



LAST NAME: _____ FIRST NAME _____

DOB: ____/____/____

**PSYCHIATRIC INTAKE AND TREATMENT PLAN-PART I
TO BE FILLED BY PATIENT**

PLEASE PRINT

Date	Age	Gender <input type="checkbox"/> M <input type="checkbox"/> F
Current address:		<input type="checkbox"/> Married <input type="checkbox"/> Single <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed

If patient is a child, he/she live with: Biological parent Stepmom Stepdad Other:

How did you hear about our services?

Have you experienced any of the following in the PAST or CURRENTLY (WITHIN THE LAST TWO WEEKS)?
Please indicate P for PAST or C for CURRENT for EACH SYMPTOM you have experienced:

<table border="0" style="width:100%;"> <tr> <td style="text-align: center;"><u>P</u> <u>C</u></td> <td><input type="checkbox"/> <input type="checkbox"/> depression</td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> changes in appetite: ___ increase ___ decrease</td> <td></td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> sleep disturbance</td> <td></td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> fatigue</td> <td></td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> low self-esteem</td> <td></td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> thoughts of suicide</td> <td></td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> getting into fights</td> <td></td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> wishing you were dead</td> <td></td> </tr> <tr> <td><input type="checkbox"/> <input type="checkbox"/> manic episodes</td> <td></td> </tr> <tr> <td><input 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Other Problems that are not listed above:

When did the problem start?

Have you ever witnessed or experienced a traumatic event that involved death or serious injury? No Yes

Details:

Any history of violence? Against Property Against People Only Thoughts of

Details:

Please list all of your current medications including over the counter pills:

Medication	Duration	Dosage	Medication	Duration	Dosage

Are you on birth control? No Yes ***Are you pregnant?*** No Yes



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1. PAST PSYCHIATRIC HISTORY

Have You Ever Been Admitted To A Psychiatric Hospital: No Yes Number of times: ____

Date of Last hospitalization: ____/____/____

Date of First Hospitalization: ____/____/____

Have you seen a psychiatrist? No Yes **How about a therapist:** No Yes

Any history of: Suicidal thoughts Suicidal Gestures Suicide Attempts History of –self harm/self-mutilation

Please Explain: _____

Have you ever taken any psychiatric medications other than those listed as current? Please list:

Medication	Dates/Duration	Dosage	Response	Reason Discontinued

2. SUBSTANCE ABUSE HISTORY – please complete if applicable

	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
Alcohol							
Caffeine (pills or beverages)							
Cocaine							
Crystal Meth-Amphetamine							
Heroin							
Inhalants							
LSD or Hallucinogens							
Marijuana							
Methadone							
Pain Killers							



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	No	Yes/Past or Yes/Now	Route	How Much	How Often	Date/Time of Last Use	Quantity Last Used
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Nicotine							
Other							

Have you ever been arrested or convicted? No Yes: When _____ for (check below):

DWI Drug Related Domestic Violence Other: _____

Please explain: _____

Do you have a P.O.? Yes No Name: _____ What County? _____

Charge? _____

Please continue to the next page



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Have you ever been in drug treatment in any of the following settings:

Treatment	Date(s)	Provider's Name	Place of Treatment
Outpatient SA Counseling			
IOP			
Detox Program			
Residential Treatment			
Suboxone Medication			
Other:			

Do you have any concerns about these items below:

1. Decrease in food intake and/ or appetite: No Yes (explain): _____

2. Weight loss or gain of 10 lbs. in the last 3 months: No Yes (explain): _____

3. Dental Problems: No Yes (explain): _____

4. Eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or inducing vomiting:
 No Yes (explain): _____

Would you like a nutrition referral? No Yes

5. Exercise No Yes (explain): _____

6. Video games No Yes (explain): _____

7. Extreme use of internet, social media, pornography No Yes (explain): _____

8. Gambling No Yes (explain): _____

9. Other No Yes (explain): _____



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3. MEDICAL HISTORY

Allergies: Medication NONE or LIST : _____

Food NONE or LIST : _____

Any other Allergies? NONE or LIST : _____

Are you diagnosed with: No current medical problems

Asthma High blood pressure Diabetes Heart Disease Stroke High Cholesterol Thyroid Cancer

Other Medical problems: *please list:* _____

History of Surgeries: No Yes – Details: _____

History of Head Injury: No Yes- **Loss of Consciousness:** No Yes _____

History of Seizures: No Maybe Yes _____

4. FAMILY PSYCHIATRIC HISTORY – Any one in your family suffers from:

Depression Anxiety Disorder Bipolar disorder Alcoholism Drug Abuse Schizophrenia Suicide Homicide

Details: _____

5. SOCIAL HISTORY

Birthplace: _____ # of Siblings: _____ Birth order: _____ Occupation of Mother: _____
Father: _____

History of Abuse: No Yes If yes, was it (circle all that applies) verbal physical sexual

Details: _____

Who raised you: _____ How was your childhood? _____

How far did you go in school? GED: No Yes High School: No Yes

College: _____ Post Grad: _____

Have you skipped a grade: No Yes Were you in Special Education: No Yes

Problems in school: No Yes *Explain:* _____

What do you do for a living? _____ Current Employment: _____

Marital Status: Married In a relationship Single Divorced Separated Widowed # of Children: _____

Sexuality: Heterosexual Homosexual Bisexual Military Experience: No Yes _____

Who do you live with? _____

Current Social Support: _____

Spirituality: _____

Hobbies / Interests: _____



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6. CURRENT HEALTH CARE PROVIDORS: For Permission to Contact any of them, Please check the appropriate box:

PREVIOUS PSYCHIATRIST: _____ Phone (____) _____ - _____

Address: _____ Contact: No Yes

CURRENT PSYCHOTHERAPIST/COUNSELOR: _____ Phone (____) _____ - _____

Contact: No Yes

CURRENT PRIMARY CARE PHYSICIAN: _____ Phone (____) _____ - _____

Address: _____ Contact: No Yes

OTHER: _____ Phone (____) _____ - _____

Address: _____ Contact: No Yes

7. Treatment Goals: (What would you like to achieve from visiting the clinic, please list according to their importance)

(1)

(2)

(3)

Is there anything else you would like to tell us about yourself?

Print Name:

Signature:

Date

Form Filled Out by:

(Print Name) (Signature) (Date) (Relationship to Patient)

Patient or Parent/Guardian of child under the age of 18 must sign above.

This form has been reviewed for completion and accuracy.

(Print Name) (Signature) (Date)

This form has been reviewed by the provider for evaluation purposes.

(Print Name) (Signature) (Date)



Notice of Professional Psychiatric Services General Office and Financial Policies

Patient Name: _____

D.O.B. ____/____/____

We believe it is in the best interest of your care to keep you informed of our office policies. Please carefully read each item below and initial each item if you do not have any questions, followed by your signature at the bottom of page 2. If you have any questions, our staff will be happy to help.

1. All patients who do not have commercial insurance, or have insurance that we are not contracted with, are expected to pay in full at the time services are rendered. ____ **(initial)**
2. For all patients with a commercial insurance policy for a carrier we are contracted with, we will file with your primary insurance company and accept payment per our contracted rate. We will file to your secondary claim up to two times. If we have not received payment after the second filing, the balance will become patient responsibility. You must file your tertiary insurance claims yourself. For any services rendered which are unbillable to your insurance; you will be notified in advance, and payment from the patient is expected at the time of service ____ **(initial)**
3. Prior to your visit at our office, we will contact your insurance company to verify your benefits under your plan. Please remember that each individual plan is different so we will never know exactly how your insurance will pay your claim until it is processed by your insurance company. With the information you provide, we will be able to determine the approximate payment due at the time services are rendered as well as learn of any authorizations required by your plan. ____ **(initial)**
4. You agree to provide our office with any changes in insurance. You agree to provide us with a copy of your insurance card any time there is a change. If we do not have the correct insurance information on file, you will be responsible for the full amount owed. ____ **(initial)**
5. If you have a copay, it must be paid in full at the time of your visit. This is in accordance with your insurance agreement. If you have a deductible and it has not yet been satisfied, you must pay 100% of the billed charges at the time of your visit. If you have a co-insurance plan, you will be charged a percentage of the billed charges for your visit. ____ **(initial)**
6. In the event of an overpayment, you may choose to have the funds refunded to you or we can apply them to future dates of service. However, refunds less than \$100.00 will not be issued if there are outstanding insurance claims. ____ **(initial)**
7. In the event of a balance due, we request that payment and/or arrangements be made within 30 days. The office will mail out statements monthly. It is your responsibility to ensure that we have the correct address on file. Our office will also keep you informed of any balance you may have. It is our policy that the ability to receive services might be suspended if your current balance exceeds \$200 unless a payment agreement is in writing and is approved by the office manager to overcome the unpaid balance. If you have a question regarding your balance, please contact the billing department. ____ **(initial)**
8. Please remember that, just as PPS has a contract with your insurance company, you do as well. In order for us to be contractually obligated to accept the payment and discounts your insurance offers you, you must follow the guidelines set forth by your insurance carrier. It is your responsibility to participate in the insurance guidelines, which includes prompt payment of services rendered, or your contract may be voided. ____ **(initial)**

**Notice of Professional Psychiatric Services
General Office and Financial Policies page 2**

Patient Name: _____

D.O.B. ____/____/____

9. Visit Authorizations: PPS will keep track of the number of visits in regards to any authorizations required by your insurance. However, please be aware that this is also your responsibility. You are required to know the benefits of your plan, the number of visits allowed, and if further authorizations are required. _____ **(initial)**

10. Appointment Reminders: As a courtesy, PPS will set up automated appointment reminders. You will receive a reminder text at least 48 hours prior to your upcoming appointment. It is your responsibility to provide PPS with the correct phone number for the automated texts. Therefore, our no show/late cancel policy is strictly enforced. You will be charged \$60.00 per missed visit/ late cancel visit unless you call us 24 hours before your appointment. _____ **(initial)**

11. Re-establishing services: If you are not seen at the regularity of your provider's request or within a 3-month window, you will be considered discharged from the agency and will be required to re-establish as a new patient if you want to restart services. If you are participating in our OMT program and are not seen in over a month you may be required to re-establish as a new patient. _____ **(initial)**

12. Form Requests / Medical Records: If you need forms completed or records sent outside of the office, we will be happy to do so. You will need to schedule a specific paperwork appointment in order to get forms completed by your provider. Records requests will be executed within 30 business days of your signing the release form. *Please ask staff for a Release of Information Form.* There is a charge per page and/or per request. There is an additional fee if you need the request expedited. All of these charges are in line with industry standards, and are usually not covered by your insurance. Payment is expected for these services at the time of the request. _____ **(initial)**

By signing below, I agree that I have read and understand the financial policies above. I understand that I am responsible for all charges that are not covered by my insurance, and in the event of a no show/late cancel or form requests/medical records request; these charges are completely my responsibility and my insurance carrier/third party payor will not be billed.

Patient Printed Name

_____/_____/_____
Date

Patient / Parent / Legal Guardian Signature



PATIENT INFORMATION

DATE: _____

Patient's Name: _____ Date of Birth: _____
Street Address: _____ City _____ State: _____ Zip: _____
Cell Phone #: () _____ Home Phone #: () _____ Work #: () _____
Social Security #: _____ Sex: M F Marital Status: _____ Race: _____
Patient's Employer: _____ Occupation: _____
Contact in Case of Emergency: _____ Phone #: () _____
Family Doctor: _____ Referring Doctor: _____

Preferred Contact Phone #: () _____ PPS may leave PHI on my answering machine /voicemail: Yes No
PPS may leave the following: appointment information detailed information test or lab results response to my inquiry /question
Email Address: _____ PPS may email appointment reminders: Yes No

Insurance Information: Please give receptionist your card(s)

Primary Insurance: _____ Phone #: () _____
Insured Name: _____ Relation to Patient: _____
Insured Policy ID#: _____ Group #: _____
Insured DOB: _____ Insured Employer: _____ Insured S.S.#: _____
Insurance coverage provided through Employer Individual Policy Workers Comp Auto Accident Policy

Secondary Insurance: _____ Phone #: () _____
Insured Name: _____ Relation to Patient: _____
Insured Policy ID#: _____ Group #: _____
Insured DOB: _____ Insured Employer: _____ Insured S.S.#: _____
Insurance coverage provided through Employer Individual Policy Workers Comp Auto Accident Policy
If Medicare is secondary circle reason: working spouse has insurance Veteran disabled other: _____

If Patient is a Minor:

Mother's Name: _____ Date of Birth: _____ Home PH # () _____
Mother's Employer: _____ Bus. PH #: () _____ Social Security #: _____
Father's Name: _____ Date of Birth: _____ Home PH # () _____
Father's Employer: _____ Bus. PH #: () _____ Social Security #: _____

Please read and sign below:

I certify that the information given by me in applying for payment under Title XVII of the Social Security Act is correct. I authorize my physician to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare/insurance claim. I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician services to my physician on claims for which they have accepted assignment and I authorize the physician to submit a claim to Medicare for payment on my behalf. I request payment under the medical insurance program be made to my physician on any bills for services furnished me by my physician for which they have accepted assignment. I further release my physician to release medical information concerning my treatment to Blue Shield or other insurance carriers and authorize payment of medical benefits from those carriers to be made directly to my physician on claims for which they have accepted the assignment. I also understand that I am responsible for payment for services not covered by the Medicare program or my insurance carrier.

I also authorize my physician's office to provide my medical information to other organizations or entities for the determination and payment of benefits. I authorize my physician's office to permit my insurance companies or third party payors to review / audit my medical chart if they so request. I assign benefits otherwise payable to me to my physician. I understand that I am financially responsible for the charges for any services rendered to me by my physician(s).

I have reviewed the practice's PRIVACY POLICY _____ (INITIAL HERE)

I have reviewed the OFFICE FINANCIAL POLICY _____ (INITIAL HERE)

I have reviewed the CONSENT for TREATMENT _____ (INITIAL HERE)

I understand that copies are available upon request.

Signature: _____ Date: _____

If this is a worker's compensation visit or auto accident account we must have that information on an additional form. Please ask the receptionist for the appropriate paperwork.

PRIVATE INSURANCE REQUIRES A COPAY TO BE PAID AT THE TIME OF SERVICE, if applicable.

