HARBOR PSYCHIATRY & MENTAL HEALTH

4631 Teller Ave #100 Newport Beach, CA 92660 Phone: 949-887-7187 Fax 949-476-3080

PATIENT REGISTRATION INFORMATION

Patient's Last Name: _____Patients First Name:_____

Date of Birth: _____ Sex: Male/Female Marital Status:_____

Full SSN: _____ Phone #: _____

Full Home Address:

_____

Street City State Zip Code

Do you consent to receive automated reminder calls at this phone number? Yes/ No
If Yes, please sign_____
Email: _____
Do you consent to allowing any/ all communication (medical &/or mental documentation, billing statements and financial information) being sent to the email address above? Yes / No
Emergency Contact: _____ Phone #:_____
Relation to Patient: _____
Preferred Pharmacy:

_____

Name Location Phone #

How did you hear about our clinic?

_____

INSURANCE INFORMATION

(Please give your insurance card & driver's license to receptionist)

Person responsible for bill: _____DOB: _____
Address: _____Phone #: _____

PRIMARY INSURANCE

Insurance Company: _____ Member/Subscriber ID:_____
Subscriber's Name: _____ Relationship to Subscriber:_____
Subscriber's SSN: _____ DOB:_____Copayment $_____
Policy #: _____ Auth#:_____
if applicable CalOptima/MediCal Members Only

SECONDARY INSURANCE if APPLICABLE

Insurance Company: _____ Member/Subscriber ID:_____
Subscriber's Name: _____ Relationship to Subscriber:_____
Subscriber's SSN: _____ DOB:_____Copayment $_____
Policy #: _____

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NOTICE OF PRIVACY PRACTICES - Psychology & Psychiatry Services

This notice describes how psychological and medical information about you may be used and disclosed and how you can get access to this information.

The following information provides details about the provisions of the Health Insurance Portability and Accountability Act (HIPAA) and your rights concerning privacy and your psychological records. HIPAA requires that we provide you with a Notice of Privacy Practices for treatment, payment and health care operations. The law requires that we obtain your signature acknowledging that we have provided or offered you this information.

Disclosures for treatment, payment, and healthcare operation

We may use or disclose your **protected health information** (PHI), for certain treatment, payment, and health care operations purposes without your authorization. In certain circumstances we can only do so when the person or business requesting your PHI gives us a written request that includes certain promises regarding protecting the confidentiality of your PHI.

Uses/disclosures requiring authorization

We may use or disclose the minimum necessary PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. In those instances when we asked for information for purposes outside of treatment and payment operations, we will obtain an authorization from you before releasing this information. We will also need to obtain an authorization before releasing your psychotherapy & medication management notes. These are notes we have made about our conversation during a private, group, joint, or family therapy session, which we have kept separate from the rest of your medical record. These notes are given a greater degree of protection than PHI.

You may revoke or modify all such authorizations (of PHI or psychotherapy notes) at any time; however, the revocation or modification is not effective until we receive it. When the state (California) laws are more protective than HIPAA, the more stringent requirements will apply.

Possible uses with neither consent nor authorization

We may use or disclose the minimum necessary PHI without your consent or authorization in the following circumstances:

. **Child Abuse**: Whenever we, in our professional capacity, have knowledge of or observe a child, or reasonably suspect, a child under age 18 has been the victim of abuse or neglect, we must immediately report such to a police department or sheriff's department, county probation department, or county welfare department. Also, if we have knowledge of or reasonably suspect that mental suffering has been inflicted upon a child or that his or her emotional well-being is endangered in any other way, we may report such to the above agencies.

. **Elder and Dependent Adult Abuse**: If we, in our professional capacity, have observed or have knowledge of an incident that reasonably appears to be physical abuse, abandonment, abduction, isolation, financial abuse or neglect of an elder or dependent adult, or if we are told by an elder or dependent adult that he or she has experienced these or if we reasonably suspect such, we must report the known or suspected abuse immediately to the adult protective services agency or the local law enforcement agency.

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We do not have to report such an incident if:

1) We have been told by an elder or dependent adult that he or she has experienced behavior constituting physical abuse, abandonment, abduction, isolation, financial abuse or neglect;
2) We are not aware of any independent evidence that corroborates the statement that the abuse has occurred;

3) the elder or dependent adult has been diagnosed with a mental illness or dementia, or is the subject of a court-ordered conservatorship because of a mental illness or dementia; and
4) in the exercise of clinical judgment, we reasonably believe that the abuse did not occur.

- **Serious Threat to Health or Safety**: If you or your family member communicate to me that you pose a serious threat of physical violence against an identifiable victim, we must make reasonable efforts to communicate that information to the potential victim and the police. If we have reasonable cause to believe that you are in such a condition, as to be dangerous to yourself or others, we may release relevant information as necessary to prevent the threatened danger.
- **Health Oversight**: If a complaint is filed against us with the California Board of Psychology, the Board has the authority to subpoena confidential mental health information from us relevant to that complaint.
- **Judicial or Administrative Proceedings**: If you are involved in a court proceeding and a request is made about the professional services that we have provided you, we must not release your information without 1) your written authorization or the authorization of your attorney or personal representative; 2) a court order; or 3) a subpoena duces tecum (a subpoena to produce records) where the party seeking your records provides us with a showing that you or your attorney have been served with a copy of the subpoena, affidavit and the appropriate notice, and you have not notified us that you are bringing a motion in the court to quash (block) or modify the subpoena. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court- ordered. We will inform you in advance if this is the case.
- **Worker's Compensation**: If you file a worker's compensation claim, we may disclose to your employer your medical information created as a result of employment-related health care services provided to you at the specific prior written consent and expense of your employer so long as the requested information is relevant to your claim provided that is only used or disclosed in connection with your claim and describes your functional limitations provided that no statement of medical cause is included.

Your rights regarding your protected health information (PHI)

. *Right to Request Restrictions* –You have the right to request restrictions on certain uses and disclosures of PHI about you. However, we are not required to agree to all restrictions you request. An important exception is your right to request non- disclosure to your health plan for which you pay out-of-pocket unless the disclosure is for treatment purposes or in the rare event disclosure is required by law.

. *Right to Receive Confidential Communications by Alternative Means and at Alternative Locations* – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, we will send your bills to another address.)

. *Right to Inspect and Copy* – You have the right with your written request to inspect or obtain a copy (or both) of PHI and/or psychotherapy notes in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. On your request, I will have 30 days to respond to your request with one 30-day extension and will discuss with you the details of the request and denial process. There will be a small charge to cover the cost of paper copies and labor. We must provide you access to electronic health records and other electronic records in the electronic form and format requested by the individual if the records are readily reproducible in that format. Otherwise, we must provide the records in another mutually agreeable electronic format. Hard copies are permitted only when you reject all readily reproducible e- formats.

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. *Right to Amend* – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. On your request, we will discuss with you the details of the amendment process.

. *Right to an Accounting* – You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization. On your request, we will discuss with you the details of the accounting process.

. *Right to Prohibit the Sale of PHI* – Your absence of a written authorization means you are prohibiting the sale of your PHI. Marketing or research uses would be examples of reasons to sell PHI.

. *Right to a Paper Copy* – You have the right to obtain a paper copy of the HIPAA Notice from me upon request, even if you have agreed to receive the Notice electronically.

Psychologist's/ Physician's Duties

. We are required by law to maintain the privacy of PHI and to provide you with a notice of our legal duties and privacy practices with respect to PHI.

. We must notify you if unsecured PHI is breached. Because your PHI will be encrypted, no notification will be required. No risk assessment of unsecured PHI will need to be conducted if notification of a breach is made.

. We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes, however, we are required to abide by the terms currently in effect.

. We are allowed to send unencrypted emails if you are advised of the risk and still request that form of transmission.

. We are allowed to make relevant disclosures to your family after death under essentially the same circumstances such disclosures were permitted before death.

. We are allowed to tell you about a third-party product or service without your written authorization when: we receive no compensation for that product or service, our communication with you is face to face, it involves general health promotion, and/or it involves government or government-sponsored programs.

. If we revise my policies and practices (indicated in the HIPAA Notice), we will provide current clients with a revised notice, at their request, in person or by mail to their home address. All new clients receive a copy during their first session.

Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Harbor Psychiatry and Mental Health at (949) 887-7187.

I have read and understand the above Notice of Privacy Practices.

_____

Patient/Parent/Guardian Signature

_____ _____

Please print name Date

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Welcome to our Practice.

This document contains important information about our professional services and business policies. It also contains summary information about the Health Insurance Portability and Accountability Act (HIPAA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and health care operations. Although these documents are long and sometimes complex, it is very important that you understand them. When you sign this document, it will also represent an agreement between us. We can discuss any questions you have when you sign them or at any time in the future.

PSYCHOLOGICAL SERVICES

Therapy is a relationship between people that works in part because of clearly defined rights and responsibilities held by each person. As a client in psychotherapy, you have certain rights and responsibilities that are important for you to understand. Your therapist has corresponding responsibilities to you. These rights and responsibilities are described in the following sections.

Psychotherapy has both benefits and risks. Risks may include experiencing uncomfortable feelings, such as sadness, guilt, anxiety, anger, frustration, loneliness and helplessness, because the process of psychotherapy often requires discussing unpleasant aspects of your life. However, psychotherapy has been shown to have benefits for individuals who undertake it. Therapy often leads to a significant reduction in feelings of distress, increased satisfaction in interpersonal relationships, greater personal awareness and insight, increased skills for managing stress and resolutions to specific problems. But, there are no guarantees about what will happen. Psychotherapy requires a very active effort on your part. In order to be most successful, you will have to work on things we discuss outside of sessions.

The first 2-4 sessions will involve a comprehensive evaluation of your needs. By the end of the evaluation, I will be able to offer you some initial impressions of what our work might include. At that point, we will discuss your treatment goals and create an initial treatment plan. You should evaluate this information and make your own assessment about whether you feel comfortable working with your therapist. If you have questions about their procedures, they should be discussed whenever they arise. If your doubts persist, your therapist will be happy to help you set up a meeting with another mental health professional for a second opinion.

THERAPY APPOINTMENTS

As a typical rule, we will be reserving one (1) hour per week (or as often as treatment plan prescribes) to hold your place. If you need to cancel or reschedule a session, we ask that you provide us with a minimum of 24-hours' notice. If it is possible, we will try to find another time to reschedule the appointment. In addition, you are responsible for arriving for your session on time; if you are late, your appointment will still need to end on time.

PROFESSIONAL FEES FOR MEDICATION MANAGEMENTS

The standard fee for the initial visit (without insurance) is $300.00, and each subsequent visit is $150.00. You are responsible for paying at the time of your appointment unless prior arrangements have been made. Any checks returned by your bank as unpayable are subject to an additional fee of $25.00 to cover bank fees that we incur. If you refuse to pay your debt, we reserve the right to use an attorney/ collections agency to secure payment.

PROFESSIONAL FEES FOR THERAPY

The standard fee for the initial intake (without insurance) is $200.00, and each subsequent visit is $100. You are responsible for paying at the time of your session unless prior arrangements have been made. Any checks returned

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by your bank as unpayable are subject to an additional fee of $25.00 to cover bank fees that we incur. If you refuse to pay your debt, I reserve the right to use an attorney/ collections agency to secure payment.

PRORATED FEES

In addition to weekly appointments, it is our practice to charge this amount on a prorated basis (we will break down the hourly cost) for other professional services that you may require such as report writing, telephone conversations that last longer than 15 minutes, attendance at meetings or consultations which you have requested, or the time required to perform any other services which you may request of your therapist. If you anticipate becoming involved in a court case, we recommend that we discuss this fully before you waive your right to confidentiality. If your case requires our participation, you will be expected to pay for the professional time required even if another party compels testimony.

CONFIDENTIALITY/ NOTICE OF PRIVACY PRACTICE

Our policies about confidentiality, as well as other information about your privacy rights, are fully described in a separate document entitled Notice of Privacy Practices. If you would like a complete copy of this, please ask at the front desk. Please remember that you may reopen the conversation at any time during our work together.

PARENTS & MINORS

While privacy in therapy is crucial to successful progress, parental involvement can also be essential. It is our policy not to provide treatment to a child under age 13 unless s/he agrees that I can share whatever information I consider necessary with a parent. For children 14 and older, I request an agreement between the client and the parents allowing me to share general information about treatment progress and attendance, as well as a treatment summary upon completion of therapy. All other communication will require the child's agreement, unless I feel there is a safety concern (see also above section on Confidentiality for exceptions), in which case I will make every effort to notify the child of my intention to disclose information ahead of time and make every effort to handle any objections that are raised.

LIMITS OF CONFIDENTIALITY

The law protects the privacy of all communications between a patient and a licensed clinical psychologist. In most situations, a psychologist can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements imposed by HIPAA. However, there are some situations in which a psychologist may be permitted or required to disclose information without the patient's consent or authorization. These situations include:

1. If there is a reasonable suspicion or evidence that a child under age 18 is suffering or has been the victim of child abuse (including sexual and physical abuse, and neglect), the law requires that a report be filed with the appropriate governmental agency (Child Protective Services) and legal authorities. A report may also be made if we know or reasonably suspect emotional abuse of mental suffering inflicted upon a child.

2. If we have reasonable suspicion or evidence that an elder or dependent adult is suffering or has been the victim of abuse (including sexual, physical, emotional and financial abuse, neglect, abandonment, abduction, isolation), the law requires that we report to legal authorities and/or the State Department of Social Services.

3. If a patient (or a family member of the patient) communicates an imminent threat of physical violence against an identifiable victim (the patient's intent to harm or plan to harm), we are required to take protective actions including notifying the potential victim (s), and contacting the police. We may also seek hospitalization for the patient.

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4. If a patient communicates intent and/or a plan to harm himself/herself (commit suicide), we are required to notify legal authorities and make reasonable attempts to protect the patient including seeking hospitalization and notify family members who can help provide protection.

CONTACTING YOUR PSYCHIATRIST/ THERAPIST

Your psychiatrist/ therapist may often not be immediately available by telephone. They will not answer their phones when they are with clients or otherwise unavailable. At these times, you may leave a message or send an email and your call/ email will be returned as soon as possible, but it may take a day or two for non-urgent matters. If, for any number of unseen reasons, you do not hear back from or they are unable to reach you, and you feel you cannot wait for a return call or email, or if you feel unable to keep yourself safe, go to your local Hospital Emergency Room or call 9-1-1 and ask to speak to the mental health worker on call.

____Initials ----- NO-SHOW or CANCELLATION

If you miss an appointment without canceling or cancel with less than a 24-hour notice, the policy is to collect a $50 or $75 fee (unless it is agreed that you were unable to attend due to circumstances beyond your control). It is important to note that insurance companies do not provide reimbursement for cancelled sessions; thus you will be responsible for the fee described above.

CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I ;_____

HEREBY AUTHORIZE: Providers at Harbor Psychiatry & Mental Health TO TRANSMIT TO ME BY NON-SECURE MEDIA THE FOLLOWING TYPES OF PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

. Information related to the scheduling of meetings or other appointments
. Information related to billing and payment

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means. I understand that I am not required to sign this agreement in order to receive treatment. I also understand that this authorization will terminate at the end of my treatment or I may terminate this authorization at any time.

CONSENT FOR PSYCHOTHERAPY

Your signature below indicates that you have read this Agreement and the Notice of Privacy Practices and agree to their terms.

I understand & agree to the clinic policy with regards to missed appointments and outstanding balances

_____ _____

Signature of Patient/Representative Date

_____

Printed Name of Patient/ Representative

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Permission to Verbally Discuss Protected Health Information

Harbor Psychiatry and Mental Health knows that privacy regulations have an impact on our customer service to you, especially when it comes to discussing information about you with family, friends and others you designate who are involved in your care. We have established a process that allows you to tell us who we may talk with about your medical care. This includes appointment and scheduling information, lab and test results, treatment information and billing information.

How can I give others permission to get verbal information about me?
Complete the Permission to Verbally Discuss Protected Health Information form on the reverse side of this page to let us know to whom we may speak about your information. Check the appropriate boxes to indicate what information we may discuss. You may also send us a letter with this information.

How is the information on the form used?
Anytime your designated person calls or makes a request on your behalf, we will verify the individual has your permission to receive the information and then we will share the information.

What are some examples of when this might be useful?

- If an elderly parent wants an adult child to help understand medical treatment instructions
- If an adult child is helping with billing questions
- If a friend is helping an elderly patient with health issues
- If a college student wants information shared with a parent
- If an adult child calls to find out his/her parent's appointment time

Can the person I designate also get copies of my medical records?
No, they can only receive verbal information. To get copies of medical records, you must complete a separate Authorization form available at our office, or by calling 949-887-7187.

What if I change my mind?
You can change or revoke (stop) this process at any time by writing to us at the address shown below, or by calling 949-887-7187.

What happens if I don't complete this form?
We will continue to protect your private health information as required by law.

Where do I send the completed form or any changes?
Mail to: Harbor Psychiatry and Mental Health
4631 Teller Ave Suite 100
Newport Beach, CA 92660
Or Fax to
949-476-3080

_____ _____
Name of person to share information with Relationship to patient

_____ _____
(Signature of Patient) (Date)

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FINANCIAL RESPONSIBILITY

Harbor Psychiatry and Mental Health participates with most major health plans and will accept payment directly from them. As a courtesy to you, we will send claims in to your primary, and secondary carriers, if necessary. However, it is important that you understand your insurance policy and benefits are an arrangement (contract) between you and your insurance company. You are personally responsible for all allowable fees as directed by your insurance company, as well as non-covered services that you have agreed to. These fees are usually categorized as a Copay, a Co-Ins (percentage), or a Deductible. Certain insurance plans will authorize a specific number of visits for a certain period of time. Please be sure that you are aware of these details, as you will be personally liable for any visits that fall outside of that scope and are denied by your plan. When in doubt, please verify this information with your insurance company. Our staff will make their best effort to verify insurance eligibility and benefits, but ultimately it is the patient's responsibility to know their policy and coverage. All patients that present without valid insurance information will be considered a Self-Pay Patient and will be required to pay at the time service is rendered, unless prior arrangements have been made.

I have read and understand Harbor Psychiatry & Mental Health's financial responsibility agreement.

_____ _____

Patient Printed Name Patient Signature, if of legal age.

_____

Date

_____ _____

Parent/Guardian Printed Name Parent/Guardian Signature

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MEDICATION APPOINTMENT CANCELLATION / NO SHOW POLICY

Thank you for trusting your psychiatric care to Harbor Psychiatry & Mental Health. When you schedule an appointment we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment.

Please see our Appointment Cancellation / No Show Policy below:

Effective **October 1, 2019**

- Any established patient who fails to show or cancels / reschedules an appointment and has not contacted our office with at least **24 hours notice** will be considered a No Show and charged a **$50.00 fee.**
- Any established patient who fails to show or cancels / reschedules an appointment with no 24 hour notice a **second time** will be charged a **$75.00 fee.**
- If a **third** No Show or cancellation / reschedule with no 24 hour notice should occur the patient may be **dismissed** from Harbor Psychiatry & Mental Health.
- The fee is charged to the patient, not the insurance company, and is **due at the time of the patient's next office visit.**
- As a courtesy, when time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above policy will remain in effect.
- Failure to adhere to a treatment plan may result in termination / dismissal of care from Harbor Psychiatry & Mental Health.

Cal-Optima Patients:

- Any established patient who fails to show or cancels / reschedules an appointment and has not contacted our office with at least 24 hours notice will be considered a No Show.
- Any established patient who fails to show or cancels an appointment without a 24 hour notice a **second time can no longer make a scheduled appointment and can only be seen with a same day appointment or as a walk-in.** Please be aware that there is no guarantee that you will be seen on a walk-in appointment and there may be a long wait time. It's advised that you call the office the morning that you wish to be seen.
- Any established patient who fails to show to **3 appointments** including therapy and or same day appointments may be **dismissed** from Harbor Psychiatry & Mental Health.
- Failure to adhere to treatment plan may result in termination / dismissal of care from Harbor Psychiatry & Mental Health.

I have read and understand the Medical Appointment Cancellation / No Show Policy and agree to its terms:

_____ _____

Signature of Patient/Representative Date

_____

Printed Name of Patient/ Representative

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HPMH PSYCHOTHERAPY NO-SHOW AND CANCELLATION POLICY

Please be aware that our providers block 40-60 minutes of their time when you schedule a therapy appointment. When a client no-shows to their appointment, or cancels an appointment that goes unfilled, our provider is not compensated for that time that they have reserved for you. For this reason, we require that clients in therapy show a level of commitment and responsibility that allows for therapy to be successful, and also allows our practice to continue providing care. Remember that if our providers are not adequately compensated for their work they cannot be here to help our clients.

Effective October 1, 2019

1. Recurring therapy appointments cannot be scheduled beyond 6 weeks.
2. If a client fails to show to an initial psychotherapy appointment, they incur a $75 no-show fee and will not be given another appointment until that no-show fee is paid.
3. In order to schedule recurring appointments, there will need to be a credit card on file and any no shows will be automatically charged to that card.
4. If a client cancels or reschedules 2 consecutive therapy appointments with 24 notice, the client can no longer schedule recurring appointments and all future recurring appointments will be automatically cancelled. This is an indication that the client may no longer be committed to recurring therapy.
5. If a client no-show to 3 psychotherapy appointments, HPMH may terminate therapy services at the provider's discretion due to the patients lack of commitment to treatment.
6. Failure to show to a same day therapy appointment is considered a no-show and a no-show fee applies

CalOptima Patients:

1. Recurring therapy appointments cannot be scheduled beyond 6 weeks.
2. If a patient fails to show to an initial psychotherapy appointment they will not be given another appointment.
3. The first no-show is waived.
4. On the 2nd no-show all future recurring appointments are cancelled, and the client can no longer schedule recurring appointments and can only schedule therapy one appointment at a time.
5. If a patient no-show to 3 psychotherapy appointments, HPMH may terminate therapy services at the provider's discretion due to the patient's lack of commitment to treatment.
6. If a client cancels or reschedules 2 consecutive therapy appointments with 24 notice, the client can no longer schedule recurring appointments and future recurring appointments will be automatically cancelled. This is an indication that the client may no longer be committed to recurring therapy.
7. Failure to show to a same day therapy appointment is considered a no-show.

_____ _____

Signature of Patient/Representative Date

_____

Printed Name of Patient/ Representative

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Psychological Testing No-Show Policy / Spravato Treatment No-Show Policy

Psychological Testing

There is a great deal of staff time and effort that goes into obtaining insurance authorization for psychological testing. Additionally we must block out 2 hours from the providers schedule for the patient. For these reasons we require a 72 hour notice for all psychological testing appointment cancellations. Failure to do so will result in a $150 No Show fee.

Additionally for patients with CalOptima, failure to provide 72 hour notice for these types of appointments will also result in not being able to make appointments in advance and therefore needing to make appointments "Same-Day". There is no guarantee there will be open appointment availability for same day testing appointments.

Spravato Treatment

We must reserve a treatment room for 2.5 hours, and set aside provider time for each patient that is undergoing Spravo treatment. There is also time that goes into obtaining insurance authorization, scheduling and delivery of the medication. For these reasons, we require 72 hour notice for all appointment cancellations. Failure to do so will result in at $150 No Show fee. For patients with CalOptima, failure to provide 72 hour notice for appointment cancellations will result in being required to make appointments only on the day they would like to be seen. There is no guarantee that there will be open appointment availability for day of appointments.

_____
Signature

_____
Patient or Person authorized to Consent

_____
Date

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Mental Health Intake Form

Name_____Date_____
Date of Birth _____ Primary Care Physician_____
Current Therapist/ Counselor_____ Phone_____

What are the problem(s) for which you are seeking help? (Chief Complaint)
1._____
2._____
3._____
What are your treatment goals?
_____
_____
_____
_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( ) Depressed mood	**( ) Racing thoughts**	**( ) Excessive worry**
( ) Unable to enjoy activities	**( ) Impulsivity**	**( ) Anxiety attacks**
( ) Sleep pattern disturbance	**( ) Increase risky behavior**	**( ) Avoidance**
( ) Loss of interest	**( ) Increased libido**	**( ) Hallucinations**
( ) Concentration/forgetfulness	**( ) Decrease need for sleep**	**( ) Suspiciousness**
( ) Change in appetite	**( ) Excessive energy**	**( ) Decreased libido**
( ) Excessive guilt	**( ) Increased irritability**	**( ) _____**
( ) Fatigue	**( ) Crying spells**	**( ) _____**

Past Medical History:
Allergies_____ Current Weight _____ Height _____
List ALL current prescription medications and how often you take them: (if none, write none)

Medication Name	Total Daily Dosage	Estimated Start Date

Current over-the-counter medications or supplements: _____
_____
Current medical problems: _____
_____
_____
_____
_____
Past medical problems, non psychiatric hospitalization, or surgeries: _____
_____
_____
_____

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For Women Only: Are you currently pregnant or do you think you might be pregnant? ( ) Yes ( ) No.
Are you planning to get pregnant in the near future? ( ) Yes ( ) No
Are you breastfeeding? _____
For All Patients: Do you currently drive? ( ) Yes ( ) No

Personal Medical History:

Thyroid Disease ----------	Y__ N__	Diabetes ----------	Y__ N__
Kidney Disease ----------	Y__ N__	Bulimia/ Eating Disorders----------	Y__ N__
Renal Impairment----------	Y__ N__	Mania----------	Y__ N__
Urinary Retention----------	Y__ N__	Cardiomyopathy----------	Y__ N__
Prostatic Hypertrophy----------	Y__ N__	Congestive Heart Disease----------	Y__ N__
Liver Disease ----------	Y__ N__	Electrolyte Abnormalities----------	Y__ N__
Anemia----------	Y__ N__	Arteriovenous Malformation-------	Y__N__
Porphyria----------	Y__ N__	Epilepsy or seizures ----------	Y__N__
Abnormal White Blood Count-------	Y__ N__	Chronic Pain ----------	Y__N__
Asthma----------	Y__ N__	Head trauma ----------	Y__N__
Pulmonary Impairment----------	Y__ N__	Seizures----------	Y__N__
Sleep Apnea----------	Y__ N__	Glaucoma----------	Y__N__
Stomach or intestinal problems---	Y__N__	Tics----------	Y__ N__
Cancer (type) ----------	Y__N__	Parkinson's Disease----------	Y__ N__
Fibromyalgia----------	Y__N__	Confusion or difficulty w/memory-----	Y__ N_
Heart Disease----------	Y__N__	Head injury/ loss of consciousness---	Y__ N__
High Cholesterol ----------	Y__N__	Blurry or Double-vision----------	Y__ N__
High Blood Pressure----------	Y__ N__	Visual, Sensory/Auditory Hallucinations	Y__ N__
Low Blood Pressure----------	Y__ N__	Psychosis----------	Y__N__
Arrhythmia----------	Y__ N__	Abnormal EKG----------	Y__ N__
Cardiac structural abnormalities---	Y__ N__		

Past Psychiatric History:
Outpatient Treatment ( ) Yes ( ) No -- If yes, please describe when, by whom, and nature of treatment.

Reason	Dates Treated	By Whom

Psychiatric Hospitalization ( ) Yes ( ) No If yes, describe for what reason, when and where.

Reason	Date Hospitalized	Where

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Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, Response and Side Effects (if you can't remember all the details, just write in what you do remember).

Antidepressants

Prozac (fluoxetine)_____
Zoloft (sertraline)_____
Luvox (fluvoxamine)_____
Paxil (paroxetine)_____
Celexa (citalopram)_____
Lexapro (escitalopram) _____
Effexor (venlafaxine) _____
Cymbalta (duloxetine) _____
Wellbutrin (bupropion) _____
Remeron (mirtazapine) _____
Silenor (doxepin) _____
Anafranil (clomipramine) _____
Elavil (amitriptyline) _____
Brintellix (vortioxetine)_____
Viibryd (vilazodone)_____
Pristiq (desvenlafaxine)_____
Fetzima (levomilnacipran)_____

Mood Stabilizers

Tegretol (carbamazepine)_____
Lithium_____
Depakote (valproate) _____ _____
Lamictal (lamotrigine) _____
Tegretol (carbamazepine) _____
Topamax (topiramate) _____
Neurontin (gabapentin)_____
Zyprexa (olanzapine)_____
Geodon(ziprasidone)_____
Abilify (aripiprazole) _____

Antipsychotics/Mood Stabilizers	Dates	Dosage	Response/Side-Effects
Seroquel (quetiapine)			
Clozaril (clozapine)			
Haldol (haloperidol)			
Latuda (lurasidone)			
Risperdal (risperidone)			

Sedative/Hypnotics

Ambien (zolpidem) _____
Sonata (zaleplon) _____
Rozerem (ramelteon)_____
Restoril (temazepam) _____
Desyrel (trazodone) _____

ADHD Medications

Adderall (amphetamine) _____
Concerta (methylphenidate) _____
Ritalin (methylphenidate) _____

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Strattera (atomoxetine) _____
Vyvanse_____

Antianxiety Medications

Xanax (alprazolam) _____
Ativan (lorazepam) _____
Klonopin (clonazepam) _____
Valium (diazepam) _____
Tranxene (clorazepate) _____
Buspar (buspirone) _____
Gabapentin_____

Alcohol & Opioid Dependency

Suboxone, Subutex (buprenorphine naloxone)_____
Methadone, Revia (naltrexone)_____
Vivitrol (naltrexone)_____

Family Psychiatric History:

Has anyone in your family been diagnosed with or treated for:

Bipolar disorder	( ) Yes ( ) No	Schizophrenia	( ) Yes ( ) No
Depression	( ) Yes ( ) No	Post-traumatic stress	( ) Yes ( ) No
Anxiety Anger	( ) Yes ( ) No	Alcohol abuse	( ) Yes ( ) No
	( ) Yes ( ) No		
Suicide	( ) Yes ( ) No	Other substance abuse	( ) Yes ( ) No
		Violence	( ) Yes ( ) No

If yes, who had each problem? _____
Has any family member been treated with a psychiatric medication? ( ) Yes ( ) No
If yes, who was treated, what medications did they take, and how effective was the treatment?
Family Medical History: _____
_____
_____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No
If yes, for which substances? _____
If yes, where were you treated and when? _____
_____
On average, how many days per week do you drink any alcohol? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
Have you ever felt you should cut down on your drinking or drug use? ( ) Yes ( ) No
Have people annoyed you by criticizing your drinking or drug use? ( ) Yes ( ) No
Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No
Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No
Have you used any illicit drugs in the past 3 months? ( ) Yes ( ) No
If yes, which ones? _____
Have you ever abused prescription medication? ( ) Yes ( ) No
If yes, which ones and for how long? _____
_____

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Check if you have ever tried the following:

Tobacco History:

How you ever smoked cigarettes? ( ) Yes ( ) No

Currently? **( )** Yes **( )** No How many packs per day on average? _____ How many years? _____

In the past? **( )** Yes **( )** No How many years did you smoke? _____ When did you quit? _____

Pipe, cigars, or chewing tobacco: Currently? **( )** Yes **( )** No In the past? **( )** Yes **( )** No

What kind? _____ How often per day on average? _____ How many years? _____

Family Background and Childhood History:

Were you adopted ( ) Yes ( ) No

Where did you grow up? _____

List your siblings and their ages: _____

Did you parents' divorce ( ) Yes ( ) No If so, how old were you when they divorced?_____

If you parents divorced, who did you live with? _____

Educational History:

Highest Grade Completed? _____ Where? _____

Did you attend college? _____ Where? _____Major? _____

What is your highest educational level or degree attained? _____

Occupational History:

Are you currently: ( ) Working ( ) Student ( ) Unemployed ( ) Disabled ( ) Retired

How long in present position? _____

What is/was your occupation? _____

Where do you work? _____

Relationship History and Current Family:

Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( )Widowed

If not married, are you currently in a relationship? ( ) Yes ( ) No If yes, how long? _____

Have you had any prior marriages? ( ) Yes ( ) No.

Do you have children? ( ) Yes ( ) No If yes, list ages and gender: _____

_____

Trauma History:

Do you have a history of being abused emotionally, sexually, physically or by neglect? ( ) Yes ( ) No.

Legal History:

Have you ever been arrested? _____ Do you have any pending legal problems? _____

Do you have access to guns? If yes, please explain_____

Housing:

List everyone who currently lives with you: _____

SUICIDE RISK ASSESSMENT :

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No.

If YES, please answer the following. If NO, please skip to the next section.

Do you currently feel that you don't want to live? ( ) Yes ( ) No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Do you feel hopeless and/or worthless? _____

Have you ever tried to kill or harm yourself before? _____