KaraLee & Associates PC
CENTER FOR SELF & FAMILY

NEW PATIENT INFORMATION: Ages 18+

Patient Last Name: Patient First Name: Patient Middle Name:

DOB: SSN:

Gender Assigned at Birth: M [ ] F [ ] Gender Identity:

Address: City: Zip:

Home Phone: Cell Phone: Email:

EMERGENCY CONTACT INFORMATION

First & Last Name: Relationship: Phone:

INSURANCE INFORMATION

Primary Insurance: Policy #: Group #:

Subscriber Name: Subscriber DOB: Relationship:

SSN: Employer:

Secondary Insurance: Policy #: Group #:

Subscriber Name:

Subscriber Date of Birth: Relationship:

Social Security Number: Employer:

I AGREE THAT ALL INFORMATION LISTED ABOVE IS CORRECT & I CONSENT TO TREATMENT.

PATIENT/GUARDIAN SIGNATURE **DATE**

ATTENDANCE AND FINANCIAL POLICIES

Thank you for choosing KaraLee & Associates, P.C. as your mental health care provider. Please understand that payment of services rendered is considered part of your treatment and is expected at each session.

KaraLee & Associates, P.C. providers accept most insurance carriers, but each patient may be responsible for an annual deductible or co-payment, depending on their insurance provider. It is the patient's responsibility to keep track of their appointments and to keep their financial accounts current including copays, deductibles, and service fees.

By initialing each paragraph below, you are stating that you understand our attendance and financial policies.

_____(initial here) I agree to notify my clinician when canceling an appointment at least 24 hours in advance.

_____(initial here) I understand that if I miss my initial appointment, I will incur a $140.00 fee and services will be terminated.

_____(initial here) I understand that KaraLee & Associates, P.C. has the right to charge me $140.00 for missed appointments and cancellations with less than a 24-hour notification. Missed appointments or cancellations fees cannot be billed to my insurance company.

_____(initial here) I agree that if for any reason a check is returned on my account, I will be responsible for a $35 returned check fee in addition to the original fee(s) for service(s).

_____(initial here) I agree to notify KaraLee & Associates, P.C. of any changes in my address, phone number, insurance, or responsible party, if applicable, prior to my next appointment.

_____(initial here) I understand that if my balance remains unpaid for more than 90 days and/or exceeds $200, KaraLee & Associates, P.C. may refer my account to a collection agency, and future services may be withheld.

_____(initial here) I understand that I am financially responsible for services provided, whether or not paid for by insurance. Any service charges which are not covered by my insurance provider are my responsibility. Detailed fees for service are listed on the following page.

_____(initial here) I acknowledge that I have the right to receive a "Good Faith Estimate" if I am not using insurance to pay for my service.

ATTENDANCE AND FINANCIAL POLICIES (CONTINUED)

Potential Fees Incurred by Patient	Fee Associated
Records Request (legal, insurance or personal use)	Base Fee: $30.60 plus: Pages 1-20: $1.53 per page Pages 21-50: $0.77 per page Pages 51+: $0.31 per page
Records Request (continuation of care, records faxed to another medical office only)	Free of Charge
Paperwork/Forms to be Completed by Clinician or Psychiatrist short/long-term disability FMLA worker's compensation disability probation letters for school, lawyers, etc.	**Fee determined by time needed to complete:** 15 minutes: $62.50 30 minutes: $125.00 45 minutes: $187.50 60 minutes: $250.00
Cancellation of Appointment with Clinician or Psychiatrist (less than 24-hour notice given)	$140.00
Private Pay Clients (no insurance or insurance not used)	Clinicians - Initial Appointment: $210.00 Clinicians - Subsequent Appointments: $140.00 Psychiatrist - Initial Appointment: $250.00 Psychiatrist - Medication Reviews: $85.00

PATIENT/GUARDIAN SIGNATURE **DATE**

ADVANCED BENEFICIARY NOTICE OF NON-COVERAGE

Patient Name: _____ DOB: _____

Insurance: _____ ID#_____

I, _____ agree to arrange a payment plan with my provider
(print name here)
to continue services in the event that my insurance coverage lapses or does not cover services rendered. I understand that an Advanced Beneficiary Notice Form (below) must be filled out prior to continuing services.

REASON FOR ADVANCED BENEFICIARY NOTICE
(Patient/Guardian is responsible for any or all of the following reasons)

1. Maximum visits per insurance contract have been reached.
2. Client is insured by straight Medicaid.
3. Deductible, copay, and coinsurance are not eligible for secondary insurance payment.
4. No-show or Late Cancel with therapist/psychiatrist/nurse practitioner.

Amount of Payment Responsibility

Doctor/Nurse Practitioner Evaluation = $250; Medication Review = $85; Clinician Initial Session =$210; Clinician Subsequent Sessions = $140; No-Show / Late Cancel = $140

I agree that I am the responsible party and KaraLee & Associates, P.C. may ask for payment at the time services are rendered. By signing below, I understand that in the event that my insurance does not pay for mental health services, I agree to pay the amount due for services.

PATIENT/GUARDIAN SIGNATURE **DATE**

CREDIT CARD AUTHORIZATION REQUIRED FOR ALL CLIENTS

CREDIT CARD AUTHORIZATION

By signing this form, you are authorizing charges to your credit card by KaraLee & Associates, P.C. for services rendered.

I understand this authorization will remain in effect until I cancel it in writing and I agree to notify KaraLee & Associates, P.C. in writing of any changes in my account information or termination of this authorization.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form.

Credit Card Number:	
Credit Card Expiration:	
Credit Card Security Code: (usually, 3 digits located on the back of your card)	

I authorize KaraLee & Associates, P.C. to charge my credit card.

PATIENT/GUARDIAN SIGNATURE **DATE**

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that the KaraLee & Associates, P.C. Notice of Privacy Practices is available to me upon request.

PATIENT/GUARDIAN SIGNATURE **DATE**

CONSENT FOR TREATMENT

I hereby consent to receive treatment for therapeutic/psychological services through KaraLee & Associates, PC.

PATIENT/GUARDIAN SIGNATURE **DATE**

COMPLIANCE WITH CLINIC REQUIREMENTS

I hereby acknowledge an understanding of KaraLee and Associates, P.C. requirements. It is required to engage in ongoing therapy in order to maintain appointments with the psychiatrist/nurse practitioner.

PATIENT/GUARDIAN SIGNATURE **DATE**

UNDERSTANDING OF LEGAL PARTICIPATION

I hereby acknowledge the legal participation limits of KaraLee and Associates, PC. Therapists and Psychiatrists do not participate in custody proceedings, custody assessments, or court hearings.

PATIENT/GUARDIAN SIGNATURE **DATE**

INFORMED CONSENT FOR TELEHEALTH

Telehealth services are used when mental health staff are not physically present to evaluate your mental health needs and, if appropriate, prescribe medications. Mental Health staff may be present at another location and available to serve you through available technology.

I understand:

1. The potential risk of telehealth services is that there could be a partial or complete failure of equipment being used which could result in telehealth staff's inability to complete the evaluation, mental health services, and/or prescription process.

2. There is no permanent video or voice recording kept of the telehealth service's session.

3. All existing confidentiality protections apply.

4. All existing laws regarding client's access to mental health information and copies of mental health records apply.

5. I have the right to withdraw consent to telehealth services at any time by submitting a revocation of consent in writing.

I understand that I must be in a private location during all telehealth sessions.

PATIENT/GUARDIAN SIGNATURE **DATE**

COORDINATION OF CARE WITH PRIMARY CARE PHYSICIAN
NOT A REQUEST FOR RECORDS

Patient Name: DOB:

Authorize [ ] Do Not Authorize [ ]

The release of any information to my physician by KaraLee & Associates, PC and…

Physician Name: Phone #: Fax #:

Address: City: State: Zip:

To exchange information regarding mental/health/substance abuse treatment. The information exchanged may include diagnosis, medications prescribed and/or any medical concerns related to care. The purpose of this disclosure is for the coordination of care between KaraLee & Associates, P.C., and my physician. This release expires upon termination of my treatment with KaraLee & Associates, P.C., or upon my written request.

PATIENT/GUARDIAN SIGNATURE **DATE**

PERSONAL HISTORY

Presenting Symptoms

- ☐ Anger
- ☐ Anxiety
- ☐ Appetite change
- ☐ Decreased concentration
- ☐ Excessive worry
- ☐ Feeling hopeless
- ☐ Homicidal Ideations
- ☐ Hyperactivity
- ☐ Irritability
- ☐ Mood swings
- ☐ Paranoia
- ☐ Racing thoughts
- ☐ Sleep problems
- ☐ Suicidal Feelings

Presenting Concerns

- ☐ Academic Issues
- ☐ Behavior Issues
- ☐ Health Issues
- ☐ Legal Issues
- ☐ Relationship Issues
- ☐ Sexual Issues

Why have you come into treatment?

What would you like to accomplish by coming to KaraLee & Associates, P.C.?

SUICIDE & SELF-HARM

(circle or check yes or no)

	yes	no
Have you ever thought about suicide or harming yourself? (If yes, describe when and how in the space provided below…)	☐	☐
Do you have a history of suicide attempts or self-harm? (If yes, describe when and how in the space provided below…)	☐	☐
Do you currently feel suicidal? (If yes, please explain in the space provided below…)	☐	☐

Explain:

HOMICIDAL ISSUES

(circle or check yes or no)

	yes	no
Have you ever thought about killing or harming others? (If yes, describe when and how in the space provided below…)	☐	☐
Do you have a history of committing murder or harming others? (If yes, describe when and how in the space provided below…)	☐	☐
Do you currently feel homicidal? (If yes, please explain in the space provided below…)	☐	☐

Explain:

TRAUMA HISTORY

Have you experienced any of the following…

(If answered yes to any, please explain in the space provided below…)

(circle or check yes or no)

emotional abuse		**yes**	**no**	
physical abuse		**yes**	**no**	
sexual abuse		**yes**	**no**	
emotional neglect		**yes**	**no**	
physical neglect		**yes**	**no**	
physical assault		**yes**	**no**	
sexual assault		**yes**	**no**	
crime-related events		**yes**	**no**	
general disaster		**yes**	**no**	

Explain:

SOCIAL INFORMATION

Do you usually spend leisure time: [ ] Alone [ ] With family [ ] With friends

Describe your strengths:

Describe your hobbies:

EDUCATION & EMPLOYMENT

EDUCATION LEVEL:

Circle or check one…

Did not complete high school.		GED		High School Diploma		Vocational Training	
Associate's Degree		Bachelor's Degree		Master's Degree		Doctorate	

Have you experienced academic difficulties? [ ] Yes [ ] No

Have you experienced behavior difficulties? [ ] Yes [ ] No

OCCUPATION:

If employed, name of employer: _____

Job Title: _____

If a student, name of school: _____

Major: _____

Circle or check one…. ☐ Homemaker ☐ Retired ☐ Unemployed

What are your primary means of financial support?

☐ Self-Employed ☐ Full/Part Time Job ☐ Parents ☐ Spouse ☐ Retirement ☐ Disability

Have you ever served in the military? ☐ Yes ☐ No

If so, what branch? ☐ Army ☐ Air Force ☐ Coast Guard ☐ Navy ☐ Marines

Enlistment Date: Discharge Date:

FAMILY INFORMATION

Marital status: ☐ Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widowed

Spouse/Partner name: _____ **Age:** _____ **Living with you?** ☐ Yes ☐ No

Number of Siblings:

☐ I do not have children

Child/Adolescent Name	Age	Biological/Step/Adopted	Lives with you? (circle or check one)
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No
			☐ Yes ☐ No

Describe your relationship with your family:

(circle or check one)

At Childhood: ☐ Poor ☐ Strained ☐ Good ☐ Excellent

At Adulthood: ☐ Poor ☐ Strained ☐ Good ☐ Excellent

At Present: ☐ Poor ☐ Strained ☐ Good ☐ Excellent

(OPTIONAL)

(circle or check one)

Were you raised in a home that practiced religion? ☐ No ☐ Yes

Are you currently practicing religion? [ ] No [ ] Yes

☐ Catholic ☐ Christian ☐ Hindu ☐ Jewish ☐ Protestant ☐ Muslim ☐ Other:

Which ethnic group do you identify with?

☐ African American/Black ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other: _____

LEGAL HISTORY

Are you currently involved in: ☐ Probation ☐ DUI/OWI ☐ Divorce ☐ Custody

Explain:

SUBSTANCE USE

ALCOHOL USE:

Do you currently drink? ☐ No ☐ Yes: What is your weekly consumption? _____

Have you ever been told you should cut down on drinking? ☐ No ☐ Yes

Have you ever felt bad about your drinking habits? ☐ No ☐ Yes

Have you ever attended an AA/SMART group? ☐ No ☐ Yes: When? _____

Have you ever received a DWI, OWI, or DUI? ☐ No ☐ Yes: When? _____

Have you ever been treated for alcohol use? ☐ No ☐ Yes: When? _____

DRUG USE:

Do you use illegal drugs or drugs not prescribed to you? ☐ No ☐ Yes

Drugs used:

☐ Amphetamines ☐ Benzodiazepines ☐ Barbiturates ☐ Crack ☐ Cocaine

☐ Heroin ☐ Opiates ☐ Medical Marijuana

☐ Other:

Have you ever attended an NA group? ☐ No ☐ Yes: When?

Have you ever been treated for drug use? ☐ No ☐ Yes: When?

CAFFEINE USE: **[ ]** NOT APPLICABLE

How many cups per day of the following?

Coffee	
Tea	
Soda	
Energy Drinks	

SMOKING: Please check below the response that best summarizes your CIGARETTE smoking status

[ ] Never Smoked

[ ] Former smoker: Month/Year Quit: _____

[ ] Current smoker: Average number of cigarettes smoked per day: _____

MEDICAL HISTORY

Are you experiencing any physical pain at this time? [ ] Yes [ ] No

If yes, where?

Describe your current health: [ ] Poor [ ] Fair [ ] Good [ ] Very Good

Check all that apply to yourself or an immediate family member…

Myself

	Current	Past						
Abuse: Emotional/Physical/Sexual				Mother		Father		Sibling
Alcohol Abuse				Mother		Father		Sibling
ADD/ADHD				Mother		Father		Sibling
Anxiety				Mother		Father		Sibling
Asthma				Mother		Father		Sibling
Appendicitis				Mother		Father		Sibling
Bed wetting				Mother		Father		Sibling
Birth defects				Mother		Father		Sibling
Cancer				Mother		Father		Sibling
Chest pain				Mother		Father		Sibling
Chicken pox				Mother		Father		Sibling
Diabetes				Mother		Father		Sibling
Diarrhea				Mother		Father		Sibling
Exploitation				Mother		Father		Sibling
Fainting				Mother		Father		Sibling
Hearing				Mother		Father		Sibling
High blood pressure				Mother		Father		Sibling
Migraines				Mother		Father		Sibling
Nausea				Mother		Father		Sibling
Psychiatric hospitalization				Mother		Father		Sibling
Other:				Mother		Father		Sibling

Explain:

MEDICATION LOG

List prescribed or over-the-counter medication(s), herbal supplements, and medical marijuana you **currently** take below…

Medication	Dosage	Frequency	Prescriber

Allergies/Side Effects:

Pharmacy Name:

Phone Number:

MEDICAL HISTORY (CONTINUED)

List any major accidents, injuries, and/or surgeries: ☐ Not Applicable

Type _____

Reason _____

Date _____

Type _____

Reason _____

Date _____

Type _____

Reason _____

Date _____

Type _____

Reason _____

Date _____

Do you have any diet or nutritional concerns? [ ] No [ ] Yes
If yes, please explain:

Have you gained weight in the last 60 days? [ ] No [ ] Yes
If yes, please explain:

Have you lost weight in the last 60 days? [ ] No [ ] Yes
If yes, please explain:

Do you ever (circle or check an item)...

over-eat [ ] induce vomiting [ ] use laxatives [ ] exercise to get rid of calories [ ] skip meals

THERAPY GOALS

Please list what you hope to accomplish during therapy.

1.

2.

3.

4.

Signature of Patient/Guardian Completing Form **Date**

Therapist Signature with Credentials **Date**

Physician Signature with Credentials **Date**


KaraLee
&
Associates PC
CENTER FOR SELF & FAMILY