The Psychiatry Group PLLC

5904 N Division St, Spokane, WA 99208 - (844) 495-4357

Adult Intake & Consent

You can fill this out on paper, or complete it online.

Where is your permanent home?

[ ] Washington [ ] California [ ] Idaho [ ] Another state

Patient information

First name: _____ Middle: _____ Last: _____
Date of birth: _____ Phone: _____ Other phone: _____
Email: _____ Preferred language: _____
Address: _____ City: _____ ZIP: _____
Emergency contact: _____ Phone: _____ Relationship: _____

Insurance / claim (if any)

Insurance: _____ Claim #: _____ Date of injury: _____
Employer: _____ Claim manager: _____ Legal rep: _____

Why are you seeing us?

Reason: _____
Medical conditions: _____ Allergies: _____
Current medications: _____
Mental health history / hospitalizations / past attempts to harm yourself: _____
Alcohol: _____ Cannabis: _____ Nicotine/vape: _____ Other drugs: _____

Telehealth

Your visits are usually by secure video. You must tell us where you are during each visit. Telehealth is not an emergency service. In a crisis call or text 988, or call 911.
[ ] I understand and agree to receive care by telehealth.

Use of HIPAA-compliant AI tools

We use HIPAA-compliant AI tools as part of our normal clinical workflow. They may listen during your visit and help prepare notes. AI does not replace your provider, does not diagnose or prescribe, and can make mistakes; your provider reviews the information and is responsible for your care. Agreeing is required for routine care. You may withdraw permission for future AI use.
[ ] I understand and agree to the use of HIPAA-compliant AI tools, including ambient listening and processing of my visit.

Treatment

I agree to receive psychiatric evaluation and treatment. Care may include evaluation, diagnosis, medication management, psychotherapy, labs, and referrals. Results cannot be guaranteed.
[ ] I agree to treatment.

Medications

Take medications only as directed. Ask for refills before you run out. Some medications require an appointment before a refill. Medication decisions are made by your treating clinician.
[ ] I have read this.

Text messages (optional)

We can send appointment reminders to your phone. Message/data rates may apply. Reply STOP to stop.
[ ] I agree to receive text messages. (Optional - not required for treatment.)

Financial policy

When it applies, we bill your insurance. You may be responsible for deductibles, copays, coinsurance, noncovered services, or other balances when permitted by your coverage and the law.
[ ] I understand the financial policy.

Missed appointments

Please cancel at least 24 hours before. A missed appointment or late cancellation may result in a $100 fee (new patient) or $75 fee (follow-up). Insurance usually does not pay these.
[ ] I understand the missed appointment policy.

Privacy

We protect your health information as required by law. You will receive our Notice of Privacy Practices.
[ ] I acknowledge the Notice of Privacy Practices.

Ending or transferring care

You or the practice may end care when appropriate. When required we give reasonable notice and help you find another provider. When clinically appropriate and legally permitted, we may provide a limited medication supply for a safe transition.

Patient name: _____ DOB: _____
Signature: _____ Date: _____