

NEW PATIENT PAPERWORK

Date: _____ Referred by: _____
 Patient Name: _____ Previous Name (if any): _____
 Parent or Legal Guardian name (if applicable): _____
 Who is responsible for this account? _____ Relationship to patient: _____
 Patient Date of Birth: _____ Patient Age: _____ Patient Social Security#: _____
 Pt. Gender: Male Female Are you a Veteran? Yes No
 Pt. Marital Status: Single Married Widowed Divorced Separated Significant Other
 Spouse name (if applicable): _____ Spouse Date of Birth: _____
 Home Address: _____ City, State, Zip: _____
 Billing Address (if different): _____ City, State, Zip: _____
 Home Phone: _____ Cell Phone: _____ Other: _____
 Can we leave a message at any of these numbers? Yes No Message#: _____
 E-mail address: _____ Would you like to be contacted by e-mail? Yes No
 Do you have a primary care provider? Yes No Provider name: _____
 Pharmacy: _____ Location: _____
 Do you have a living will or durable power of attorney? Yes No I don't know I would like more information
 What is your primary language? English Spanish Other: _____
 Do you speak any other languages? Yes No If yes, please specify: _____
 Race: African American Caucasian Hispanic Native American Other: _____
 Religious preference: Atheist Catholic Christian No preference Other: _____
 Are you employed? Yes No If yes, who is your employer? _____
 Are you a student? Yes No If yes, where do you attend school? _____
 Are you a ward of the state? Yes No If yes, who is your caseworker? _____

Do you have Medicare? Yes No If yes, what is your Medicare ID number? _____
 Do you have Medicaid? Yes No If yes, what is your Medicaid ID number? _____
 Do you have insurance coverage? Yes Please provide the information requested below.
 No If no, please speak with our office manager or billing manager.

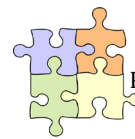
NOTICE: IF YOU DO HAVE INSURANCE AND DO NOT PROVIDE US WITH CORRECT INFORMATION, YOU WILL BE RESPONSIBLE FOR ALL CHARGES

PRIMARY INSURANCE

Subscriber (cardholder) Name: _____ DOB: _____
 Relationship to patient: _____ Subscriber Social Security #: _____
 Insurance Company: _____ Effective Date: _____
 ID Number: _____ Group Number: _____
 Subscriber Mailing Address: _____ City, State, Zip: _____
 Subscriber Phone Number: _____ Alternate Phone: _____

SECONDARY INSURANCE

Subscriber (cardholder) Name: _____ DOB: _____
 Relationship to patient: _____ Subscriber Social Security #: _____
 Insurance Company: _____ Effective Date: _____
 ID Number: _____ Group Number: _____
 Subscriber Mailing Address: _____ City, State, Zip: _____
 Subscriber Phone Number: _____ Alternate Phone: _____



Patient name: _____

INFORMED CONSENT

By signing this form, I acknowledge that I have been offered a copy of Mental Health Alliance’s Consent to Treat and that if I have any questions or concerns regarding the informed consent, I can contact Mental Health Alliance. I understand that by signing this form I am giving my permission for myself or my child/dependent to receive services and medication management by Mental Health Alliance.

Client (or parent/guardian’s) Signature

Date

Staff Initials

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

By signing this form, I authorize Mental Health Alliance’s office to release any information necessary to expedite insurance, EAP, or self-pay claims. I understand that I am responsible for any, and or all charges (i.e., copayments, deductibles, payment plans, and self-pay plans) based on insurance coverage or other arrangements. I also understand that if I do not have or provide insurance information, my account will be considered Self Pay and I am responsible for ALL charges at the time of service.

client (or parent/guardian’s) Signature _____ *Date:* _____ *Staff Initials* _____

NOTICE OF PRIVACY PRACTICES

By initialing below, I acknowledge that I have been offered a copy of the Notice of Privacy Practices for Mental Health Alliance and if I have any questions or concerns regarding the Notice or my privacy rights or would like a copy of this form, I can contact Christine’s office or visit <https://mentalhealthalliance.biz>

Client (or parent/guardian’s) Initials _____ *Date* _____ *Staff Initials* _____

CLIENT RIGHTS AND RESPONSIBILITIES STATEMENT

By initialing below, I acknowledge that I have been offered a copy of the Client’s Rights and Responsibilities Statement for Mental Health Alliance and if I have any questions or concerns regarding the Statement or my responsibilities or would like a copy of this form, I can contact Christine’s office or visit <https://mentalhealthalliance.biz>

Client (or parent/guardian’s) Initials _____ *Date* _____

DESCRIPTION OF SERVICES

Medication Management is the use of prescription medication to control symptoms of behavioral health problems. A prescription for medication can be written by a physician (MD), Physician Assistant (PA) or Nurse Practitioner (APRN).

There are many different medications available, and the med provider decides, after gathering a full history, which one(s) to use. After a patient starts medication, the provider generally will want to see him/her back in the office in two weeks to see how he/she is doing. Often it takes time to find the most effective medication for a patient. Dosages might need to be changed, different medications tried, others added to help with side effects, etc. Part of medication management now may include DNA testing. Once the patient is stable, appointments can be spaced out to be several months apart. If a provider decides medication is appropriate for a patient, they will discuss the risks and benefits of their options. Initial appointments generally last 60 minutes and follow-up visits are 15 minutes.

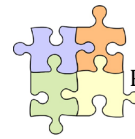
Sometimes a person experiences an acute problem situation and medication helps during this time. When the situation resolves itself, the patient can discontinue using medication. Other patients have chronic conditions and use medication on an ongoing basis.

By initialing below, I acknowledge that I have been offered a copy of the description of med management services for Mental Health Alliance and if I have any questions or concerns regarding services or would like a copy of this form, I can contact Mental Health Alliance or visit www.mentalhealthalliance.biz.

Client (or parent/guardian’s) Initials _____ *Date* _____ *Staff Initials* _____

Staff Signature

Date



AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ Telephone _____

Information to be disclosed:

Pick Up Prescriptions

Person(s) to whom this information may be given *(verification of identification may be requested)*.

Pick Up Medications

Person(s) to whom this information may be given *(verification of identification may be requested)*.

Appointment Information

Person(s) to whom this information may be given *(verification of identification may be requested)*.

Coordination of Care between Health Care Providers

I, _____, hereby authorize Mental Health Alliance to converse with and to disclose information regarding my behavioral health treatment including, but not limited to, any treatment for alcohol and drug abuse, mental disorder or developmental disability to _____ *(Primary Care Provider)* for the specific purposes of providing coordination and continuity of care. My primary care physician shall not be entitled to any information beyond such treatment information without my written consent. I understand that this primary care consent form shall remain in effect throughout the course of treatment.

I DO NOT give consent to release information to my Primary Care Physician

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I have been informed what information will be given, its purpose, and who will receive the information. Information is protected by Federal confidentiality rules (42 FR Part 2). I understand that I may revoke this consent at any time. This consent automatically expires after one year or on completion of treatment, unless renewed annually by initialing and dating the bottom of this form. Revocation of someone will be indicated by striking through the name and initialing and dating.

Signed _____
(Patient or Personal Representative)

(Date)

Signed _____
(Witness)

(Date)

Mental Health Alliance

Scheduling and Payment information

Payment for providers in this office are due at the time of service. This includes self-payments for those without insurance as well as patients who will be paying co-payment amounts and deductible amounts.

Under the Health Insurance Portability Act of 1996 (HIPAA), it is now a federal crime to defraud private insurance companies. Failure to collect co-pays is also a violation of the False Claims Act. Violations can result in fines and criminal prosecution for providers.

According to the law, we cannot routinely waive co-insurance or co-payment fees. If you feel that you are unable to pay the full amount, you must speak with the billing manager to see if there are arrangements that can be made for payment following a payment schedule. You must do this **BEFORE** your first appointment.

As providers, we are responsible for collecting all payments due from the patient, after which we file with your insurance company to receive the amount to be paid by insurance. If we do not collect co-insurance payments at the time of service, and a patient subsequently refuses to pay, we can be held accountable for that, and could potentially face criminal charges, and be deactivated from that insurance company as a provider for anyone using that insurance.

We are obligated to report to your insurance company any refusal of payments or delinquent payments. For the patient, not paying your co-payments could result in losing your insurance.

If you believe you will not be able to pay in full for an appointment, you must make payment arrangements with the billing manager in advance of the appointment.

If you do not make payment arrangements in advance and cannot pay for your appointment, we may reschedule your appointment.

I acknowledge that I have received a copy of the payment information for Mental Health Alliance and affiliate providers.

Patient name (printed) _____

Signed _____
(Patient or Personal Representative)

(Date)

Signed _____
(Witness)

(Date)

Patient name: _____

Health History for New Patients

Your answers on this form will help your provider get an accurate history of your medical concerns and conditions. Please complete this entire packet. If you cannot remember specific details, please provide your best guess.

Main reason for today's visit: _____

Other concerns: _____

If you have seen any other providers for psychiatric medications, please list their name and when you saw them:

Please list the names of any current or previous therapist/counselor and when you saw them:

Please list any previous psychiatric hospitalizations, include the name or city of hospital and dates:

In the past **2 weeks**, have you been bothered by: little interest or pleasure in doing things? **No** **Yes**
Feeling down, depressed, or hopeless? **No** **Yes**

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.

I DO NOT TAKE ANY MEDICATIONS

Medication	Dose (e.g., mg/pill)	How many times per day?
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

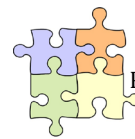
more on back

Allergies or intolerance to medications (include type of reaction): **NONE** _____

Symptoms:

Please check any behaviors or symptoms that you have frequently:

- | | | | |
|--|---|---|---|
| <input type="checkbox"/> aggression | <input type="checkbox"/> emotional | <input type="checkbox"/> recurring thoughts | <input type="checkbox"/> Alcohol dependence |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> restless (can't sit still) | <input type="checkbox"/> anger | <input type="checkbox"/> forgetful |
| <input type="checkbox"/> sexual difficulties | <input type="checkbox"/> antisocial behavior | <input type="checkbox"/> hallucinations | <input type="checkbox"/> sick often |
| <input type="checkbox"/> anxiety | <input type="checkbox"/> heart palpitations | <input type="checkbox"/> sleeping problems | <input type="checkbox"/> avoiding people |
| <input type="checkbox"/> hopelessness | <input type="checkbox"/> social difficulties | <input type="checkbox"/> chest pain | <input type="checkbox"/> impulsivity |
| <input type="checkbox"/> suicidal thoughts | <input type="checkbox"/> crying | <input type="checkbox"/> Inattention | <input type="checkbox"/> depression |
| <input type="checkbox"/> thoughts disorganized | <input type="checkbox"/> Irritability | <input type="checkbox"/> trauma/abuse history | <input type="checkbox"/> judgment errors |
| <input type="checkbox"/> difficulties in school/work | <input type="checkbox"/> trembling/shaking | <input type="checkbox"/> disorientation | <input type="checkbox"/> loneliness |
| <input type="checkbox"/> withdrawing | <input type="checkbox"/> distractibility | <input type="checkbox"/> memory impairment | <input type="checkbox"/> worrying |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> mood shifts | <input type="checkbox"/> phobias and fears | <input type="checkbox"/> drug use |
| <input type="checkbox"/> nightmares | <input type="checkbox"/> changes in eating habits | <input type="checkbox"/> panic attacks | <input type="checkbox"/> elevated mood |
| <input type="checkbox"/> paranoid | <input type="checkbox"/> other(s) (specify) _____ | | |



Women's Health History

Total number of pregnancies: _____ Total number of births: _____
 Date (month/day if known) of the last menstrual period (if you are still menstruating): _____
 Age you started your menstruation cycle: _____
 Age at end of menstruation cycle: _____

OTHER HEALTH ISSUES:

Tobacco Use:

1. Do you smoke cigarettes? Yes No Never have (If you have never smoked, skip to the Alcohol Use section now)
2. Do you want to quit smoking? Yes No Maybe Have you tried quitting in the past? Yes No
3. Quit date: _____ How many months/years did you smoke? _____
4. Approximately how many packs a day do/did you smoke? _____

Other tobacco use: Pipe Cigar Snuff Chew e-cigarettes vaping Other: _____

Alcohol & Drug Use:

1. # of caffeinated drinks per day _____ Type: Soda Coffee Energy Drinks
2. # of alcoholic drinks per week _____ Type: Beer Wine Liquor
3. Have you ever felt like you should cut down on your drinking? Yes No
4. Do people often criticize you about your drinking? Yes No
5. Have you ever felt bad or guilty about your drinking? Yes No
6. Have you ever had a drink first thing in the morning? Yes No
7. Do you use marijuana or recreational drugs? Yes No
8. Have you ever used needles to inject drugs? Yes No

SOCIAL HISTORY

1. What is your highest level of education (circle one):
 K 1 2 3 4 5 6 7 8 / 9 10 11 12 / GED 1 2 3 / 1 2 3 4 +
 Grade School High School Vocational School College
2. Marital Status: __Single __Married __Divorced __Separated __Widowed __Partner __Other: _____
3. Spouse/Partner's name: _____ Number of children: _____
4. Number of grandchildren: _____ Number of great grandchildren: _____
5. Do you have any siblings? __Yes __No Number of sisters: _____ Number of brothers: _____
6. Who lives at home with you? _____
7. Are you employed? __Yes __No
 - If yes, who is your employer? _____ How long? _____
 - If you are not employed, choose the reason for your unemployment: __Retired __In between jobs __Leave of Absence __Disabled __Homemaker
 Other: _____
8. Do you have any beliefs or practices from your religion, culture, or otherwise that we should know about? Please indicate below
 - No, I have no beliefs or practices that need to be included in my care.**
 - Beliefs or practices: _____

Sexual Activity

1. Are you currently sexually active? __Yes __No
2. Your sexual partners have been: __Male __Female __Both
3. Birth control method, please circle: condom pill diaphragm vasectomy IUD Depo shot
 Implant none other _____



PERSONAL/FAMILY MEDICAL HISTORY: Circle any of the following conditions for **you personally**. If you have a family member with any of the following conditions, please write their relationship to you, i.e. mother, brother, etc. I was adopted and/or don't know my family medical history No personal history to report

- ADHD _____
- Alcohol/Drug abuse _____
- Allergies _____
- Anemia _____
- Anxiety _____
- Arthritis _____
- Asthma _____
- Atrial fibrillation _____
- Autism Spectrum Disorder _____
- Back Injury _____
- Bipolar _____
- Bladder problems _____
- Blood clots _____
- Cancer, Type: _____
- Cataracts _____
- Chronic Fatigue Syndrome _____
- Chronic Pain _____
- Cirrhosis _____
- Concussion _____
- Congestive Heart Failure (CHF) _____
- Dementia _____
- Diabetes _____
- Ear infections _____
- Eating disorder _____
- Eczema _____
- Endometriosis _____
- Fibromyalgia _____
- GERD/Heartburn _____
- Glaucoma _____
- Gout _____
- Headaches _____

- Hearing Loss _____
- Heart attack _____
- Heart Disease _____
- Hepatitis, Type: A B C _____
- High blood pressure _____
- High Cholesterol _____
- Irritable Bowel Syndrome (IBS) _____
- Learning disabilities _____
- Liver Disease _____
- Kidney problems _____
- Migraine Headaches _____
- Motor Vehicle accident _____
- Multiple Sclerosis (MS) _____
- Neuropathy _____
- Osteoporosis _____
- Prenatal exposure to alcohol/drugs _____
- PTSD _____
- Schizophrenia _____
- Seizure/Epilepsy _____
- Sexually transmitted Disease _____
- Skin Conditions: _____
- Sleep apnea (Use CPAP) _____
- Stomach Ulcer _____
- Stoke / TIA _____
- Suicide attempt _____
- Thyroid _____
- Traumatic Brain Injury (TBI) _____
- Tuberculosis (TB) _____
- Other _____

Surgical History Procedure(s)

Please include date, if known

- Appendectomy _____
- Back/neck surgery _____
- Biopsy, Location: _____
- EGD (Stomach scope) _____
- Cataract _____
- C-section _____
- Colonoscopy _____
- Ear tubes _____
- ECT _____
- Oral surgery _____
- Gallbladder removal: _____
Circle one laparoscopic or abdominal
- Heart surgery _____

- Heart catheterization _____
- Hernia repair _____
- Hysterectomy: _____
Circle one Laparoscopic Vaginal Abdominal
- Joint surgery: _____
 Which joint? _____
- Mastectomy _____
- Ovary removal: Right Left Both _____
- Sinus surgery _____
- Tonsillectomy _____
- Tubal Ligation _____
- Vasectomy _____
- Wisdom teeth-under anesthesia _____
- Other: _____