Divine Psychology, LLC

PATIENT INTAKE FORM

Name: _____ Date:_____

Address: _____
Street City State Zip

Sex: ☐ Male ☐ Female Date of Birth: _____ SS#: _____
Emergency Contact:_____ Phone:_____
Relationship To Patient:_____

Referring Physician/Practice:_____ Phone:_____

Employment Information
Employed F/T_____ Employed P/T_____ Student F/T_____ Student P/T_____
Not Employed_____ Self Employed_____ Retired_____ Active Military_____
Retired Military_____

Employer/School:_____
Address: _____
Street City State Zip

Insurance Information
Insurance Company: _____Insured's Name:_____

Insurance Policy Number:_____ Insured's Date of Birth:_____

Insurance Group Number:_____ Insurance Phone:_____

Date of injury or onset of symptoms: _____

Are you seeking treatment because of a work-related injury? ☐Yes ☐No

Are you seeking treatment because of a car accident? ☐Yes ☐No

Are you involved in a lawsuit because of your injury or symptoms? ☐Yes ☐No

DIVINE PSYCHOLOGY & PRO PERFORMANCE THERAPY

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED OR DISCLOSED AND HOW YOU CAN OBTAIN ACCESS TO INFORMATION. PLEASE REVIEW IT CAREFULLY.

DIVINE PYSCHOLOGY'S LEGAL DUTY

Divine Psychology is required by law to protect the privacy of your personal health information, provide this notice about our information practices, and follow the information practices that are described herein.

USES AND DISCLOSURES OF HEALTH INFORMATION

Divine Psychology uses your personal health information primarily for treatment, obtaining payment for treatment, conducting internal administrative activities, and evaluating the quality of care that we provide. For example, Divine Psychology may use your personal health information to contact you to provide appointment reminders, or information about treatment alternatives or other health related benefits that could be of interest to you. Divine Psychology shares your personal health information with Pro Performance Therapy for collection purposes. Divine Psychology may also use or disclose your personal health information without prior authorization for public health purposes, for auditing purposes, and for emergencies. We may provide de-identified information for research studies. We also provide information when required by law. In any other situation, Divine Psychology's policy is to obtain your written authorization before disclosing your personal health information. If you provide us with a written authorization to release your information for any reason, you may later revoke that authorization to stop future disclosures at any time.

Divine Psychology and Pro Performance Therapy may change its policy at any time. When changes are made, a new Notice of Information Practices will be posted in a common area of our clinic. You may also request an updated copy of our Notice of Information Practices at any time.

PATIENT'S INDIVIDUAL RIGHTS

You have the right to review or obtain a copy of your personal health information at any time. You have the right to request that we correct any inaccurate or incomplete information in your records. You also have the right to request a list of instances where we have disclosed your personal health information for reasons other than treatment, payment, or other related administrative purposes. You may also request in writing that we not use or disclose your personal health information for treatment, payment, and administrative purposes except when specifically authorized by you, when required by law, or in emergency circumstances. Divine Psychology will consider all such requests on a case-by-case basis, but the Company is not legally required to accept them.

CONCERNS AND COMPLAINTS

If you are concerned that Divine Psychology may have violated your privacy rights or if you disagree with any decisions we have made regarding access or disclosure of your personal health information, please contact our HIPAA Compliance Office at the address listed below. You may also send a written complaint to the US Department of Health and Human Services. For further information on Divine Psychology's health information practices, or if you have a complaint, please contact the following office:

HIPAA Compliance Officer
Divine Psychology, LLC
Sara M. Vélez, Psy.D.
645 Hembree Parkway, Ste A
Roswell, Georgia 30076
(770) 449-5152
FAX: (866) 821-7683
www.divine-psychology.com
www.properformancetherapy.com

We ask you to sign this acceptance/acknowledgement of our HIPAA Notice of Privacy Practices. We also ask you to sign an Authorization for Release of Information form to assure you that we do indeed live up to our policies. You can request a copy of this form anytime.

Thank you for your business!

After receiving and reading the Divine Psychology & Pro Performance Therapy Notice of Privacy Practices, please acknowledge below.

Acknowledgment of Receipt of Notice of Privacy Practices

Patient Name:_____

DOB:_____

By signing below, I acknowledge that I have received the Divine Psychology & Pro Performance Therapy Notice of Privacy Practices.

_____ _____
Signature of Patient or Legal Representative Date

The privacy, security, and confidentiality of your health information are important to us. Please let us know how you prefer us to contact you with results, questions, or appointment reminders.

Please select and number in the order we should attempt:

___ Home phone – Can we leave a message? ___yes ____no Phone Number: _____

___ Cell phone – Can we leave a message? ___yes ____no Phone Number: _____

___ Work phone – Can we leave a message? ___yes ____no Phone Number: _____

___ Email: _____

___ Mail to home address: _____

___ Telephone and message to another person: _____

Please list any other persons to whom we may discuss your healthcare treatment and/or payment information. Many patients take this opportunity to list a spouse and/or an adult child or caregiver who often participates in their healthcare decisions and payment.

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Name: _____Relationship: _____

Medical & Psychological Screening Forms

It is important to gather information about your medical and psychological history to provide you with the highest quality care. Please fill out this form to the best of your knowledge. Thank you!

The information was completed accurately and to the best of my knowledge.

Name: _____ Signature: _____ Date: _____

When applicable, please check if *you* or an immediate *family* member has had the following conditions:

Osteoarthritis? _____ Heart Disease? _____ Rheumatoid Arthritis? _____

Diabetes? _____ Stroke? _____ Angina/Chest Pain? _____

Cancer? _____ Osteoporosis? _____ High Blood Pressure? _____

Allergies? _____ Skin Disease/Rash? _____ Asthma? _____

Broken Bones/Fracture? _____ Blood Disorder? _____ Lung Problems? _____

Circulation/Vascular Issues? _____ Muscular Dystrophy? _____ Head Injury? _____

Low/High Blood Sugar? _____ Thyroid Problems? _____ Depression? _____

Multiple Sclerosis? _____ Kidney Problems? _____ Addiction? _____

Seizures/Epilepsy? _____ Neurologic Disorder? _____ STD? _____

Ulcers/Stomach Problems? _____ Infectious Disease? _____ Liver Problems? _____

In the past 6 months, have you experienced the following:

An overall health change? _____ Chest Pain/Angina? _____ Cough? _____

Shortness of Breath? _____ Dizziness/Fainting? _____ Weakness? _____

Coordination Problems? _____ Balance Problems? _____ Fatigue? _____

Fever/Chills/Night Sweats? _____ Nausea or Vomiting? _____ Headaches? _____

Numbness or Tingling? _____ Trouble Sleeping? _____ Hearing Issues? _____

Change in Bowel or Bladder? _____ Weight Loss or Gain? _____ Vision Problems? _____

Are you currently… Under Stress? _____ Depressed? _____ Pregnant? _____

Do you drink alcohol? ___ How many drinks do you generally have per week? _____ Quit Date: _____

Have you ever smoked? ___ How many packs per day and for how long? _____ Quit Date: _____

Do you exercise? ___ How often? _____

Which activities?_____

What are you being seen for today? _____

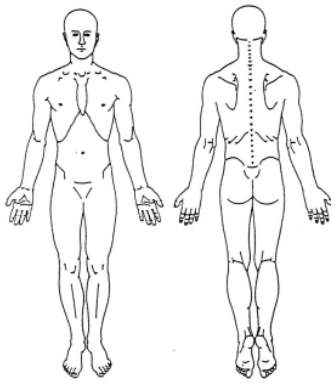
How long has this been affecting you? _____ Is your condition improving ___ same___ worse ___

What are your goals/What would you like to be able to do? _____

Please list/describe anything else that you feel is important or relevant: _____

PAIN, INJURY, & ILLNESS:

Fill in the Area of Concern



Scale: 0 is no pain and 10 is worst pain
Pain at worst _____
Pain at best_____

Functional Activities:

Please circle the activities listed below that you perform with difficulty or discomfort as a result of your injury.
Kneeling Sleeping Balance Feeling Stairs Squatting Bending Walking Pulling Carrying Pushing Standing Grasping Reaching Crawling Handling Sitting Working Reading Computer Lifting Cough/Sneeze

Grooming/Activities of Daily Living/Housework:
Brushing Teeth Pulling on Shirt Shoes/Socks Using Toilet Bathing Shaving Driving Trousers/Pants Lifting Vacuuming Laundry Cleaning Tub Making beds Washing Dishes Cooking Sweeping Scrubbing Floor Mopping
Grocery Shopping Sex

Recreational Activities:
Jogging Hiking Bicycling Walking Golfing Skiing Aerobics Swimming Movies
Socialize with friends

Mental Health Screening Form–III (MHSF–III)

Instructions:
Please note, each item refers to your *entire life history, not* just your current situation.

Please circle "yes" or "no" for each question.
1. Have you *ever* talked to a psychiatrist, psychologist, therapist, social worker, or counselor about an emotional problem? Yes____ No____

2. Have you *ever* felt you needed help with your emotional problems, or have you had people tell you that you should get help for your emotional problems? Yes____ No____

3. Have you *ever* been advised to take medication for anxiety, depression, hearing voices, or for any other emotional problem? Yes____ No____

4. Have you *ever* been seen in a psychiatric emergency room or been hospitalized for psychiatric reasons? Yes____ No____

5. Have you *ever* heard voices no one else could hear or seen objects or things which others could not see? Yes____ No____

6. (a) Have you *ever* been depressed for weeks at a time, lost interest or pleasure in most activities, had trouble concentrating and making decisions, or thought about killing yourself? Yes____ No____
(b) Did you ever attempt to kill yourself? Yes____ No____

7. Have you *ever* had nightmares or flashbacks as a result of being involved in some traumatic/terrible event? For example, warfare, gang fights, fire, domestic violence, rape, incest, car accident, being shot or stabbed? Yes____ No____

8. Have you *ever* experienced any strong fears? For example, of heights, insects, animals, dirt, attending social events, being in a crowd, being alone, being in places where it may be hard to escape or get help? Yes____ No____

9. Have you *ever* given in to an aggressive urge or impulse, on more than one occasion, that resulted in serious harm to others or led to the destruction of property? Yes____ No____

10. Have you *ever* felt that people had something against you, without them necessarily saying so, or that someone or some group may be trying to influence your thoughts or behavior? Yes____ No____

11. Have you *ever* experienced any emotional problems associated with your sexual interests, your sexual activities, or your choice of sexual partner? Yes____ No____

12. Was there *ever* a period in your life when you spent a lot of time thinking and worrying about gaining weight, becoming fat, or controlling your eating? For example, by repeatedly dieting or fasting, engaging in much exercise to compensate for binge eating, taking enemas, or forcing yourself to throw up? Yes____ No____

13. Have you *ever* had a period of time when you were so full of energy and your ideas came very rapidly, when you talked nearly nonstop, when you moved quickly from one activity to another, when you needed little sleep, and when you believed you could do almost anything? Yes____ No____

14. Have you *ever* had spells or attacks when you suddenly felt anxious, frightened, or uneasy to the extent that you began sweating, your heart began to beat rapidly, you were shaking or trembling, your stomach was upset, or you felt dizzy or unsteady, as if you would faint? Yes____ No____

15. Have you *ever* had a persistent, lasting thought or impulse to do something over and over that caused you considerable distress and interfered with normal routines, work, or social relations? Examples would include repeatedly counting things, checking and rechecking on things you had done, washing and rewashing your hands, praying, or maintaining a very rigid schedule of daily activities from which you could not deviate. Yes____ No____

16. Have you *ever* lost considerable sums of money through gambling or had problems at work, in school, or with your family and friends as a result of your gambling? Yes____ No____

17. Have you *ever* been told by teachers, guidance counselors, or others that you have a special learning problem? Yes____ No____

FINANCIAL POLICY: Please read and sign below.

Our Financial Policy is designed to promote due diligence and provide a proactive rather than reactive strategy. With your participation, this policy will minimize and potentially eliminate errors and miscommunication about your insurance or other financial arrangement for payment. We will not become involved in disputes between you and your insurance company regarding, but not limited to; deductible, co-insurance, co-payments, covered services, pre-authorization, and usual and customary charges.

As a courtesy, we will verify your coverage, but we cannot guarantee the accuracy of the information we receive. We will bill your insurance on your behalf, however, you are ultimately responsible for the payment of your bill. It is your responsibility to know your level of coverage. You are responsible for payment of any co-payment at the time of service for any co pay, deductible, and coinsurance as determined by your contract with your insurance carrier, or any cash based services provided by Divine Psychology. If you have secondary insurance, you must present this information on your initial visit.

Many insurance companies have additional stipulations that may affect your coverage. You are responsible for any amount not covered by your insurer. If your insurance carrier denies any part of your claim, or if you and/or your physician elect to continue therapy past your approved period, you will be responsible for your account balance in full. If your account is not paid in full and is referred to a collection agency, any fees incurred in collecting on your unpaid balance will be your responsibility. For your convenience, we accept cash, checks and most major credit cards. A fee of $25 is charged to a patient's account for any returned checks. Patients will receive a statement every 30 days, if applicable. Payments can be made at each of our offices, mailed to the address on your statement, or by calling our billing department at (770) 449-5152. You may also may access our on-line bill payment option after you receive a statement. If you do have any concerns paying your bills, please ask us if you need to set-up a customized payment plan.

I have read the above policy regarding my financial responsibility to Divine Psychology for providing rehabilitative services to the above-named patient or me. I certify that the information provided is, to the best of my knowledge, true and accurate. I authorize my insurer to pay any benefits directly to Divine Psychology I agree to pay Divine Psychology the full and entire amount of all bills incurred by me or the above-named patient, if applicable, any amount due after payment has been made by my insurance carrier.

Responsible Party Signature_____Date_____

CANCELLATION/NO SHOW POLICY

Divine Psychology schedules patients to provide the highest level of quality care, while attempting to accommodate our patient's schedules at their convenience. By providing a reserved appointment time, we can minimize your wait time and assure continuity of your treatment. We understand that emergencies and other scheduling conflicts arise and are sometimes unavoidable. While we are sensitive to circumstances, chronic cancellations and no shows prevent us from accommodating other patients, as well as affecting your care.

Divine Psychology requires at least a 12 hours' notice for cancellations. Patients who do not give 12 hours' notice will be responsible for a $35.00 charge. You can notify our office of a cancellation by phone or email. Each appointment that is a NO SHOW will be subject to a charge on the first offense. This charge is not covered by Workers' Compensation, health insurance, or a third-party payer. It will be the responsibility of the patient to pay this charge.

After missing two appointments without notice, you may be placed on a same day scheduling policy for your treatments, which would not allow you to schedule any appointments in advance. This will require you to call for an open appointment on the day you would like to receive treatment. We will do everything possible to accommodate you, as the space on our schedule permits.

Please note that your attendance is recorded in your medical record and is available for your physician or third party payer to view. A patient's refusal to initial does not exempt them from this policy.

Thank you for giving us the opportunity to serve you, and please feel free to ask us any questions concerning our services, policies and fees.

Responsible Party Signature_____Date_____