke? No  Yes

If Yes, how much for how long? \_\_\_\_\_

Do you drink alcohol? No  Yes

If Yes, how much and how often? \_\_\_\_\_

Do you use recreational drugs? No  Yes

If Yes, what kind(s), how much, how often?  
\_\_\_\_\_

**STRENGTHS**

What leisure activities do you enjoy? \_\_\_\_\_

What talents or skills are you proud of? \_\_\_\_\_