*O*ptima Behavioral Health, Inc.
New Patient Packet – Adult

New Appointment Check List

Please review all items carefully. All items [6] must be addressed for you to successfully be seen in our office.	
☐	**[1]** You must have valid State ID with your current address. If your ID does not have your current address additional documentation must be presented at time of service (e.g. utility bill).
☐	**[2]** You must present your insurance card at the beginning of the visit or you will be charged the self-pay rate.
☐	**[3]** Any cancelation **must** be made 24 business hours in advance of your scheduled appointment. Canceling without proper notice will result in a late cancelation fee.
☐	**[4]** A medication list that indicates name, strength, and dosage of all medications must be provided. If you do not remember all medications please contact your pharmacy for a list.
☐	**[5]** Please verify your mental health benefits (which can sometimes be different than your medical plan). We collect copays at the time of service. For plans that have unmet deductible or out of pocket expenses you may be asked to pay ahead on your coinsurance and deductible at 50% of the UCR (usual customary rate).
☐	**[6]** If your insurance requires authorization please advise the staff at or before the time of check-in.

Notice for ADD & Schedule IV Medications

For those coming in for **ADD medication** (Schedule II: Ritalin, Adderall, Vyvanse) and/or a **Schedule IV medication** (Alprazolam, Xanax, Klonopin, Clonazepam, Ativan, Lorazepam): If you are currently being prescribed any of these medications and want to continue, please complete a HIPAA release and have your current prescribing physician send us your records **prior to your initial visit**. If you have any questions please contact our office.

*O*ptima Behavioral Health, Inc.

Date: _____ / _____ / _____

Patient Demographic Information			
First Name:	**Last Name:**		
Date of Birth:	**Social Security Number:**		
Address:			**Apt./Unit #:**
City:		**State:**	**Zip Code:**
Sex: Male | Female	**Marital Status:** Married | Single | Divorced | Widowed | Other		
Race:	**Ethnicity:**		
Primary Phone: ( )	**Alternate Phone:** ( )		
Primary Phone Type: Cell | Work | Home (Landline)	**Alt. Phone Type:** Cell | Work | Home (Landline)		
Where may we leave a message? Primary Phone | Alternate Phone | No Messages			
Email Address:			
Employed: Full-time | Part-time | Unemployed	**Student:** Yes | No		
Employer:	**Student Status:** Full-time | Part-time | N/A		
Emergency Contact (Name):			
Emergency Contact (Number): ( )	**Emergency Contact (Relation):**		

Responsible Party (For Minors Only)	
☐ **SAME AS ABOVE**	
First Name:	**Last Name:**
Address:	
Primary Phone:	**Alternate Phone:**

Insurance (Primary Only)	
First Name:	**Last Name:**
Relationship to Patient: Self | Spouse | Significant Other | Parent | Family | Other	
SSN:	**Ins. ID:**
DOB:	**Ins. Group Number:**
Address:	
Primary Phone:	**Employer:**

Name: _____

*O*ptima Behavioral Health, Inc.

Office Policies

At Optima Behavioral Health, Inc. (herein referred to as OBH) we are committed to providing exemplary and affordable healthcare in a caring environment. Below is an outline summary of our office policies. If you have any questions feel free to ask us.

1. Prescription **refills outside of an appointment** (e.g., missed appointment, not seen in requested follow-up time, lost script, etc.) will incur an administrative fee of $20. Prescriptions will not be refilled after 12:30 PM EST on Fridays, nor on weekends or holidays. Medication refills are not faxed to pharmacies nor are refill requests accepted via fax from pharmacies.
2. An **on call physician is available for urgent problems only**, from 5:00 PM – 10:00 PM EST during weekdays and 9:00 AM – 10:00 PM EST on weekends and holidays. Prescriptions will not be filled by the on call physician. If your phone cannot receive private or blocked numbers, then you will not be able to receive the return phone call from the on call physician.
3. Please **contact the office at least 24 business hours prior to your appointment if you're unable to keep it**. Cancellations without proper notice (late arrival, same day cancellation, weekend cancellations, etc.) or not showing to an appointment (no show) are subject to a late cancellation fee that is 50% of the UCR (Usual Customary Rate).
4. Our office does attempt to make **reminder calls as a courtesy** 48 hours prior to your appointment. If you do not receive a reminder call it is not an acceptable reason to waive any late cancellation or no show fees.

For patients with healthcare insurance, please remember that the contract exists between you and your insurance company, not between your clinician and the insurance company. We encourage you to be familiar with your insurance policy. There may be times where your insurance company is not able to cover all services provided, therefore leaving you responsible for payment (such as with deductibles or yearly allowances, etc.). Federal and state laws, along with insurance carrier contracts, prohibit Optima Behavioral Health, Inc. from being able to adjust off or waive co-pays, deductibles, and any other patient responsible balance after insurance has been billed.

Policy Overview:

1. **Professional services are charged to the patient not to the insurance company.** We will file your claim with your primary insurance company, after being processed by your insurance company we will send you a bill that reflects your balance due, payment in full is expected at that time.
2. We will **only bill secondary insurance if it is Medicare.**
3. **Co-payments are due at the time of service**, otherwise a $10 administrative fee will be added to your account balance. Failure to provide co-payment may result in the rescheduling of your appointment.
4. **All balances must be paid on at time of service.** Not paying on a balance (outside of a co-pay, co-insurance, or deductible assessed at time of service) will result in a $10 administrative fee being added onto the balance.
5. Patients **without insurance or that have out of network coverage** will be required to make a full payment at the time of service. A prompt pay discount for paying in full may be offered. Accepting a prompt pay discount excludes you from being able to submit a claim (such as out of network).
6. **Forms or paperwork deemed above standard patient care** may be assessed a fee that is patient responsibility. All disability related paperwork will carry a $25 base fee, and is subject to change per the completing provider. Fee payment is required prior to the releasing of forms or paperwork.
7. All fees are subject to change.
8. We accept cash, check, and most major credit cards.
9. All balances over 90 days, for which there is no payment plan, will be sent to collections and your relationship with OBH may be terminated due to conflict of interest.

Signature: _____ **Date:** _____ / _____ / _____

Printed Name (if non-patient): _____
Relationship to Patient: Parent | Guardian | Other

*O*ptima Behavioral Health, Inc.

Office Consents and Disclosures

Consent to Provide Treatment
I voluntarily consent and authorize the providers of OBH to provide mental health care (including but not limited to diagnosis and treatment plan) that is deemed medically necessary according to their professional opinions and third party insurers.

During treatment, it may be necessary for OBH to share protected health information with other health care providers that assist with patient care. Please see our Notice of Privacy Practices for additional information.

Authorization to Contact Professional Referral Source
Unless otherwise noted, OBH is authorized to notify and share my medical records (such as, but not limited to diagnosis and treatment plan) to ensure integrated health care with any referral sources.

Authorization and Release of Information for Billing
I authorize my insurance benefits to be paid directly to OBH. I understand that I am financially responsible for this account unless other arrangements have been made.

I understand and authorize OBH to release any medical information that may be necessary (including protected health information) to request claim reimbursement from the insurance carriers or other payers to whom claims have been or are being submitted.

Credit Information and Collection Fees
I understand and agree that if payment on this account is not made I will pay reasonable attorney's fees and the 25% collection fees incurred for the collection process. I also understand that I will need to have my protected health information released to the appropriate gathering agencies.

Marketing Notice
Patient authorization is required in order to disclose for any and all marketing at OBH. To opt in initial here _____.

Fundraising Notice
Patients have the right to opt out of any and all fundraising activities of OBH. To opt in initial here _____.

I certify that I have read the above mentioned policies and I am the patient or am duly authorized to execute the above agreement for the patient and accept its terms.

Patient Name (First and Last): _____

Relationship to Patient: Self | Parent | Guardian

Signature: _____ **Date:** _____ / _____ / _____

Printed Name (if non-patient): _____

*O*ptima Behavioral Health, Inc.

Patient Acknowledgement Form
Notice of Privacy Practices

Patients may request a copy of the **Notice of Privacy Practices** by contacting the front office. This notice is also available online at the practice website www.optimabh.com – About Us > Policies > HIPAA / Privacy Policies.

☐ I have received a copy of Optima Behavioral Health, Inc.'s Notice of Privacy Practices.

☐ I have declined or do not wish to obtain a copy of the Notice of Privacy Practices at this time.

Patient Name (First and Last): _____

Relationship to Patient: Self | Parent | Guardian

Signature: _____ **Date:** _____ / _____ / _____

Printed Name (if non-patient): _____

Name: _____

***O*ptima Behavioral Health** **Biopsychosocial History**

DOB: _____ Age: _____ Person completing form: Self, Other: _____

Professional Referral Source: (name and address) _____

_____

Symptom Check list: (Circle symptoms that describe you **today**)

Agitated	Desperate	Distracted	Impaired Performance
Chest Pain	Irritable	Appetite Increase	Indecisive
Cry Often	Hear Voices	Suspicious	Anxiety Attacks
Fearful	Overly Tired	See "things"	Obsessive/Compulsive
Helpless	Guilt	Can't Concentrate	Over Sleeping
Homicidal	Depressed	Self-Harm thoughts/actions	Average energy
Hopeless	Rapid Speech	Aggressive	Avoidance of People
Mood Swings	Anxious	Appetite Decrease	Sexual Difficulties
No pleasure	Cutting	Defiant	Impulsive
Restless/On Edge	Confused	Feeling "out of control"	High Energy
Withdrawn	Anger/Aggressive	Racing Thoughts	Headaches
Worry a Lot	Sad	Personality Changes	Insomnia

Current Stressors: _____

_____

Medical History:

Date of Last Complete Physical Exam: _____ Problems? _____

Primary Care Physician (or Pediatrician): _____

Accidents/Surgeries/Procedures: _____

_____

Family History: (Please indicate next to the diagnosis any family member that has been diagnosed with the following)

Diabetes		Heart Disease	
Cancer (type)		Hypertension	
Chronic Kidney Disease		High cholesterol	
Obesity		Osteoporosis	

Name: _____

Number of Children: _____daughters _____sons

Number of siblings: _____sisters _____ brothers

Parents: Please circle one of the following

Mother	Living	Deceased
Father	Living	Deceased

Mental Health: Is there a history in the family of:

Condition	**Who/type**
Mental Health Disorders	
Substance abuse	
Victim of Violence	

Current Medications: (Include Over the Counter) **None**

Medication	**Dosage**	**How taken**	**Last date taken**	**Prescriber**
EX: *Aspirin*	*81 mg*	*1 a day*	*Yesterday*	*Dr. J Smith*

Past Psychiatric Medications: _____

Medication Allergies **AND** Reactions: _____

Name: _____

Past Psychiatric/Psychological Treatment History:

For the following: Please identify where treated, dates and if possible by whom if any of the following apply to you.

Individual Outpatient Therapy_____

Family/Marital Therapy _____

Partial/IOP Hospitalization _____

Medication Management_____

Inpatient Hospitalization _____

Social History:

Chemical abuse/dependency History:

Have you ever felt you should cut down on your drinking	**Yes**	**No**
Have people annoyed you by criticizing your drinking	**Yes**	**No**
Have you ever felt bad or guilty about your drinking	**Yes**	**No**
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover	**Yes**	**No**
Is there a patient history of alcohol, marijuana, street drugs, and/or medication abuse/dependence	**Yes**	**No**

If Yes, please explain: _____

Current Alcohol Use: Yes / No / Socially / Occasionally / Daily / Never drank / Stopped drinking /
Previous attempts to quit / Recent increase OR decrease / Recovering alcoholic

Quantity: _____per day/week/month/year Type of alcohol: Beer wine Other: _____

Current Drug Use: Yes No Quantity: _____

Name: _____

Drug Abused	Age at onset	Dose/Amount	How Often	Last Used

Caffeine Use: No Yes: Amount consumed on a daily basis: _____

Smoker: Current every day Current some days Previous history Never Unknown

Exercise: No Yes, if yes how often and for how long: _____

Marital History: Never married Currently married Single Divorced Widowed

Sexual History: Active: Yes / No Orientation: Heterosexual Homosexual Bisexual Transgender

Work History: Current full-time Current part-time Retired Unemployed Disabled

Occupation: _____

Highest Level of Education: BA/BS High School Diploma GED Master's Degree Doctoral Degree Technical Degree
Elementary education, level completed_____

Have you been told you have learning difficulties/ impairments? No Yes: If yes, please explain:

_____

What community resources do you need or use? (Social groups, clubs, extracurricular activities for children and adolescents, church, social services, community resources)_____

Current Living arrangements: Alone With Parents Spouse/Significant Other Children

Roommate(s) Group Home Nursing Home/Assisted Living

Has there been exposure to abusive behaviors? Yes No If **Yes** answer the following:

Current Exposure: Yes No Past Exposure: Yes No When? _____

Who was the abuser? _____ Type: Physical/ Sexual/ Verbal/ Emotional

Did it occur: Within or Outside of the Family Unit

Veteran or Military Service? No Yes: If yes, branch: _____

Religion: Protestant Catholic Jewish Other: _____

How significant a role does religion play in your life: Very / Somewhat / Minor / None

Name: _____

RISK ASSESSMENT (put an X in the box if the answer is yes)

	Current	**Past**
Have you ever had thoughts of hurting yourself?		
Have you ever had thoughts of committing suicide?		
Have you ever had a plan to commit suicide?		
Have you ever made threats to kill yourself?		
Have you ever made a suicide attempt?		
Have you ever mutilated yourself? (ex. cutting, burning)		
Have you ever had thoughts of harming someone else?		
Have you ever had plans to harm someone else?		
Have you ever attempted to harm someone else?		
Have you ever made threats to harm someone else?		

PHQ-9

Over the last 2 weeks, how often have you been bothered by any of the following	Not at all	Several days	More than half the days	Nearly every day
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling asleep or staying asleep or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
Moving or speaking so slowly that other people could have noticed? Or the opposite – being so fidgety or restless that you have been moving around a lot more than usual				
Thoughts that you would be better off dead or hurting yourself in some way				
If you checked of any problems, how difficult have these problems made it for you to do your work, take care of things at home or get along with other people?				

Total PHQ-9 score: _____

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____