LAST NAME:_____ **FIRST NAME**_____

DOB: ____/____/____

PSYCHIATRIC INTAKE AND TREATMENT PLAN-PART I

TO BE FILLED BY PATIENT

PLEASE PRINT

Date:	Age:	Gender: ☐ M ☐ F
Current address:		☐ Married. ☐ Single ☐ Separated ☐ Divorced ☐ Widowed

If patient is a child, he/she lives 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:

P	C		P	C	
☐	☐	depression	☐	☐	increased energy (even when not sleeping)
☐	☐	changes in appetite: ___increase ___decrease	☐	☐	racing thoughts
☐	☐	sleep disturbance	☐	☐	panic attacks
☐	☐	fatigue	☐	☐	anxiety
☐	☐	low self-esteem	☐	☐	irritability
☐	☐	thoughts of suicide	☐	☐	muscle tension
☐	☐	getting into fights	☐	☐	obsessions (intrusive repetitive thoughts)
☐	☐	wishing you were dead	☐	☐	specific fears or phobias
☐	☐	manic episodes	☐	☐	compulsions (repetitive acts that are unreasonable)
☐	☐	anger	☐	☐	easily distracted
☐	☐	forgetfulness	☐	☐	hallucinations
☐	☐	impulsivity	☐	☐	paranoia
☐	☐	homicide thoughts	☐	☐	mood swings
☐	☐	pain, if not receiving treatment would you like a referral: ☐y ☐n			

Other problems 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? ☐No ☐Yes : ☐ Against Property ☐ Against People ☐ Only Thoughts of Violence
Details:

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

Medication	Duration	Dosage	Medication	Duration	Dosage
1.			6.		
2.			7.		
3.			8.		
4.			9.		
5.			10.		

Are you on birth control? ☐No ☐Yes: _____ Are you pregnant? ☐No ☐Yes

LAST NAME:_____FIRST NAME_____

DOB: ____/____/____

1. *PAST PSYCHIATRIC HISTORY*

Have you received services from:	Reason	Name	Location	Date(s)	Cause of termination (if applicable)
Counselor					
Psychiatrist					
Hospitalization					

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 on page 1*? Please list:

Medication	Dates / Duration	Dosage	Response	Reason Discontinued

Family Psychiatric History: ☐No ☐ Yes If yes, please explain

Relationship	Diagnosis
	1. _____ 2. _____ 3._____
	1. _____ 2. _____ 3._____

LAST NAME:_____FIRST NAME_____

DOB: ____/____/____

2. *SUBSTANCE USE 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							
PCP							
Stimulants (pills)							
Tranquilizers/ Sleeping Pills							
Ecstasy							
Nicotine							
Other							

Have you ever been in drug/ alcohol treatment in any of the following settings?

Treatment	Date(s)	Facility Name	Location
Outpatient Counseling / IOP			
Detox Program			
Residential Treatment			
Other:			

3. LEGAL HISTORY

Have you ever been arrested or convicted? ☐No ☐Yes For: ☐ DWI ☐ Drug Related ☐ Domestic Violence ☐ Other: _____

When (Dates): _____

Please explain: _____

_____

Do you currently have a P.O? ☐ No ☐Yes P.O. Name: _____What County? _____

Charge(s)? _____

_____

Please continue to the next page

LAST NAME:_____FIRST NAME_____

DOB: ____/____/____

3. MEDICAL HISTORY

☐ No History of medical problems

Have you been diagnosed with:

☐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 _____

Allergies: Medication ☐ NO ☐ YES List: :_____

Food ☐ NO ☐ YES List: :_____

Any other Allergies? ☐ NO ☐ YES List: :_____

Current PCP Name: _____ Location: _____

When was your last office visit? _____ Would you like us to contact them? ☐No ☐Yes PCP Phone#: _____

Do you have any concerns about these items below?

1 Eating habits ☐No ☐Yes (explain): _____

Has there been a change in weight in the last 3-6 months? ☐No ☐Yes (Please circle) ↑ ↓ How much? _____

2. Exercise Routine: ☐No ☐Yes (explain): _____

3. Video games ☐No ☐Yes (explain): _____

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

_____

5. Gambling: ☐No ☐Yes (explain): _____

6. Other: ☐No ☐Yes (explain): _____

Professional Psychiatric Services

LAST NAME:_____ **FIRST NAME**_____

DOB: ____/____/____

4. 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 emotional

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: _____

Relationship Status: ☐Married ☐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: _____

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.

_____	_____	___/___/___
(Provider Name)	(Provider 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)**

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 ready and understand the financial policies above. I understand that I am responsible for all charges that are not covered by my insurance, an 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.

Professional Psychiatric Services

PATIENT NAME: _____

DOB: _____/_____/_____

SS#: _____

CONSENT TO TREAT

I hereby certify that Professional Psychiatric Services Physician, Clinician or Independent Contractor providing services has informed me of their professional qualifications, certifications and/or licensure; has provided both an explanation of client's rights and responsibilities, has made the privacy notice available and has informed me of their assessment, diagnosis, and treatment plan. By signing below, I agree to participate in the proposed treatment as recommended.

_____ _____

Patient Signature Date Physician, Clinician or Independent Contractor Date

If treatment is for a minor,

I _____ custodial parent / legal guardian of:
(Name of parent/legal guardian)

_____, age _____, authorize
(Name of Minor) (Age of Minor)

Professional Psychiatric Services to assess and treat my child in an outpatient mental health setting. I agree to take part in the process as needed, and understand the forma of treatment nay include any combination of the following: individual sessions with minor child, family sessions and sessions with parental unit(s).

_____ _____

Parent/Legal Guardian Signature Date Physician, Clinician or Independent Contractor Date