Sang H. Suh, M.D.

REGISTRATION FORM

Today's Date:			Referred to clinic by:	
PATIENT INFORMATION				
Patient's last name:	First name:		Marital status:	
Is this your legal name? ◯ Yes ◯ No	If not, what is your legal name?	Birth date:	Age:	Sex: ◯ M ◯ F
Address:	City	State	Zip	
Social Security no.:	Home phone no.:	Cell phone no.:		
Patent's Occupation/Employer:				
INSURANCE INFORMATION				
(Please give your insurance card to the receptionist.)				
Please indicate primary insurance:				
Subscriber's name:	Subscriber's S.S. no.:	Birth date:	Group no.:	Policy no.:	Copayment: $
Patient's relationship to subscriber:				
Name of secondary insurance (if applicable):	Subscriber's name:	Group no.:	Policy no.:	
Patient's relationship to subscriber:	Other:			
IN CASE OF EMERGENCY				
Name of local friend or relative (not living at same address):	Relationship to patient:	Home phone no.:		
The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the physician. I understand that I am financially responsible for any balance. I also authorize [Name of Practice] or insurance company to release any information required to process my claims.				
Patient/Guardian signature	Date			

Sang H. Suh, M.D.

MEDICAL RELEASE FORM

Today's Date:

MY AUTHORIZATION

I, _____, hereby authorize Dr. Suh to RECEIVE, USE OR RELEASE specified confidential medical, psychiatric (including alcohol and/or drug) and/or educational information from the below indicated persons/agencies and for the stated reasons. I understand that this authorization extends to all or any part of the records/information.

PERSONS/AGENCIES

Name:	Address:	Phone:

Patient's relationship to subscriber:

Purpose: To aid in the success of treatment, to provide continuity of care

Information to Use or Release: Ability to talk with and release all healthy care information in my medical record

PERSONS/AGENCIES

Name:	Address:	Phone:

Patient's relationship to subscriber:

Purpose: To aid in the success of treatment, to provide continuity of care

Information to Use or Release: Ability to talk with and release all healthcare information in my medical record

PERSONS/AGENCIES

Name:	Address:	Phone:

Patient's relationship to subscriber:

Purpose: To aid in the success of treatment, to provide continuity of care

Information to Use or Release: Ability to talk with and release all healthcare information in my medical record

I understand, and I do not have to sign this authorization in order to get healthcare benefits. However, I do have to sign an authorization form to receive healthcare when the purpose is to create healthcare information for a third party.

I may revoke this authorization in writing. If it did, it would not affect any actions already taken by Dr. Suh based on upon this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance.

Patient/Guardian signature _____ Date _____

Sang H. Suh, M.D.

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND FINANCIAL AGREEMENT

(Pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and RCW 70.02.120)

PMETS ("Covered Entity") keeps a record of the healthcare services we provide you. You may ask to see and copy that record. You may also ask to correct that record. We will not disclose your record to others unless you direct us to do so or unless the law authorizes or compels us to do so. You may see your record or get more information about it by contacting our Privacy Officer, Santosh Agnoni, M.D. Written requests should be made to the Privacy Officer at the following address:

2820 Northup Way, Suit 105, Bellevue, WA 98004

Our Notice of Privacy Practices describes in more detail how your health information may be used and disclosed, and how you can access your information.

PATIENT ACKNOWLEDGMENT:

BY MY SIGNATURE BELOW I ACKNOWLEDGE RECEIPT OF THE NOTICE OF PRIVACY PRACTICES..

VERIFICATION OF MEDICAL CONSENT: l, the undersigned, hereby agree and consent to the plan of care proposed to me by the Covered Entity. I understand that l, or my authorized representative, have the right to decide whether to accept or refuse medical care. I will ask for any information I want to have about my medical care and will make my wishes known to the Covered Entity and/or its staff. The covered Entity shall not be liable for the acts or omissions of independent contractors.

AUTHORIZATION TO RELEASE INFORMATION: l, the undersigned, hereby authorize the Covered Entity and/or its staff, to the extent required to assure payment, to disclose any diagnosis and pertinent medical information to a designated person, corporation, governmental agency or third party payer which is liable to the Covered Entity for the Covered Entity's charges or who may be responsible for determining the necessity, appropriateness, or amount related to the Covered Entity's treatment or charges, including medical service companies, insurance companies, workmen's compensation carriers, Social Security Administration, intermediaries, and the State Department of Health and Human Services when the patient is a Medicaid or Medicare recipient. This consent shall expire upon final payment relative to my care.

FINANCIAL AGREEMENT:

_____ (INITIAL) I DO NOT HAVE DSHS COVERAGE

PRIVATE PAY: l, the undersigned, hereby agree, whether signing as agent or as a patient, to be financially responsible to the Covered Entity for charges not paid by insurance. I understand this amount is due upon billing..

INSURANCE COVERAGE: J certify that the information given to me in applying for payment under government or private insurance is correct. I hereby assign payment directly to the Covered Entity for benefits otherwise payable to me. Any portion of charges not paid by the insurance company will be billed to me and is then due and payable within thirty (30) days of invoice. I understand the Covered Entity will verify my insurance coverage but that this does not guarantee payment by the insurance company and I will be responsible for all non-covered charges. I understand that it is my responsibility to determine the coverage limits of my insurance.

I understand a minimum monthly fee of 1% (annual rate of 12%) may be charged for late payment on all balances not covered by insurance. This is in addition to a charge for reasonable attorney fees, court costs, and collection agency expenses incurred to collect the amount due.

_____ _____

Patient or legally authorized individual signature | Date

_____ _____

Printed name if signed on behalf of the patient | Relationship (parent, legal guardian, personal representative)

Sang H. Suh, M.D.

PATIENT DISCLOSURE

Welcome! We hope that you find the treatment you receive here efficient and effective.

Please take a moment to review the information below before receiving or before continuing to receive services. If you have any questions about these or any other topics, please ask our office staff for clarification.

Our Practice:

Dr. Sang Suh provides psychiatric care to our patients by the way of psychiatric evaluation and ongoing medication management. We are psychiatrists but not counselors or therapist.

Confidentiality:

All interaction between the patient and the psychiatrist are confidential. Please take a moment to review the HIPAA Compliance Notice of Privacy Practices that you have received from our office staff for a comprehensive explanation of our privacy policies.

Emergencies:

During posted office hours, you may call Dr. Suh if you have a psychiatric emergency. The number is (425) 979-7850. However, you must call 911 or go to your nearest emergency facility, if Dr. Suh is delayed or unavailable for ANY reason.

Laboratory Tests:

Lab tests may be required by Dr. Suh. These tests can be essential for the continued prescription of certain medications. Most insurance companies require orders for laboratory test that are validated by our primary care physicians and/or be conducted at designated labs. You will need to contact your insurance company for details when/if laboratory rests are required by Dr. Suh.

Appointments:

Dr. Suh is capable of doing both in office appointments as well as virtual (telemedicine). Appointments are typically made by contacting Dr. Suh's office staff. To ensure the highest quality of care and to monitor treatment plans as scientifically as possible, follow-up appointments should be made and kept as recommended by Dr. Suh.

If you have an immediate life-threatening emergency, call 911 rather than the office (since calling the office may result in an unforeseen delay). However, often problems that arise between sessions can and should be managed by scheduling an earlier appointment.

Scheduled appointment times are reserved especially for you. If an appointment is cancelled with less than 48 business hour notice, we reserve the right to charge $50 for that appointment. If an appointment is missed entirely, it will be considered a “No Show” and we reserve the right to charge $75 for that appointment. Repeated “Now Shows” and late cancels could result in discontinuation of further services.

Reports/Letters:

Requests for letters or reports discussing your treatment or certain details of your treatment are not in the realm of our services. However, we understand that occasionally these requests are made. If you require a letter or report, we reserve the fight to charge a reasonable fee for that service.

Insurance:

As a courtesy to you, we verify your benefits.

Please be aware that the insurance companies and managed care companies do not guarantee that the information they give us is correct. Therefore, we cannot guarantee this information either.

_____ _____

Patient or legally authorized individual signature Date

_____ _____

Printed name if signed on behalf of the patient Relationship (parent, legal guardian, personal representative)

Sang H. Suh, M.D.

ELECTRONIC PRESCRIPTION INFORMATION

Dr. Suh uses electronic prescriptions. Please provide the information for your pharmacy of choice. This will be considered your default pharmacy and all future prescriptions will be sent to this pharmacy. If you are in need of changing the pharmacies for whatever reasons, please contact the office to make this happen. Dr. Suh requests that most all prescription refill requests be made through your pharmacy and ask specifically that this be done in an electronic format. Faxes should be avoided due to inconsistencies and unreliability.

Pharmacy:

Name: _____ Phone number: _____

Address:_____

City State Zip

Please complete the following 4 screening tools prior to the appointment

PATIENT HEALTH QUESTIONNAIRE (PHQ-9)

ID #: _____ **DATE:** _____

Over the last *2 weeks,* how often have you been bothered by any of the following problems?
(use "✓" to indicate your answer)

	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 overeating	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 figety 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
		add columns	+	+

(Healthcare professional: For interpretation of TOTAL, please refer to accompanying scoring card). TOTAL:

10. If you checked off *any problems,* how *difficult* have these problems made it for you to do your work, take care of things at home, or get along with other people?

- Not difficult at all _____
- Somewhat difficult _____
- Very difficult _____
- Extremely difficult _____

GAD-7 Anxiety

Over the last two weeks, how often have you been bothered by the following problems?	Not at all	Several days	More than half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it is hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid, as if something awful might happen	0	1	2	3

Column totals _____ + _____ + _____ + _____ =

Total score _____

If you checked any problems, how difficult have they 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: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The PHQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr. Spitzer at ris8@columbia.edu.

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.”
GAD-7 total score for the seven items ranges from 0 to 21.

0–4: minimal anxiety

5–9: mild anxiety

10–14: moderate anxiety

15–21: severe anxiety

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (✓) the answer that best applies to you.
Please answer each question as best you can.

	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...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 you didn't really miss it?	◯	◯
...you were much more talkative or spoke 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 much 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 telephoned 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? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and **an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.**

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1875.

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

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B