**Personal Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**First MI Last**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Work Cellular**

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: ▢ Female ▢ Male Birth Date: \_\_\_\_\_\_/\_\_\_\_\_\_\_/\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: ▢ Single ▢ Married ▢ Other Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Employment Status: ▢ Employed □ Full-time □ Part-time ▢ Student □ Full-time □ Part-time

Is Patient’s condition related to: ▢ Employment ▢ Auto Accident ▢ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Responsible Party (ONLY If other than yourself)** ​***This is the person that is*** ​***financially***​ ***responsible (billing statements).***

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**First MI Last**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Work Cellular**

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Sex: ▢ Female ▢ Male Birth Date: \_\_\_\_\_/\_\_\_\_\_\_/\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Marital Status: ▢ Single ▢ Married ▢ Other Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Employment Status:** ▢ Employed □ Full-time □ Part-time ▢ Student □ Full-time □ Part-time

**Insurance Information**

ARE YOU THE POLICY HOLDER? Yes No: \*IF NO - Complete ALL of the Policyholder Information section below\*

Name of Policyholder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Insurance Company: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gov/State Funded? (Medicaid) \_\_\_\_

Policy ID/Member ID: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Group Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

​**Policyholder Information (If different than patient)**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**First MI Last**

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Zip Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Work Cellular**

Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: ▢ Female ▢ Male Birth Date: \_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Marital Status: ▢ Single ▢ Married ▢ Other Spouse’s Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Relationship to the insured: ▢ Self ▢ Spouse ▢ Child ▢ Other

***\* If you are covered under another insurance plan, please fill out another intake front page & write “SECONDARY INSURANCE” on the top\****

**Emergency Contact Information:**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number: (\_\_\_\_\_\_)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

P**atient’s or authorized person’s signature: I authorize the release of any medical or other information necessary to process this claim. I also request**

**payment of government benefits either to myself or the party below. I authorize payment of medical benefits to Mindfulness, LLC for services.**

**Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FINANCIAL POLICY / AGREEMENT**

**SESSIONS:**

Medical management sessions are typically scheduled as 25 minutes in length as scheduled as the provider deems medically necessary. Psychotherapy sessions are typically scheduled as 50 minutes in length as the provider deems medically necessary. You can always call the office in an emergency at (304) 699-1419. If the therapist cannot talk with you, they will call you back as soon as possible. **\*\*PHONE CALLS exceeding 15 minutes will be billed as follows:**

**15 to 30 minutes $40 (not billable to insurance)**

**30 to 60 minutes $80 (not billable to insurance)**

We do have voicemail available if you need to cancel any appointments after business hours. **ANY APPOINTMENTS NOT CANCELED WITH 24-HOUR NOTICE WILL BE CHARGED A FEE OF $75 (not billable to insurance).** This also applies to any appointments that you miss: **ANY APPOINTMENTS THAT YOU ARE A "NO SHOW" WILL BE CHARGED A FEE OF $75** (not billable to insurance). The ONLY exceptions to this policy are when driving conditions are hazardous (in which case we will be happy to schedule a FaceTime or phone appointment), or **if you are insured by Medicaid/Medicaid MCO’s as your only insurance; however, recurring missed appointments with no 24-hour cancellation may result in termination of services.**

**\_\_\_\_\_\_\_\_\_\_\_\_ initial**

**PAYMENT POLICY:**

All payments for services are due at the time of your scheduled appointment during check-in. As a courtesy, we will bill any insurance you may have; but copays, coinsurance, and deductibles are **due at the time of service**. If we do not participate with your insurance, you agree that you are considered a “Self Pay” client. We are happy to assist in explaining how your insurance has processed your visits; however, it is your responsibility to understand your coverage and benefits and the amounts that you owe for the services you receive. If payment is not made at the time of service, a late payment fee of 10% may be assessed for each date of service that is not paid.

**In any custody situation, the parent that brings the child for treatment, is responsible for any payment.**

**● COURT: If required to testify in court, the provider’s rate is $250.00 per hour**

**● LETTER: If a written letter/report to either the court or attorney is requested, a fee of $50.00 will be charged to the requesting parent.**

**\_\_\_\_\_\_\_\_\_\_\_\_ initial**

**\*\*If copays are not paid at the time of service, a 10% billing fee may be charged to your account.\*\* \_\_\_\_\_\_\_\_\_\_\_\_ initial**

**DOCUMENTS:**

Documents (documents, letters, reports, FMLA, etc.): Fees for any documents, letters, reports, etc. are NOT billable to insurance and are required to be paid before they will be released, faxed, mailed, etc.

**\_\_\_\_\_\_\_\_\_\_\_\_ initial**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature of Patient (if minor over 12 years of age) Signature of Parent / Guardian Date**

**CONFIDENTIALITY**

Confidentiality is one of the most important elements of healthcare, and one of your most important rights. Within certain legally defined limitations, any information revealed by you or learned about you from another source during the course of our work together, will be kept strictly confidential, and will not be revealed to another person or agency, without your written permissions.

However, there are a few exceptions to this policy: If, in your provider’s professional judgment, you threaten to harm yourself or another person; or if your provider believes that a child or elder is being abused or neglected.

As you may know, your health insurance company may help cover the cost of your sessions, but in order for claims to be processed, insurance companies require that we provide them with certain information including a clinical diagnosis. All insurance companies claim to keep all information confidential, but once they receive this information, we have no control over what they do with it and who may see it. If you are concerned with this, you may want to contact your insurance company before authorizing us to bill them.

If you choose for us not to bill your insurance, and to pay for services privately, you may do so at the time of service. Once the insurance company has been billed, you may not change to self-pay, as we are contractually obligated with the insurance company to follow their guidelines and pricing, as well as their processing and applications of copays, coinsurances, deductibles, etc.

If you are under 16 years of age, you should be aware that your parents, in most cases, can view your records without your permission. However, we can refuse to allow that to happen without a court order.

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Signature of Patient (if minor over 12 years of age) Signature of Parent / Guardian Date**

**ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES**

The Health Insurance Portability & Accountability Act of 1996 (HIPAA) is a federal law that provides privacy protections and patient rights regarding the use and disclosure of protected health information (PHI) that is used for the purpose of treatment, payment, and healthcare operations. HIPAA requires that **Mindfulness LLC** post and provide you with a Notice of Privacy Practices to inform you of your rights as well as how your information can legally be used and disclosed. This notice is included in the Notice of Information Practices and Privacy Statement and you may request a separate copy of the currently effective notice at any time. **Mindfulness LLC** has the right to change the terms of this notice from time to time and is required to provide you with an updated copy if and when that occurs. It is very important that you read this notice carefully before you initiate treatment with **Mindfulness LLC**.

HIPAA requires that we obtain your signature acknowledging that we have provided you with this information. You may refuse to sign this acknowledgment, in which case we must document our good faith effort to obtain acknowledgment and the reason why it was not obtained. I, the undersigned, hereby acknowledge that I have received a copy of the currently effective NOTICE OF INFORMATION AND PRIVACY PRACTICES for **Mindfulness LLC.** A copy of this signed and dated document shall be as effective as the original.

**I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, have received a copy of this office’s notice of privacy practices.** ​

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**PLEASE PRINT NAME**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF SIGNATURE**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

***For Office Staff Use Only***

**WE ATTEMPTED TO OBTAIN WRITTEN ACKNOWLEDGEMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICE, BUT ACKNOWLEDGEMENT COULD NOT BE OBTAINED DUE TO:**

**\_\_\_\_ INDIVIDUAL REFUSED TO SIGN**

**\_\_\_\_ COMMUNICATIONS BARRIERS PROHIBITED OBTAINING THE ACKNOWLEDGEMENT   
 \_\_\_\_ AN EMERGENCY SITUATION PROHIBITED US FROM OBTAINING ACKNOWLEDGEMENT**

**\_\_\_\_ OTHER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**SIGNATURE OF PROFESSIONAL DATE OF SIGNATURE**

Reason for your visit/why are you here? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please explain more about this issue: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any more issues you have?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Family Members: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationships: Are you in a relationship? (Circle all that apply) Married Betrothed Committed Casual

Do you have friends? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Are they close? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have trouble with them? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have pets? ▢ Yes ▢ No What kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Military Service: ▢ Active ▢ Retired ▢ National Guard ▢ None Discharged: ▢ Yes ▢ No Honorably: ▢ Yes ▢ No

Branch: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Position and Rank: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Psychiatric / Substance Abuse Information**

| Substance  Category | Common Names  (​Circle all that apply) | Never  Used | Did Use  But Quit | Less than  one time  per month | 1-4 times  per month | 1-4 times  per week | 1+ times  per day | Age  first used |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
| Caffeine | Coffee/tea, No Doz, Soda/Pop, Chocolate, Energy drinks |  |  |  |  |  |  |  |
| Tobacco | Cigarettes, Snuff,  Cigars, Chewing  Tobacco |  |  |  |  |  |  |  |
| Alcohol | Beer,Wine, Hard Liquor |  |  |  |  |  |  |  |
| Marijuana | Marijuana, Dabs,  Hashish, Grass,  Reefer, Hash Oil |  |  |  |  |  |  |  |
| Cocaine | Coke, Snow, Crack, Rock, Blow, Nose Candy |  |  |  |  |  |  |  |
| Other Stimulants | Amphetamines, speed, Crank, Dexedrine, Diet Pills |  |  |  |  |  |  |  |
| Inhalants | Glue, Gasoline, Aerosols, Dusters, Poppers, Rush, Nitrous Whippets |  |  |  |  |  |  |  |
| Opiates | Codeine, Vicodin  (Hydrocodone), MS Contin Kadian (morphine) |  |  |  |  |  |  |  |
| Hallucinogens | LSD, Peyote,Mescaline, PCP, Acid, Mushrooms, Ecstasy |  |  |  |  |  |  |  |
| Depressants | Benzodiazepines, Klonopin, Xanax, Ativan, Valium, Pentobarbital |  |  |  |  |  |  |  |
| Over the  Counter Drugs | Cold Pills, Diet Pills, Cough Syrup, Compose, Sleep Aids, Mini-Thins, Yellow Jackets |  |  |  |  |  |  |  |

Have you ever been treated for alcohol or drug use or abuse? ▢ Yes\* ▢ No

\*If yes, for which substances, when, and where were you treated? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ONLY For Minors / Children:**

Where were you born? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Birth weight: \_\_\_\_\_\_\_\_ pounds \_\_\_\_\_\_\_\_ ounces

Were there any developmental delays? ▢ No ▢Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of School Attending: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Grade: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are there any learning problems? ▢ No ▢Yes: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Current Job: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Length of time there: \_\_\_\_\_\_\_\_\_\_ How long have you been working? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical History:**

Primary Care doctor name, address, phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name of any other medical doctor you currently receive treatment from, the reason/condition seen for, name, address, phone number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medical Issues:**

Date: Reason:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past Surgeries:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Head Injuries/Concussions/Headaches: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date last Eye Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date last Dental Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Special Diet: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current medications (include name, dose, and reason you are prescribed/taking): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Past psychiatric medications (include name, dose, and reason you are prescribed/taking): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ MEDICATION Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ REGULAR Allergies: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is there any information that you would like to add? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please check the following words that apply to you:**

| ▢ Social / Outgoing | ▢ Assertive | ▢ Impulsive | ▢ Note liked by others | ▢ Intelligent |
| --- | --- | --- | --- | --- |
| ▢ Not easily depressed | ▢ Out of control | ▢ Impatient / Edgy | ▢ Can’t concentrate | ▢ Self controlled |
| ▢ Resourceful | ▢ Unimaginative | ▢ Disrespectful | ▢ Creative | ▢ Mostly able to relax |
| ▢ Can forgive | ▢ Patient | ▢ Isolated / Loner | ▢ Full of hate | ▢ Financially stressed |
| ▢ Respects others | ▢ Bottled up | ▢ Worthless | ▢ Perfectionist | ▢ Can ask for help |
| ▢ Unstable | ▢ Unattractive | ▢ Stable | ▢ Secure | ▢ Have enough money |
| ▢ Insecure | ▢ Secure | ▢ Faithful | ▢ Physically unattractive | ▢ Can accept love from others |
| ▢ Motivated | ▢ Happy | ▢ Confident | ▢ Shy / Backwards | ▢ Worthwhile / “good enough” |
| ▢ Stupid / Dumb | ▢ Unfaithful | ▢ Lazy | ▢ Unmotivated |  |
| ▢ Depressed | ▢ Easily discouraged | ▢ Passive / Pushover | ▢ Tense most of the time |  |
| ▢ Other- Description: | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

**Please check the following words that apply to you:**

| ▢ Death of a child/spouse | ▢ In-law troubles | ▢ Death of a close friend | ▢ Death of a close family member |
| --- | --- | --- | --- |
| ▢ Divorce | ▢ Marital separation | ▢ Major injury or illness | ▢ Detention or jail/other institution |
| ▢ Marriage | ▢ Fired from work | ▢ Marital reconciliation | ▢ Retirement |
| ▢ Major change in health | ▢ Pregnancy | ▢ Sexual difficulties | ▢ Major change in behavior of family member |
| ▢ Gaining a new family member | ▢ Change in financial state | ▢ Change in job | ▢ Change in amount of arguments with spouse |
| ▢ Taking on a significant mortgage | ▢ Foreclosure on mortgage | ▢ Default on loan | ▢ Change in responsibility at work |
| ▢ Child leaving home | ▢ Began formal schooling | ▢ Trouble with boss | ▢ Graduated formal schooling |
| ▢ Major change in spiritual  activities | ▢ Minor violations of the law | ▢ Vacation | ▢ Major change in social activities |
| ▢ Change in eating habits | ▢ Stressful Holiday | ▢ New school | ▢ Change in residence |
| ▢ Other - description: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | | | |

**Please check any of the following issues you are currently having:**

| ▢ Custody issues | ▢ Behavior of adult children | ▢ Health problems in family | ▢ Personal health problems |
| --- | --- | --- | --- |
| ▢ Substance abuse | ▢ Substance dependence | ▢ Excessive computer use | ▢ Problems with pornography |
| ▢ Interpersonal problems | ▢ Unfaithful partner | ▢ Distance from loved one | ▢ Gambling |
| ▢ Anger problems | ▢ Parenting problems | ▢ School problems | ▢ Victim of physical/sexual abuse |
| ▢ Depression | ▢ Financial difficulty | ▢ Grief | ▢ Family relationships |

**Please check any of the symptoms that apply to you:**

| **Physical** | **Emotional** | **Thoughts** | **Behaviors** |
| --- | --- | --- | --- |
| ▢ Headaches | ▢ Sadness | ▢ Memory problems | ▢ Using drugs or alcohol |
| ▢ Bowel/stomach | ▢ Worry | ▢ Paranoia | ▢ Avoiding loved ones |
| ▢ No appetite | ▢ Overexcited | ▢ Confusion | ▢ Missing work or school |
| ▢ Dizziness | ▢ Agitated | ▢ Repetitive thoughts | ▢ Laugh or cry inappropriately |
| ▢ Tremors | ▢ Panicky | ▢ Racing thoughts | ▢ Nervous habits |
| ▢ Muscle weakness | ▢ Nervous | ▢ Attention problems | ▢ Losing temper |
| ▢ Fainting spells | ▢ Empty | ▢ Thoughts of escape | ▢ Becoming violent |
| ▢ Hair, skin problems | ▢ Grieving | ▢ Decision problems | ▢ Risky behaviors |
| ▢ Jaw problems | ▢ Despair | ▢ Poor judgment | ▢ Grind teeth |
| ▢ Reproductive problem | ▢Hopelessness | ▢ Hallucinations | ▢ Less or more sexual contact |
| ▢ Sexual problems | ▢ Fits of rage | ▢ Disorganized thinking | ▢ Less or more sleeping |
| ▢ Excessive sweating | ▢ Jealousy | ▢ Other symptoms: | ▢ Other symptoms: |
| ▢ Heart problems | ▢ Moodiness | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ▢ Heart racing/pounding | ▢ Desire to cry | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ▢ Nausea | ▢ Resentment | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ▢ Fatigue | ▢ Frustration | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| ▢ Other Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | ▢ Inadequacy  ▢ Other Symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**Please explain what you have done to cope with the symptoms and issues you have checked above: \_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**Patient Medication Reconciliation**

**Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DOB: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Your preferred Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Mail-In Pharmacy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Psychiatric Medications you are currently taking: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Systemic (all other) Medications and Doctor that prescribes them, including vitamins and supplements: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Birth control (if applicable): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Primary Care Physician and contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Specialty Physician and contact information: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Review of Systems:**

Please list any places you have problems: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Updated Patient Information and Consent**

**Payment Policy**

We require payment in full for outstanding balances before seeing any provider. If you cannot pay the balance you will be offered a payment plan. If you refuse to pay and decline the payment plan, your appointment may be canceled or rescheduled and you may be charged a late-cancellation/no-show fee. If you do not have insurance, or we do not participate with your insurance, you are considered self-pay and may qualify for our Sliding Fee Scale with reduced payments for those at or below 200% of poverty level. If you need any assistance paying your bill please let the front desk know.

**No-Show/Late-Cancellation Policy**

We schedule our appointments so that each person has the right amount of time with our providers, that’s why it is important to keep your appointment. Mindfulness also sends out a reminder a day in advance for your appointment. If you cannot keep your appointment please contact us so we may reschedule you, and accommodate others who are waiting for an appointment. If you are going to be late to your appointment, please contact the office ahead of time, if you are more than 15 minutes late to your appointment with no notice you will be rescheduled and charged a $75 no-show fee. lf you do not cancel or reschedule your appointment with at least a 24 hour notice you will be charged a $75 no-show fee which is not reimbursable by your insurance and will be billed directly to you. After three consecutive no-shows our office may terminate our services to you.

**Consent Information for Facetime/Phone Appointments**

PLEASE READ THE FOLLOWING AND ACKNOWLEDGE THAT YOU UNDERSTAND AND ACCEPT ALL PROVISIONS BY SIGNING ON THE NEXT PAGE. When you have an appointment via Facetime or phone call you will receive healthcare services such as assessment, treatment, or diagnosis using audio and video. You will not be in the same room as your provider. You will receive the same level of care that you would receive in person from your provider. Our providers take every step to ensure their servers are safe to use, but it is not guaranteed that your personal servers/Apple device is, which could potentially release personal information. This is extremely unlikely to happen, but in the event it does occur, Mindfulness is not responsible for any private information released. By using FaceTime or phone appointments you are aware of the potential risks associated with it.

**Patient Acknowledgment and Consent**

I have read this form carefully and fully understand its contents. I understand I am to pay my bill, or make arrangements to pay my bill, before seeing my provider or I will be charged a late-cancellation fee as well as have my appointment rescheduled. I understand that if I cannot make my appointment I need to cancel or reschedule with at least 24 hour notice or I will be charged a no-show fee of $75 that I will be responsible for. I understand that if I have three consecutive no\_shows my services at Mindfulness may be terminated. I understand that I cannot be anymore than 15 minutes late to my appointment or I will be rescheduled and charged a fee. I understand and agree that if I decide to have my appointment virtually via Facetime or phone call, it is not guaranteed that the servers are completely confidential and in the event my information may be released due to this Mindfulness cannot be held responsible for that.

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DOB:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell Phone:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_State:\_\_\_\_\_\_\_\_\_\_\_\_\_Zip:\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Todays Date:\_\_\_\_\_\_\_\_\_



210 2nd Street Saint Marys WV 26170

INFORMED CONSENT FOR ASSESSMENT AND TREATMENT

Name: Date of Birth:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I understand that as a subscriber to Mindfulness, LLC I am eligible to receive a range of services at Mindfulness Holistic Wellness & Healing. The type and extent of services that I will receive will be determined following an initial assessment and thorough discussion with me.

The goal of the assessment process is to determine the best course of treatment for me. Typically, treatment is provided over the course of several weeks.

I understand that if I “no show” or cancel my appointment with less than 24 hours notice, this will count against my total number of sessions.

I understand that all information shared with the clinicians at Mindfulness is confidential and no information will be released without my consent. My Mindfulness treatment records are electronic and stored on a secure server as part of my Mindfulness treatment records. Access to Mindfulness records by Mindfulness providers and vice versa is done only on a need to know basis (e.g., referral for medication, evaluations for eating disorders, etc.).

In all other circumstances, consent to release information is given through written authorization. Verbal consent for limited release of information may be necessary in special circumstances. I further understand that there are specific and limited exceptions to this confidentiality which include the following:

A. When there is risk of imminent danger to myself or to another person, the clinician is ethically bound to take necessary steps to prevent such danger.

B. When there is suspicion that a child or elder is being sexually or physically abused or is at risk of such abuse, the clinician is legally required to take steps to protect the child or elder, and to inform the proper authorities.

C. When a valid court order is issued for medical records, the clinician and the agency are bound by law to comply with such requests.

I understand that a range of mental health professionals, some of whom are in training, provide Mindfulness services. All professionals-in-training are supervised by licensed staff.

I understand that while psychotherapy and/or medication may provide significant benefits, it may also pose risks. Psychotherapy may elicit uncomfortable thoughts and feelings, or may lead to the recall of troubling memories. Medications may have unwanted side effects.

I understand that Mindfulness therapists may routinely videotape therapy sessions. I Understand that such recording(s) will be used only for educational purposes within Mindfulness and that the professionals involved will respect and protect the confidential nature of the sessions. I understand that the tapes will be the property of Mindfulness and are deleted on a regular basis. I also understand that if I object to being videotaped. It will, in no way, jeopardize my relationship with Mindfulness but may result in my having to change therapists.

If I have any questions regarding this consent form or about the services offered at Mindfulness, I may discuss them with my therapist. I have read and understood the above. I consent to participate in the evaluation and treatment offered to me by Mindfulness. I understand that I may stop treatment at any time.

Signature:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_