insights mental health & wellness

Adult Information Form

Patient Information

Name: ___________________________ Date: ___________ Sex: Male Female

Date of Birth: ______________ Age: _____________

Marital Status: Single Married Living with Someone Divorced Widowed

Address:

____

City: ________________________________ State: __________ Zip: ________________

Home Telephone: _______________________ May we leave a message? Yes ☐ No ☐

Work Telephone: _______________________ May we leave a message? Yes ☐ No ☐

Cellular Telephone: _____________________ May we leave a message? Yes ☐ No ☐

Work E-mail: ___________________________ May we send a message? Yes ☐ No ☐

Home E-mail: . May we send a message? Yes ☐ No ☐

Who referred you, or how did you become aware of our practice? _______________________

____

Emergency Contact (Name & Number): ____

Family Information

Please list all persons <u>living in your home</u>:

Name Sex Age Date of Birth Relationship Occupation

____

____

____

____

____

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Please list any children you have that are currently not living with you:

Name	Sex	Age	Date of Birth

Education Information

Circle highest grade completed:

Grade School	1	2	3	4	5	6	7	8
High School	9	10	11	12				
College	1	2	3	4				

Postgraduate Years: _______

Degree: ____________________

Business or Trade School: ____________

Employment Information

Current Employer: _______________________ Hire Date: ___________

Title/Position: ___________________________ Approximate # of hrs. per week: _________

Does your current job satisfy you? Yes No

Medical Information

Primary Care Physician: __________________________________ Phone: _________________

List any known allergies: ____

List all current medications you are taking (including dosage and time(s) taken):

____

____

Check if you have had any of the following:

____	Alcohol problems	____	Head injury	____	Stroke
____	Allergy	____	Heart disease	____	Thyroid problem

____	Arthritis	____	Hepatitis	____	Tuberculosis
____	Cancer or tumor	____	High blood pressure	____	Tremors, shakes
____	Circulation problems	____	Hospitalizations	____	Diabetes
____	Kidney disease	____	Ulcers	____	Drug abuse
____	Liver disease	____	Venereal disease	____	Dizziness
____	Nervous breakdown	____	Poor appetite	____	Emphysema
____	Sexual dysfunction	____	Headaches	____	Seizures
____	Depression	____	Physical abuse	____	Panic attacks
____	Job problems	____	Lack of confidence	____	Temper issues
____	Excessive worry	____	Death in family	____	Thoughts of hurting self/others

Current stress level (from 0-10 with 10 being the highest): ______________________________

Any other long-term medical complaints/problems: ___________________________________

____

Legal History

Have you ever been convicted of a crime? Yes No (If no, move on to next section)

I have been convicted of:

____ Shoplifting	____ Driving while intoxicated	____ Public intoxication
____ Battery	____ Drunk & disorderly	____ Possession of an illegal substance

____ Other (explain): ____

As a result of my conviction, I received:

____ Fine	____ Detention	____ Probation
____ Jail time	____Other (explain): ____________________________________	

Problems Information

Briefly describe the problem for which you are seeking help:

____

____

____

____

How have you been coping with this problem?

____

____

____

Have you ever sought help for this problem before? If so, please list when, where, and by whom you were seen.:

____

____

____

What are the goals you hope to achieve in treatment?

____

____

____

CONSENT FOR CARE

I, the patient or patient's legal representative, hereby grant permission to insights mental health & wellness to perform such assessments and therapeutic procedures as may be professionally deemed necessary or advisable and to communicate about them via telephone, mail, facsimile, and e-mail for my/the patient's diagnosis, treatment, payment, and healthcare operations. I understand that I am consenting and agreeing only to those mental health services that the Provider is qualified to provide within the scope of the Provider's or his/her direct supervisor's license, certification and training.

I am aware that the practice of mental health counseling is not an exact science and that no guarantees or promises have been made to me as to the result of treatment.

Patient Signature: ________________________________ **Date:** ____________________
(or patient's legal guardian if patient is a minor) (Electronic Signature)

Patient Printed Name: ____

HEALTH INSURANCE INFORMATION

*In order for claims to be submitted to your health insurance company the following information **must** be completely filled out and submitted with a clear copy of the front and back sides of your insurance identification card(s).*

PRIMARY HEALTH INSURANCE

Primary Insurance Company: ______________________________

Insurance Company Telephone: ______________________________

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: __________

*Subscriber on Policy: ______________________________

Subscriber ID: ______________________________ Subscriber Birth Date: __________

Subscriber Insurance Group #: ______________________

**THE SUBSCRIBER IS THE INDIVIDUAL IN WHOSE NAME HEALTH INSURANCE IS ISSUED.*

SECONDARY HEALTH INSURANCE

Secondary Insurance Company: ______________________________

Insurance Company Telephone: ______________________________

Patient's Relationship to Subscriber: ☐ Self ☐ Spouse ☐ Child ☐ Other: __________

*Subscriber on Policy: ______________________________

Subscriber ID: ______________________________ Subscriber Birth Date: __________

Subscriber Insurance Group #: ______________________

**THE SUBSCRIBER IS THE INDIVIDUAL IN WHOSE NAME HEALTH INSURANCE IS ISSUED.*

ASSIGNMENT OF BENEFITS

I hereby assign to insights mental health & wellness, my right to the insurance benefits that may be payable to me for services provided, arising from any policy of insurance, self-insured health plan, Medicare or Medicaid, in my name or on my behalf. I further authorize payment of benefits directly to insights mental health & wellness. I understand that I am responsible for satisfying the pre-certification requirements for any policy of insurance, self-insured health plan, or government plan covering services provided by insights mental health & wellness.

I understand that acceptance of insurance assignment does not relieve me from any responsibility concerning payment for medical services and that I am financially responsible for all charges whether or not they are covered by my health insurance.

Patient Signature: ______________________________ **Date:** ____________________
(or patient's legal guardian if patient is a minor) (Signed Electronically)

Patient Printed Name: ______________________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES & POLICIES, OFFICE POLICIES & PROCEDURES, AND GUARANTOR FEE SCHEDULE

As required by federal legislation, insights mental health & wellness is required to provide you with a copy of our Notice of Privacy Practice and document your receipt. You may waive your right to be provided with this Notice of Privacy Practice.

_______ I have received a copy of the Notice of Privacy Practices and Policies: In order to comply with HIPAA standards, each practice must obtain a signed acknowledgement that each direct treatment patient has received its Notice of Privacy Practices and Policies or must document a good faith effort to provide the Notice and receive a written acknowledgement of receipt. This will allow practices to use or disclose confidential information (protected health information) for treatment, payment, or healthcare operations.

_______ I have waived my right to be provided a copy of the Notice of Privacy Practice.

_______ I have received a copy of insights mental health & wellness' Notice of Office Policies and Procedures. I understand and agree to abide by them and consent to receive treatment. I understand and agree to abide by the late cancellation and missed appointment policy.

_______ I have received the Guarantor Fee Schedule and understand that if my services are not covered by my insurance carrier, that I am responsible for payment.

Patient Signature: _______________________________ **Date:** ____________________
(or patient's legal guardian if patient is a minor) (Electronically Signed)

AUTHORIZATION TO RELEASE PATIENT HEALTH INFORMATION FOR TREATMENT, BILLING, OR HEALTHCARE OPERATIONS

You are not required to give this authorization. However, claim charges denied due to a failure to provide requested documents (due to a lack of authorization) will be the responsibility of the patient.

I understand that I have the right to review the Privacy Notification prior to signing this consent. I understand that insights mental health & wellness reserves the right to change their notices and practices, and that I will notified if this occurs. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations. I understand that I may revoke this consent in writing, except to the extent that insights mental health & wellness has already taken action in reliance thereon. I also understand that insights mental health & wellness staff are not required to adhere to the restrictions requested in the event of a potentially life-threatening emergency.

Records may be needed in order to process a claim for medical services. I authorize insights mental health & wellness to release information needed for billing purposes to entities that may provide services pertaining to my physician visit, such as reference laboratories. I understand that by signing below, I am authorizing the release of all or part of my medical record for the purpose of my treatment, billing, or pertinent healthcare operations. This release may include records containing information regarding the diagnosis and/or treatment of HIV or AIDS, mental illness, and/or drug and/or alcohol addiction or abuse to any person or corporation which is or may be liable under contract for all or part of the medical charges, including but not limited to, Medicare, Medicaid, or other private or public health insurance programs, reviewing agencies, worker's compensation carriers, welfare agencies or patient's employer.*

**The patient's employer will only be contacted if necessary in order to confirm enrollment in a healthcare plan.*

Patient Signature: ________________________________ **Date:** ____________________
(or patient's legal guardian if patient is a minor) (Signed Electronically)

Patient Printed Name: ____

ELECTRONIC MEDIA/SOCIAL MEDIA POLICY

E-mail – Electronic mail will be used only for administrative communication, such as checking/arranging appointments or the communication of basic information. It will not be used to communicate therapeutic/highly personal information.

Texting – Text messages will be used only for administrative purposes, such as scheduling or changing appointments.

Social Media – In order to maintain privacy and confidentially our clinicians cannot follow or connect with any client on Facebook, Twitter or other social media outlets.

All client data stored in our database is encrypted. Text and e-mail messages are additionally protected by passwords.

Please check below if you wish to receive communication via e-mail or text message following the guidelines outlined above.

______ I would like to communicate via the e-mail address: ______________________________

______ I would like to communicate via text to the following number: ______________________

I understand that I am responsible to communicate any changes in the above information.

Patient Signature: ______________________________ Date: ____________________
(or patient's legal guardian if patient is a minor) (Signed Electronically)