Mental Health Intake Form

Personal Information

Name: _____ Date: _____
Address: _____
Phone: _____ Email: _____
DOB: _____ Sex: _____
Primary Physician: _____ Phone: _____
Current Therapist: _____ Phone: _____

Complaint

What is your major complaint? _____
Start Date: _____ Have you previously suffered from this complaint? _____
Previous therapist(s) seen for complaint: _____
Previous treatment for complaint: _____
Aggravating Factors: _____
Relieving Factors: _____

Current Symptoms (Check All That Apply)

☐ Anxiety	☐ Appetite Issues	☐ Avoidance	☐ Crying Spells
☐ Depression	☐ Excessive Energy	☐ Fatigue	☐ Guilt
☐ Hallucinations	☐ Impulsivity	☐ Irritability	☐ Libido Changes
☐ Loss of Interest	☐ Panic Attacks	☐ Racing Thoughts	☐ Risky Activity
☐ Sleep Changes	☐ Suspiciousness	☐	☐

Medical History

Exercise Frequency: _____ Exercise Type(s): _____
Allergies: _____
What medications are you currently using? _____
Previous diagnoses/mental health treatment: _____
Previously treated by: _____
Previous medications: _____
Dates treated: _____
Previous medical conditions: _____
Previous surgeries: _____

Family History

Were you adopted? _____ If yes, at what age? _____
How is your relationship with your mother? _____
How is your relationship with your father? _____
Siblings and their ages: _____
Are your parents married? _____
Did your parents divorce? _____ If yes, how old were you? _____
Did your parents remarry? _____ If yes, how old were you? _____
Who raised you? _____ Where did you grown up? _____
Family member medical conditions: _____
Family member mental conditions: _____
Treated with medication? _____
Medications: _____

Early Development

Where did you grow up? _____
How often did you move and where? _____
How old were you when you left home? _____

Have any immediate family members died? _____ Who? _____
Have any committed suicide? _____ Who? _____
Describe any neglect you suffered, and by whom: _____
Trauma suffered and by whom: _____
Abuse suffered and by whom: _____
Highest education level completed: _____
Date completed and location: _____
Have you ever served in the military? _____ If yes, where? _____
Dates of service: _____ Highest rank achieved: _____

Present Situation

Work: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired
Are you married? _____ If yes, date of marriage: _____
Are you divorced? _____ If yes, date of divorce: _____
Prior marriages? _____ If yes, how many? _____
What is your sexual orientation? _____ Are you sexually active? _____
How is your relationship with your partner? _____
Do you have children? _____ Dates of Birth: _____
How is your relationship with your child(ren)? _____
List anyone else who lives with you: _____
Are you a member of a religion/spiritual group? _____
What is your level of involvement? _____
Have you ever been arrested? _____ When and why? _____

Have You Ever Tried the Following (Check All That Apply)

☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Hallucinogens (LSD)
☐ Heroin ☐ Methamphetamines ☐ Cocaine ☐ Stimulants (Pills)
☐ Ecstasy ☐ Methadone ☐ Tranquilizers ☐ Pain Killers

If yes to any, list frequency/dates of use: _____

Have you ever been treated for drug/alcohol abuse? _____ If yes, when? _____
For which substances? _____
Do you smoke cigarettes? _____ If yes, how many per day? _____
Do you drink caffeinated beverages? _____ If yes, how many per day? _____
Have you ever abused prescription drugs? _____ If yes, which ones? _____

Anything Else You Want the Doctor to Know

_____ _____
Signature Date

Medication Record

Name: _____

Date	Medication	Dose Given	Frequency (i.e. 2x per day)	Time	am / pm

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments?	YES	NO
May we leave a message on your answering machine at home or on your cell phone?	YES	NO
May we discuss your medical condition with any member of your family?	YES	NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

FINANCIAL RESPONSIBILITY FORM

I understand and agree that I am financially responsible for all charges for any and all services rendered by VIP Integrative Healthcare. Payment in full for services and products are due at the time services are performed or products are ordered.

If the undersigned fails to make any payments due to VIP Integrative Healthcare, VIP Integrative Healthcare may at any time thereafter, without notice or demand, declare the entire unpaid balance of the account to be immediately due and payable. The undersigned promise to pay all costs of collection, including but not limited to court cost and attorney fees equal to fifteen percent (15%) of any amount due and owing to VIP Integrative Healthcare. The undersigned expressly agrees and stipulates that in any litigation or court process that is necessary, in the sole discretion of VIP Integrative Healthcare, its representative, or its attorney, to enforce payment hereunder, that the venue for any such litigation or court process shall be the federal or state courts located in the city of West Palm Beach, FL and the undersigned expressly waives any right to object to such venue for any such litigation or trial.

_____ DOB ___/___/___

PRINT CLIENT NAME

_____ _____

CLIENT SIGNATURE DATE

VIP INTEGRATIVE HEALTHCARE POLICIES AND PROCEDURES

Clients must complete and sign this form prior to your first appointment. These policies and procedures will establish the expectations you will receive from the VIP Integrative Healthcare and also what is expected from you as the client.

1. APPOINTMENTS: Please arrive to your appointment time.

• Late arrival of 15 minutes or greater for any appointment may need to be rescheduled. If the appointment must be rescheduled, then the appointment is considered missed without cancellation $90.00 charge for the appointment.

• Rescheduling appointments: You may cancel your appointment at any time prior to the appointment. If you need to reschedule call the office and follow the prompts.

2. MISSED APPOINTMENT: If you have not cancelled your appointment in advance, you (not your insurance company), will be billed $90.00 for the appointment.

3. MEDICATION REFILLS AND OTHER CLINICAL NEEDS: If you have a life threatening or emergent need please go to your nearest emergency room or call 911.

• If you have a clinical/medication need please call the office 561.909.8555 and follow the prompts to leave a brief message. Most calls left during business days (Monday-Friday) are returned by the next business day. Non-urgent calls left on Friday, Saturday or Sunday will be returned on Monday.

• Prescription Refills: During office appointments clients are given enough medication until their next appointment. Therefore, refill requests outside of office appointments are subject to a $25.00 fee.

• No Text Messages: Please note that text messages are not accepted and will be deleted upon receipt.

• Email Response: Emails are addressed as time permits therefore it is recommended you call the office for any needs.

4. INSURANCE: A current insurance card must be presented prior to the first visit and when your insurance has changed. If not, you will be responsible for the self-pay rate of the appointment.

• If VIP Integrative Healthcare Services is not contracted with your insurance carrier or your visit is a non-covered service, you are responsible for the charges.

5. CREDIT CARDS:

• If you choose to pay with a credit card the information will be stored in a secure vault within our electronic health record and considered on file.

• I hereby authorize Martine Senatus APRN to charge the credit card on file for balances more than

60 days in arrears. This includes payments for missed appointments and fees not reimbursed or covered by insurance.

6. PAST DUE ACCOUNTS:

• Any remaining balance after insurance has been filed is your responsibility.

• You will receive two bills from VIP Integrative Healthcare Services. If you have not paid in full within 60 days your account will be turned over to a collection agency. If your account is sent to a collection attorney, they will report your past due status to a Credit Reporting Agency and you will be responsible for their fees.

• I agree that VIP Integrative Healthcare Services may contact me by telephone, electronic messages, mail or cell phone as provided by me or person on my behalf or that are identified as mine at a later date. I understand that these communications may be from this medical provider and/or those providing services within the facilities of, or on behalf of, this medical provider including communications about the scheduling, treatment or payment for services rendered. These calls include but are not limited to using an automatic telephone dialing system, artificial or prerecorded voice or calls to a telephone number assigned to a paging service, cellular telephone service, specialized mobile radio service, or other radio common carrier service ("Authorized Communications"). I understand that my agreement to the terms of the Patient Consent and Assignment of Insurance Benefits is not a condition of willingness to provide treatment to me. I consent to any and all of the authorized communication methods even if I will incur a fee or a cost to receive such communications. I agree that the consent and authorizations I have provided herein may be revoked only in writing addressed to the relevant entity.

7. COMPLETION OF FORMS: A fee is charged for the completion of forms including the following but not limited to: Disability, FMLA, and Leave of Absence, also Letters regarding flying and or airline tickets, coverage of medications and letters to employers. The client will always be notified of any charges upfront and payment may be requested prior to the release of the requested forms.

This is an agreement between you (the client or responsible party of the client) and VIP Integrative Healthcare

Services. By signing this agreement, you agree to abide by all the policies and procedures stated within.

Date: _____/_____/_____ Client's Name:

_____

Signature of Client or Responsible Party:

_____

Consent to Drug Testing

I, _____, understand that VIP Integrative Health Care needs my authorization to conduct a drug test Monitoring for prescriptive purposes. I have been informed of and understand the testing procedure.

I agree to provide any specimens needed to conduct the drug test. I understand that if I refuse to undergo drug screening, Possible Discontinuation of prescriptions. I understand too that if I consent to the test and the results are positive, the results will be reported to VIP Integrative Health Care and I may be Retest for violation of VIP Integrative Health Care's drug policy. This policy exempts the use of legally prescribed medications taken under the direction of a physician.

I have taken the following drugs or substances within the last 96 hours:

Drug Name	Dosage	Physician
_____	_____	_____
_____	_____	_____
_____	_____	_____

I hereby ( ) **consent** ( ) **refuse** to consent to undergo the drug test(s). I authorize any physician, laboratory, hospital, or medical professional retained by VIP Integrative Health Care to conduct this drug test and to provide the results to VIP Integrative Health Care. I release VIP Integrative Health Care, any person affiliated with VIP Integrative Health Care, and any institution or person conducting the drug test from liability. I give this consent pursuant to all state and federal privacy statutes and waive all rights to nondisclosure of this test record and results only to the extent of the disclosures authorized in this form.

I have read and understood this consent form, and I sign without any coercion or duress by any individual or institution.

Signature:_____ Date:_____

Name:_____

Street Address:_____

City, State, Zip Code:_____

Signature of parent/guardian:_____Date:_____

Parent/guardian name:_____