Outpatient Intake Form

Patient Medical Record Information

Patient's Name: _____ Today's Date: _____

Social Security #: _____ Date of Birth: _____

Status: ☐ Single ☐ Married ☐ Other Sex: ☐ Male ☐ Female

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell Phone: _____ Emergency #: _____

How did you hear about us? _____

Education Level: ☐ Grade Level ☐ High School ☐ Some College/Tech ☐ College

Occupation: _____ School: _____

Place of Employment: _____

Name of Emergency Contact: _____ Phone #: _____

Relationship to you: _____

Patient's Current Medication (include an approximate time frame)

1. _____ Time Length: ____ Years ____ Months
2. _____ Time Length: ____ Years ____ Months
3. _____ Time Length: ____ Years ____ Months
4. _____ Time Length: ____ Years ____ Months
5. _____ Time Length: ____ Years ____ Months
6. _____ Time Length: ____ Years ____ Months
7. _____ Time Length: ____ Years ____ Months

If you are taking any other medications than what is listed above please provide the doctor with a detailed list

Allergies

Outpatient Intake Form

Health Information

Primary Care Physician: _____ Phone #: _____

Current or past illnesses, injuries, health problems:

Previous Treatment
(*Please provide hospital name as well as date and reason for hospitalization i.e. therapy, hospitalizations, drug/alcohol rehab, etc.*):

Is there a history of mental illness in the family? _____

Has the patient being seen today ever met with another Psychiatrist and/or Therapist? ☐ Yes ☐ No

If yes please provide when and the reason for visit:

Describe why you are seeking counseling and what you are hoping to achieve from it (i.e. therapy goals):

Please place a check by any symptoms or issues you are currently experiencing:

- ☐ Depression
- ☐ Insomnia
- ☐ No Appetite
- ☐ Increased Appetite
- ☐ Fatigue or low energy
- ☐ Irritability
- ☐ Can't make decisions
- ☐ Low Self-Esteem
- ☐ Mood Swings
- ☐ Anger Problems
- ☐ Sexual Problems
- ☐ Suicidal Thoughts
- ☐ Past Suicide Attempts
- ☐ Anxiety
- ☐ Feel tense
- ☐ Constant Worrying
- ☐ Panic Attacks
- ☐ Excessive Fears
- ☐ Withdrawn
- ☐ Excessive Guilt
- ☐ Flashbacks
- ☐ Nightmares
- ☐ Headaches
- ☐ Stomach Problems
- ☐ Hallucinations
- ☐ Memory Problems
- ☐ School/Work Problems
- ☐ Financial Problems
- ☐ Legal Problems
- ☐ Marital/Family Problems
- ☐ Emotional Abuse By Partner
- ☐ Physical/Sexual Partner Violence
- ☐ Emotional Abuse in Childhood
- ☐ Physical Abuse in Childhood
- ☐ Sexual Abuse in Childhood
- ☐ Recent Loss/Greif
- ☐ Abusing Alcohol
- ☐ Abusing Drugs
- ☐ Overly Suspicious/Paranoid

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Payment Information

Name: _____ Social Security # _____

Address: _____ City: _____ State: _____ Zip Code: _____

Phone: _____ Alternate Phone: _____

Insurance Information:

Primary Insurance – Policy Information

Insurance Company: _____ Policy ID #: _____

Policy Holder Name: _____ Date of Birth: _____

Policy Holder SSN: _____ Employer: _____

Secondary Insurance – Policy Information

Insurance Company: _____ Policy ID #: _____

Policy Holder Name: _____ Date of Birth: _____

Policy Holder SSN: _____ Employer: _____

Please complete Parent/Guardian information if patient being seen is under the legal age of 18 years old:

Parent/Guardian: _____ Phone: _____

(Address if Different) _____ *City:* _____ *State:* _____ *Zip:* _____

Parent/Guardian: _____ Phone: _____

(Address if Different) _____ *City:* _____ *State:* _____ *Zip:* _____

I authorized the release of medical information necessary to process this claim. My therapist will bill your insurance company. In the event that my insurance denies payment of a claim, either in whole or in part, I understand I am responsible for the payment in full.

I have obtained the necessary referrals for this visit. If not, I understand I am responsible for all by signing below, I am verifying that the above information provide is true, I have read understand and agree to all terms and conditions listed above.

We accept cash, check and credit card. Please make payment to: **Balanced Minds LLC**

Patient Signature : _____ Date: _____

Parent/Guardian Signature : _____ Date: _____

Bring Your Insurance Information, Picture ID and Co-Payment with You!

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Policies

Psychotherapy Fees:

Initial Evaluation (60 min)	$ 125.00
Psychotherapy (90 min)	$ 150.00
Psychotherapy (55 min)	$ 100.00
Psychotherapy (30 min)	$ 50.00
School Consultation	$ 100.00 (due prior to meeting)
Attendance at Meetings	$ 100.00 (due prior to meeting)
Telephone Sessions	$ 30.00 per 15 min
Letters or Reports	$ 25.00 per page
Forms (i.e. FMLA, work related documents, etc.)	$ 15.00
Return Check fee	$ 35.00
Missed Session/Late Cancellation	$ 45.00

Court Appearance.....$ 600 min charge; $300 deposit required, $175 per hour (after 3 hours)

Please Read and Initial Each Box

	Cancellation Policy: Your appointment time is reserved for you. If you arrive at your session late, the session will end at the regular scheduled time and you will be charged for the full session. If you need to cancel or reschedule, you must provide notice at least 24 hours in advance; otherwise you will be charged for the missed session/late cancellation. Your therapist has the right to terminate services after 2 consecutive missed appointments or irregular attendance problems. *** **Please note: Insurance Companies DO NOT cover Missed Session/Late Cancellation Fees.**
	Confidentiality: The HIPAA Notice of Privacy Practices and Policies given to you explain in detail the ways in which your protected health information may be used and disclosed.
	In Case of Emergency: If you are experiencing a mental health emergency, you may contact your therapist via emergency cell phone number. In the unlikely event that your therapist does not respond within a reasonable time period (usually within one hour), please call the crisis number that corresponds to the county in which you live or call 911.
	Collections: If your account is more than 30 days delinquent and arrangements have not been made, Balanced Minds, LLC reserves the right to use legal means to secure payment. The cost of collection services, attorney fees and court cost will be added to your balance. Please be aware that these actions will require disclosure of confidential information to outside collection agencies
	I authorize the use of my signature on all insurance submissions. Balanced Minds, LLC may use my health care information and may disclose such information to my insurance agency and their agents for the purpose of obtaining payment for services and determining benefits payable for related services. This consent will end 6 months after my current treatment is completed.

If you have any questions about the above police, please discuss them with your therapist.

_____ I have read and understand the above policies and agree to abide by all conditions outlined

_____ I have received a copy of the HIPAA Notice described above.

Patient Signature: _____ Date: _____

Parent/Guardian Signature: _____ Date: _____

Outpatient Intake Form

Statement of Patient Rights

- Patients have the right to be treated with dignity and respect.
- Patients have the right to fair treatment regardless of race, religion, gender, ethnicity, age, disability, or source of payment.
- Patients have the right to have their treatment and other information kept private and only disclosed to designated individuals given on release form signed by the patient.
- Patients have the right to information from staff/providers in a language they can understand as well as an explanation of their condition and treatment.
- Patients have the right to know all about their treatment choices regardless of cost coverage.
- Patients have the right to get information about their services offered by their providers and patient role in the treatment process.
- Patients have the right to request professional information about their provider.
- Patients have the right to know the clinical guidelines used in providing and/or managing their care.
- Patients have the right to provide suggestions on office policies and procedure.
- Patients have the right to complain and to know about the complaint, grievance and appeals process.
- Patients have the right to know about State and Federal laws governing their rights and responsibilities.
- Patients have the right to participate in the formation of their plan of care.

I Understand My Rights as Stated Above.

Print Name:_____ Date:_____

Signature:_____

Outpatient Intake Form

Authorization for Release of Confidential Information Primary Care Physician

Sometimes it is helpful that we make contact with your Primary Care Physician (PCP) to coordinate you care. It is important for your health and wellbeing that your care can be managed between your treating professional(s) and your primary care physician. Pleases indicate your desire about the selected provider sharing clinical information with your PCP by initialing one of the choices below.

Please check one of the following:

_____ I am giving permission for my Doctor/Therapist to communicate with my PCP

_____ I do not give permission for my Doctor/Therapist to communicate with my PCP

Patient Name: _____ Date of Birth: _____

Primary Care Physician: _____ Office Phone: _____
(Medical Doctor Name)

Patient Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Cell Phone: _____

_____ _____
Signature of Patient or Responsible Party Date

_____ _____
Balanced Minds LLC Representative Signature Date

A copy of this authorization may be used in place of the original.

I understand I may revoke this authorization by written notice but the revocation will not apply to previously released information. This release of information expires in 60 days following completion or termination of treatment. This information may be share by phone, in writing or by fax.

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Authorization to Disclose Confidential Healthcare Information

I authorize Balanced Minds LLC to disclose and share my medical and healthcare information to the following people I have checked/listed below.

○ Spouse ○ Parent ○ Sibling ○ Other

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax/ Cell Phone: _____ Emergency #: _____

Reason for Disclosure:

○ Spouse ○ Parent ○ Sibling ○ Other

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax/ Cell Phone: _____ Emergency #: _____

Reason for Disclosure: _____

○ Spouse ○ Parent ○ Sibling ○ Other

Name: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Phone: _____ Fax/ Cell Phone: _____ Emergency #: _____

Reason for Disclosure: _____

I understand I may revoke this authorization by written notice but the revocation will not apply to previously released information. This release of information expires in 60 days following completion or termination of treatment. A copy of this authorization may be used instead of the original. This information may be shared by phone, in writing, or by fax.

_____ _____

Signature of Patient or Responsible Party Date