



I Once Was Lost, But Now I'm Found, PLLC

NEW PATIENT INTAKE & CONSENT PACKET

Welcome

Thank you for choosing I Once Was Lost, But Now I'm Found, PLLC for your mental health care. Our goal is to provide respectful, compassionate, evidence-informed, trauma-informed psychiatric care in a setting where you can participate actively in treatment decisions.

Provider: Theonie Labee-Walker, MSN, PMHNP-BC

Practice Information

Office Address: 9116 Gravelly Lake Drive SE, Suite 107 - PMB 1144, Lakewood, WA 98499

Phone: 253-509-1612

Fax: 253-237-9328

Secure/Practice Email: theonielabee@gmail.com

Website: lostbutfoundpsychiatry.com

Privacy Contact: Theonie Labee-Walker, MSN, PMHNP-BC

IMPORTANT - EMERGENCY CARE

This is an outpatient psychiatric practice and does not provide 24-hour emergency or crisis services. If you are in immediate danger, believe you may harm yourself or someone else, or cannot safely wait for a response, call 911, go to the nearest emergency department, or call/text 988. Do not use routine voicemail, email, text, or portal messaging for emergencies.

Please complete the applicable sections before your first appointment. You may leave sensitive narrative items blank and discuss them directly with your provider.

1. Patient Information

Legal Name:	
Preferred Name:	
Date of Birth:	
Pronouns (optional):	
Address:	
City / State / ZIP:	
Mobile Phone:	
Email:	
Preferred Pharmacy:	
Pharmacy Phone/Location:	

Preferred contact method:

☐ Phone call ☐ Text ☐ Email ☐ Patient portal ☐ Mail

Emergency Contact

Name:	
Relationship:	
Phone:	

Other Care Providers

Primary Care Provider:	
Therapist/Counselor:	
Other Specialist(s):	

Insurance / Billing

Insurance Plan:	
Member ID:	
Subscriber Name / DOB:	

2. Psychiatric & Medical Intake

What brings you to care now?

Primary concern:

☐ Previous psychiatric treatment: ■ No ■ Yes

☐ Psychiatric hospitalization: ■ No ■ Yes

☐ History of suicide attempt or self-harm: ■ No ■ Yes ■ Prefer to discuss

☐ History of trauma: ■ No ■ Yes ■ Prefer to discuss with provider

Current therapist / frequency:

Current medications and supplements

Medication(s):

Dose / frequency:

Prescriber:

Medication allergies / reactions:

Medical history

Medical conditions:

Surgeries / hospitalizations:

Primary care provider:

Substance use (clinical information)

☐ Alcohol: ■ None ■ Current ■ Past

☐ Cannabis: ■ None ■ Current ■ Past

☐ Nicotine: ■ None ■ Current ■ Past

☐ Other substances: ■ None ■ Current ■ Past ■ Prefer to discuss

Additional information:

3. Consent for Psychiatric Evaluation & Treatment

I voluntarily consent to psychiatric services from I Once Was Lost, But Now I'm Found, PLLC. Services may include psychiatric evaluation, diagnosis, medication management, screening tools, patient education, safety assessment and planning, brief/supportive psychotherapeutic interventions when clinically appropriate, referrals, and coordination of care.

I understand that treatment is collaborative. I may ask questions about recommended treatment, including expected benefits, material risks and side effects, reasonable alternatives, and the potential consequences of declining treatment. No specific treatment outcome can be guaranteed.

I understand that I may decline or withdraw consent for treatment to the extent permitted by law. Doing so may affect the provider's ability to safely continue a particular medication or treatment plan.

I understand that this consent does not replace specific informed-consent discussions that may be appropriate for particular medications, procedures, or services.

Patient/Client Name:		
Signature:		
Legal Representative (if applicable):		

4. Telehealth Informed Consent

Telehealth uses electronic audio/video technology to provide care when the patient and provider are in different locations. I understand potential benefits include improved access and convenience, while limitations may include technology failure, privacy risks, and reduced ability to perform certain physical assessments.

- I agree to participate from a reasonably private and safe location whenever possible.
- I understand I may be asked to confirm my physical location and an emergency contact at each telehealth visit.
- I understand the provider may recommend in-person or emergency evaluation when telehealth is not clinically appropriate.
- I understand sessions will not be recorded by the practice without my knowledge and permission.
- I understand that audio-only telemedicine may have separate consent/billing requirements when applicable.
- I may withdraw consent to telehealth and discuss clinically appropriate alternatives.

Patient/Client Name:

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Signature:

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5. Psychiatric Medication Treatment Consent

I understand that psychiatric medications may be recommended as part of treatment. I will have an opportunity to discuss the reason for treatment, expected benefits, significant risks and side effects, reasonable alternatives, and questions I may have.

I agree to provide accurate information about prescription and nonprescription medications, supplements, alcohol, cannabis or other substances when clinically relevant; medication allergies; significant medical changes; and medications prescribed by other clinicians.

When relevant to medication safety, I agree to discuss pregnancy, suspected pregnancy, breastfeeding, or plans for pregnancy with my provider.

I understand that I should not change a prescribed dose or abruptly stop medication without discussing it with my provider when reasonably possible. Some medications may cause withdrawal symptoms or other adverse effects when stopped suddenly.

Medication response varies, and no specific result is guaranteed.

Patient/Client Name:

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Signature:

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6. Controlled Medication & Stimulant Treatment Agreement

If I am prescribed a controlled medication, including a stimulant or benzodiazepine, I agree to use it only as prescribed.

- I will not share, sell, trade, or intentionally use my medication in a manner different from the prescribed directions.
- I will store controlled medication securely and away from children and other individuals.
- I will tell my provider about controlled medications prescribed by other clinicians.
- I understand early replacement of lost, stolen, damaged, misplaced, or overused controlled medication is not guaranteed.
- I understand controlled medications may require regular follow-up and monitoring for safe prescribing.
- I understand the provider may review the Washington Prescription Monitoring Program when clinically appropriate or required.
- I understand clinically appropriate monitoring may be requested when necessary for safe treatment.
- I understand unsafe medication combinations, diversion, misuse, or inability to follow the treatment plan may result in modification or discontinuation of controlled-medication treatment when clinically appropriate.

This agreement does not guarantee that a controlled medication will be prescribed. Prescribing decisions are based on clinical assessment, applicable law, safety considerations, and ongoing evaluation.

Patient/Client Name:

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Signature:

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7. Communication, Text, Email & Voicemail Preferences

The practice may need to contact me about appointments, billing/insurance, prescriptions, laboratory results, treatment follow-up, and other matters related to my care. I understand that standard email and SMS/text may carry privacy and security risks.

I authorize contact by:

☐ Phone call ☐ Text/SMS ☒ Email ☐ Patient portal ☒ Mail

Voicemail preference:

- ☐ A detailed healthcare message may be left.
- ☐ Appointment/general information only.
- ☐ Please leave only the practice name and callback number.
- ☐ Do not leave voicemail.

Preferred phone:

Preferred email:

Alternative confidential contact:

I understand I may request reasonable confidential communications or update these preferences by contacting the practice.

Patient/Client Name:

Signature:

8. Prescription & Refill Policy

Routine refill requests should be submitted before medication is exhausted. Please allow 2 business days for routine refill processing.

- Refills may require a scheduled follow-up appointment.
- Medication changes generally require clinical evaluation and may not be handled solely through messaging.
- Controlled medications may have additional prescribing and follow-up requirements.
- Replacement of controlled medications reported as lost, stolen, destroyed, or taken incorrectly is not guaranteed.
- Pharmacy shortages do not guarantee that an alternative medication can be prescribed without clinical review.
- Patients are responsible for keeping the practice informed of pharmacy changes and insurance/pharmacy benefit issues.

Preferred refill method / portal instructions: _____

Patient/Client Name:

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Signature:

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9. Financial, Insurance, Cancellation & No-Show Policy

I understand that insurance verification or authorization is not a guarantee of payment. I am responsible for applicable copayments, coinsurance, deductibles, noncovered services, and other patient-responsibility amounts consistent with applicable law and my insurance plan.

Cancellation notice: Please provide at least 24 hours' notice when cancelling or rescheduling.

Late cancellation / no-show fee: \$50, when permitted by applicable law and payer contract.

■ I understand fees for noncovered administrative services, forms, letters, or records may apply when disclosed in advance and permitted by law.

■ I agree to provide current insurance and billing information and notify the practice of changes.

■ I understand balances may be due according to the practice's billing policy.

The practice will follow applicable payer contracts and law when assessing patient charges.

Patient/Client Name:

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Signature:

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10. Emergency, Crisis & After-Hours Policy

I Once Was Lost, But Now I'm Found, PLLC does not provide 24-hour emergency or crisis response.

If I am in immediate danger, believe I may harm myself or someone else, experience a medical emergency, or cannot safely wait for a response, I will call 911, go to the nearest emergency department, or call/text 988.

Routine voicemail, email, text, and patient-portal messages are not continuously monitored and should not be used for emergencies.

For urgent but non-emergency clinical concerns during business hours, contact the practice using the designated clinical communication method.

Practice phone 253-509-1612

After-hours instructions (if any): _____

Patient/Client Name:

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Signature:

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11. Authorization to Release / Exchange Health Information

Use this form when you want the practice to obtain, release, or exchange information with another person or organization. This authorization is separate from routine treatment consent.

☒ I authorize I Once Was Lost, But Now I'm Found, PLLC to: ☐ Obtain ☐ Release ☐ Exchange information

Person / Organization:

Address:

Phone:

Fax / Secure Email:

Information authorized:

☐ Psychiatric evaluation / history

☐ Diagnoses

☐ Medication information

☐ Treatment plan / progress summaries

☐ Laboratory / test results

☐ Medical records

☒ Other: _____

Purpose of disclosure:

Expiration date or event:

I understand that I may revoke this authorization in writing except to the extent action has already been taken in reliance on it. I understand treatment generally will not be conditioned on signing an authorization except where permitted by law. Information disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by HIPAA, except where other law continues to protect it. Additional protections may apply to certain records, including psychotherapy notes and substance use disorder records.

Patient/Client Name:

Signature:

Legal Representative (if applicable):

12. Notice of Privacy Practices

Effective Date: _____

Your Information. Your Rights. Our Responsibilities.

This notice describes how medical information about you may be used and disclosed, how you can obtain access to that information, and the privacy responsibilities of I Once Was Lost, But Now I'm Found, PLLC.

Your Rights

- Request access to or a copy of your paper or electronic health record, subject to applicable law.
- Ask us to correct or amend information in your record.
- Request confidential communications.
- Ask us to limit certain uses or disclosures. Some requested restrictions are not required to be accepted, except where law requires otherwise.
- Request an accounting of certain disclosures.
- Receive a paper copy of this Notice.
- Choose an authorized personal representative to act for you.
- File a privacy complaint without retaliation.

Your Choices

In circumstances where your permission is required, we will obtain it before using or disclosing your information. You may have choices regarding communication with family or others involved in your care and certain other disclosures.

Our Uses and Disclosures

We may use or disclose health information as permitted or required by law, including for treatment, payment, health care operations, public health and safety activities, legal requirements, and other purposes authorized by law. Washington law may provide additional protections for mental health information. Psychotherapy notes, when maintained separately as defined by law, receive additional protection.

Substance Use Disorder Records

Federal law provides additional confidentiality protections for certain substance use disorder patient records. Where those protections apply, the practice will use and disclose such records in accordance with applicable federal law.

Our Responsibilities

- We are required by law to maintain the privacy and security of protected health information.
- We will notify affected individuals as required if a breach compromises unsecured protected information.
- We must follow the duties and privacy practices described in the Notice currently in effect.
- We will not use or disclose information other than as permitted by law or described in the Notice unless you authorize us in writing.

Privacy Questions or Complaints

Privacy Contact / Theonie Labee-Walker, MSN, PMHNP-BC

253-509-1612

theonielabee@gmail.com

You may also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights. The practice will not retaliate against you for filing a complaint.

The current Notice will be available upon request and on the practice website if the practice maintains a website describing its services.

13. Acknowledgment of Receipt of Notice of Privacy Practices

I acknowledge that I have received or been provided access to the Notice of Privacy Practices of I Once Was Lost, But Now I'm Found, PLLC. I understand that the Notice describes how my protected health information may be used and disclosed and explains my privacy rights. I may request a paper or electronic copy of the Notice at any time.

Patient/Client Name:

Signature:

Legal Representative (if applicable):

For Practice Use Only - if acknowledgment was not obtained:

■ Good-faith effort made to obtain acknowledgment.

Reason not obtained:

Staff initials / date:

14. Patient Rights & Responsibilities

You have the right to be treated with dignity, privacy, respect, and without unlawful discrimination; to participate in treatment decisions; to ask questions; to discuss reasonable alternatives; and to decline treatment to the extent permitted by law.

As a participant in your care, please:

- Provide accurate and complete health, medication, pharmacy, and contact information.
- Ask questions when you do not understand your treatment plan.
- Inform your provider of significant changes in symptoms, medications, health, or safety.
- Attend scheduled appointments or provide appropriate notice when unable to attend.
- Use medications according to the agreed treatment plan and discuss concerns promptly.
- Treat staff and others respectfully and participate in treatment decisions.

15. Final Packet Acknowledgment

By signing below, I acknowledge that I have had an opportunity to review this packet, ask questions, and receive clarification. My signature confirms receipt and acknowledgment of the policies and consents I have signed; it does not waive rights provided by law.

I acknowledge review of the following applicable sections:

- ☐ Consent for Psychiatric Evaluation & Treatment
- ☐ Telehealth Informed Consent
- ☐ Psychiatric Medication Treatment Consent
- ☐ Controlled Medication & Stimulant Treatment Agreement
- ☐ Communication Preferences
- ☐ Prescription & Refill Policy
- ☐ Financial / Cancellation Policy
- ☐ Emergency / After-Hours Policy
- ☐ Notice of Privacy Practices

Patient/Client Name:

Signature:

Legal Representative (if applicable):

I Once Was Lost, But Now I'm Found, PLLC

CONSENT FOR AI-ASSISTED CLINICAL DOCUMENTATION (TWOFOOLD HEALTH)

Purpose

To allow your provider to focus more fully on you and the conversation during your appointment rather than primarily on typing or taking notes, I Once Was Lost, But Now I'm Found, PLLC may use Twofold Health, an artificial intelligence (AI)-assisted clinical documentation tool, with your permission.

How It Is Used

During an appointment, Twofold may process audio from the conversation to help create a transcript and draft clinical documentation. According to Twofold Health, encounter audio is processed for documentation and is not retained as a session recording after processing. Twofold also states that patient information is not used to train its AI models.

The AI-generated documentation is a draft only. Your psychiatric provider remains responsible for reviewing, correcting, and approving the final clinical note. Twofold does not independently diagnose you, prescribe medication, or make treatment decisions.

Privacy

Information processed for clinical documentation may include protected health information (PHI). The practice will use the service in accordance with applicable privacy and security requirements and its agreement with the technology provider. The final clinical documentation may become part of your medical record.

Your Choice

Use of AI-assisted documentation is voluntary. You may decline without affecting your ability to receive care, the quality of your treatment, or your relationship with your provider. Even if you consent, you may ask that Twofold not be used during a particular visit or withdraw permission for future visits.

Please select one:

- ☐ **YES, I CONSENT.** I give permission for I Once Was Lost, But Now I'm Found, PLLC to use Twofold Health for AI-assisted clinical documentation during my appointments.
- ☐ **NO, I DO NOT CONSENT.** I do not give permission for Twofold Health to be used during my appointments. I understand that declining will not affect my ability to receive care.

I understand that AI-generated documentation may contain errors or omissions and that my provider is responsible for reviewing the final clinical note. I have had an opportunity to ask questions about the use of AI-assisted documentation.

Patient Name:

Patient/Legal Representative Signature:

If signed by legal representative, relationship:

Provider/Witness: