NYSTROM & ASSOCIATES

Nystrom Billing Policies and Consent for the Release of Records

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.

Billing & Payments

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 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. **Patients seen in Minnesota only:** Minnesota Care Tax will be added where applicable, and you agree to be held responsible for these fees.

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.

Cancellations

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.

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.

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).

Attestation for Consent

Coordination with Primary Care Provider and other Nystrom Providers

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 any and all substance use disorder (SUD) records to other Nystrom providers, including providers at Nystrom Residential Treatment LLC, for purposes of treatment coordination and care.

Electronic Signature

By signing, you understand that this becomes your electronic signature for the following forms: Initial Treatment Plan, Updated Treatment Plans, and the DBT Agreement Form. The provider will ask for your verbal consent after reviewing the forms with you.

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.

_____ _____

PRINTED NAME OF PATIENT PATIENT DATE OF BIRTH

_____ _____

PRINTED NAME OF LEGAL GUARDIAN PHONE NUMBER OF LEGAL GUARDIAN

_____

ADDRESS OF LEGAL GUARDIAN

_____ _____

EMERGENCY CONTACT PHONE NUMBER OF EMERGENCY CONTACT

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____

EMAIL ADDRESS OF PATIENT OR LEGAL GUARDIAN

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 takingbuprenorphine.
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 willbe 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 heath 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 CBDproducts.
7. I understand that if I am going to have a medical procedure that will cause pain, I will let my heath 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 treatmentinclude: _____

_____

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, LTD.

Psychiatry & Medication Management
Primary Care Provider Release of Information

Address: _____
City / State: _____ Zip: _____
Phone: _____ Fax: _____

Patient Full Name: _____ **Date of Birth:** _____

Nystrom Provider: _____

☐ **Send information about my initial evaluation and treatment plan to my Primary Care Provider. Coordinate with my Primary Care Provider as necessary for care.**

(Unless otherwise specified, the option above includes all Substance Use and/or mental health related information)

☐ **Do not coordinate care with my Primary Care Provider**

☐ **I do not have a Primary Care Provider.**

I authorize Nystrom & Associates, LTD. to RELEASE to and RECEIVE from:

Primary Care Provider/Clinic: _____

Street Address: _____

City, State, Zip: _____

Phone: _____ Fax: _____

I understand the following: See 45 CFR §164.508(c)(2)(i-iii) 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. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. d. Communications resulting from this authorization will reveal I have received services from NAL/FSSI. e. My health information is protected by federal regulations and state laws. Disclosure is only allowed with my authorization, except in limited circumstance as described in NAL/FSSI 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. A photocopy of this authorization will be treated in the same manner as the original. This authorization will remain valid until care is terminated with NAL or this authorization is revoked by the patient. I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use disorder Patient Records, 42 C.F.R. Part 2 and the Health Insurance Portability and Accountability Act of 1996 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

Patient Signature: _____ **DATE**: _____

Legally authorized representative signature: _____ DATE: _____

Representative's relationship to patient (parent, guardian, etc.) _____

Name (If not signed by patient): _____

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

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

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 Cancelations:

- 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**. 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.

_____	_____
Printed Name of Patient	Patients Date of Birth
_____	_____
Printed Name of Legal Guardian	Phone Number of Legal Guardian
_____	_____
Signature of Patient or Legal Guardian	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 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. 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
Add the score for each column		**+**	**+**	

Total Score (add your column scores)	

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_____

THIS FORM HAS 2 SIDES. COMPLETE BOTH SIDES AND RETURN TO YOUR PROVIDER.

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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
Add the score for each column		**+**	**+**	

Total Score (add your column scores)	

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 Inern Med.* 2006; 166:1092-1097

A@663B 10-04-2005

THIS FORM HAS 2 SIDES. COMPLETE BOTH SIDES AND RETURN TO YOUR PROVIDER.

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: _____

_____

_____

_____

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?

_____

_____

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?

_____

_____

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:

_____

_____

_____

Medication History

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

Depression and Anxiety Medications			
Medication	**(X)**	**Medication**	**(X)**
Ascendin		Nardil/Phenelzine	
Anafranil/Clomipramine		Norpamin/Desipramine	
Auvelity		Pamelor/Nortriptyline	
Brintellix/Vortioxetine		Parnate/Tranylcypromine	
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			

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

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

ADHD MEDICATIONS

Please note: 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/Methlylphenidate 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	

ANTIANXIETY MEDICATIONS

Please note: 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	

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

Sleep/ Wake Medications			
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/Eszoplicone			

Antipsychotics			
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	

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

Herbal/Supplements			
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:

_____ _____

_____ _____

_____ _____

Family History

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

Illness	**Relationship to you** (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:

_____

_____

_____

Surgical History

Please list all surgeries you have had:

Surgical Procedure:	Year:
_____	_____
_____	_____
_____	_____

Additional Comments:

_____

_____

_____

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?
Alcohol				
Marijuana Medical Cannabis, CBD, THC				
Illicit Drugs Methamphetamine, Crank, Heroin, Ecstasy, Speed				
Prescription Drugs **Pain Medications** (oxycodone, oxycontin, Percocet, codeine, Darvon, Vicodin) **Tranquilizers** (Xanax, Valium, Ativan, Klonopin) **Stimulants** (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?_____

Comprehensive Release of Information

Address: _____

City / State: _____ Zip: _____

Phone: _____ Fax: _____

Patient Information	Name: _____ Date of Birth: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____
I Authorize	**Nystrom & Associates, Ltd. and Family Support Services, Inc.** to exchange information with:
Agency #1	Agency/Name: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Email: _____ Fax: _____
Agency #2	Agency/Name: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Email: _____ Fax: _____
Agency #3	Agency/Name: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Email: _____ Fax: _____
Agency #4	Agency/Name: _____ Address: _____ Phone: _____ City: _____ State: _____ Zip: _____ Email: _____ Fax: _____
Information to be Released	**Release records checked below:** ☐ Most Recent Diagnostic Assessment ☐ 3 Most Recent Progress Notes, and Treatment Plan ☐ Psychological Testing Interpretive Report ☐ Other: _____ **NOTE**: Unless otherwise indicated, all related records regarding Mental Health will be included. This does not include records legally defined as Psychotherapy notes. Or ☐ All Records Dated from: _____ to _____ ☐ Any/All Medical Records (Entire medical record may be sent)
Type of Communication	☐ Verbal & Email Conversation ☐ Standard Email ☐ Secure Email **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. ☐ Medical Records
Purpose of Release	Records exchanged per patient request or _____.

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. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. d. Communications resulting from this authorization will reveal I have received services from NAL/FSSI. e. My health information is protected by federal regulations and state laws. Disclosure is only allowed with my authorization, except in limited circumstance as described in NAL/FSSI 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. A photocopy of this authorization will be treated in the same manner as the original. This authorization shall be in force and effect until 1 year from date of execution at which time this authorization expires. . *Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524

Patient Signature: _____ **DATE**: _____

Or legally authorized representative

Name (If not signed by patient): _____

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

Representative's relationship to patient (parent, guardian, etc.) _____

DO NOT FORWARD TO ANOTHER PERSON OR AGENCY

For internal Use: Faxed Date: _____ Initials: _____

Guidelines for completing your Authorization for Releasing of Confidential Information

Nystrom & Associates, Ltd. (NAL), and Family Support Services, Inc. (FSSI), recognizes the importance of patient confidentiality as well as the importance of coordinating care and treatment with other professionals, family, friends, and others involved in your care. Please review all items on this form and contact NAL/FSSI with any questions concerning this form at the below listed offices or website.

Patient Information: Complete this entire section with clear and legible writing so the information easily identifies the patient whose information is being requested/released.

Information to be Released: The purpose of this section is to indicate what information you wish to be shared. Please select the appropriate box or write in date range. Selecting Any/All authorizes NAL/FSSI to share or send your entire medical record.

Type of Communication: Use this space to indicate what method you would like records transmitted. If you would only like NAL/FSSI to have verbal communicate with the identified person/agency, select the Verbal & Email option. If you wish records to be transmitted to the person or agency, select the Medical Records option

Purpose of Release: Identify the reason you need to release/request information. This helps NAL/FSSI appropriately provide care and track releasing confidential information. It informs us who may be responsible for the cost of medical records being released and is required on each release. * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524 (when applicable).

Authorization and Revocation: Signing this form (or having the legal guardian sign for a patient) will grant authorization to share/receive confidential information. Please sign and date this form to validate this authorization. If signed by someone other than the patient, you will be required to provide written proof of your authority. Unless otherwise noted this consent will automatically expire in one year from the date signed. The authorization can be revoked or can be edited at any time at your written direction to our organization.

Helpful Tips:

- ✓ If requesting records, please allow 7-10 business days for processing of the Release of Information. In some cases it can take up to 30 days (45 CFR §164.524(b)(2)(i).
- ✓ For questions or concerns regarding this form please contact your NAL facility listed below.

SUBSTANCE USE DISORDER RELEASE OF INFORMATION

Patient Information

Name: _____ Date of Birth: _____

Address: _____ Phone: _____

City: _____ State: _____ Zip: _____

I Authorize

Nystrom & Associates, Ltd. and Family Support Services, Inc.

Address: _____

City / State: _____ Zip: _____

Phone: _____ Fax: _____

Email Address: _____

To do the following:

☐ **Release to**
☐ **Receive from**

Agency/Name: _____ Phone: _____

Address: _____ City: _____ Fax: _____

State: _____ Zip: _____ Email Address: _____

Information to be Released

(What do you want sent or released?)

Check appropriate box(es):

Only release Substance Use Disorder records checked below

- ☐ Substance Use Disorder Comprehensive Assessment/Rule 25
- ☐ Letter of Recommendation
- ☐ Verification of Attendance Letter
- ☐ Substance Use Disorder Diagnostic Assessment (Mental Health DA)
- ☐ Progress Notes/Treatment Plan Reviews
- ☐ Discharge Summary
- ☐ Oral Communication
- ☐ Other: _____

NOTE: Unless otherwise indicated, all related records regarding Mental Health and Substance Use Disorder will be included. This does not include records legally defined as Psychotherapy notes.

Or

- ☐ All Substance Use Disorder Records Dated from: ____ to ____
- ☐ Any/All Substance Use Disorder Records

Purpose of Release

(Why is it needed?)

Check appropriate box(es):

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

- ☐ Personal Use/Review
- ☐ Social Security appeal /disability
- ☐ Other: _____
- ☐ Insurance payment/claim
- ☐ Litigation/legal
- ☐ Family Involvement
- ☐ Collateral Information

NOTE: Purpose for release is not required if you are requesting your own records for personal use/review. Records sent to third party must identify a purpose.

Method of Communication

(How would you like your information communicated/sent?)

Check appropriate box(es):

Electronic Methods:

- ☐ Standard email (PDF)
- ☐ Secure Email (PDF)
- ☐ FollowMyHealth (Requires FollowMyHealth account)
- ☐ CD (Password Protected PDF)

NOTE: Transmission of records via standard email is not a secure method of transmission. By choosing email,

Standard Methods:

- ☐ Phone/Email Conversation
- ☐ Fax
- ☐ Pick up
- ☐ Mail

Initial Action

(What would you like done with the release?)

- ☐ Keep On File — For Future Use
- ☐ Send Records — To Agency/Name Listed Above
- ☐ Request Records — From Agency/Name Listed Above

NOTE: If nothing is checked, release will be placed on file for future requests.

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. c. My treatment or payment for my treatment cannot be conditioned on the signing of this authorization. d. Communications resulting from this authorization will reveal I have received services from NAL/FSSI. e. My health information is protected by federal regulations and state laws. Disclosure is only allowed with my authorization, except in limited circumstance as described in NAL/FSSI 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. A photocopy of this authorization will be treated in the same manner as the original. This authorization shall be in force and effect until 1 year from date of execution at which time this authorization expires. *Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524. I understand that my substance use disorder records are protected under the Federal regulations governing Confidentiality and Substance Use Disorder Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 45 C.F.R. pts 160 & 164, and cannot be disclosed without my written consent unless otherwise provided for by the regulations. Re-disclosure of these records is prohibited without the written consent of the client.

Patient Signature: _____ **DATE**: _____

Or legally authorized representative signature: _____ DATE: _____

Representative's relationship to patient (parent, guardian, etc.) _____

Name (If not signed by patient): _____

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

For internal Use: Faxed Date: _____ Initials: _____

Guidelines for completing your Release of Information

Nystrom & Associates, Ltd. (NAL) recognizes the importance of patient confidentiality as well as the importance of coordinating care and treatment with other professionals, family, friends, and others involved in your care. Please review all items on this form and contact NAL with any questions concerning this form at the below listed offices or website.

Required Fields: In order for the release of information to be HIPAA compliant, please ensure all fields inside the bolded box are filled out. Finally, ensure the release is signed and dated.

Patient Information: Complete this entire section with clear and legible writing so the information easily identifies the patient whose information is being requested/released.

To Do the Following: Indicate clearly and legibly where or whom you wish to send/receive information from. **Be as Specific** as you can. **ALSO**, please check either: (1) Release to, and/or (2) Receive from, If you choose only to Receive information your NAL provider **CANNOT** share any information; if you choose Release only your NAL provider can only share information; if you choose both to Release **AND** Receive they may share and take in information from the agency/name listed on the form.

Information to be Received/Released: The purpose of this section is to indicate what information you wish to be shared. Please select the appropriate box or write in date range. Selecting Any/All authorizes NAL to share or send your entire medical record.

Method of Communication: Use this space to indicate what method you would like records transmitted. If you would only like NAL/FSSI to have verbal communicate with the identified person/agency, select the Verbal/Phone option. If you wish records to be transmitted to the person or agency, select one of the other available options. If you are requesting a copy of your own records, we encourage you to use one of the available electronic methods so you can quickly and easily get access to your records.

Purpose of Release: Identify the reason you need to release/request information. This helps NAL/FSSI appropriately provide care and track releasing confidential information. It informs us who may be responsible for the cost of medical records being released and is required on each release. * Fees may be charged in accordance with MN Statute 144.292 and Federal Rule 45 C.F. R. §164.524 (when applicable).

Authorization and Revocation: Signing this form will grant authorization to share/receive confidential information. Please sign and date this form to validate this authorization. If signed by someone other than the patient, you will be required to provide written proof of your authority. Unless otherwise noted this consent will automatically expire in one year from the date signed.
The authorization can be revoked or can be edited at any time at your written direction to our organization.

Helpful Tips:

- ✓ If requesting records, please allow 7-10 business days for processing of the Release of Information. In some cases it can take up to 30 days (45 CFR §164.524(b)(2)(i)).
- ✓ For questions or concerns regarding this form please contact your NAL facility listed below.

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
(CIRCLE THOSE THAT APPLY) 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? **(IF YES, CIRCLE ONE)**	Yes / No
Have you experienced unintentional weight loss or weight gain? **(IF YES, CIRCLE ONE)**	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)*	
(CIRCLE THOSE THAT APPLY) 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? *Examples: migraines, Fibromyalgia, Irritable Bowel Syndrome, etc.*	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)*	
Would you like to schedule an appointment with the Dietitian? *If you answer YES to this question, a Registration staff member will contact you to schedule for nutrition services.*	Yes / No

An initial nutrition assessment is recommended to compliment the care you are already receiving here at Nystrom and Associates. Please discuss this with the Front Office Associate after your initial appointment or call (651) 529-8671 to speak with our Registration team.