FREEDOM BEHAVIORAL HEALTH SOLUTIONS
dTMS | VR/AR THERAPY | MED MANAGEMENT

New Patient Intake Form

1. Patient Information

Patient First Name: ________________________ Middle Name/Initial: ________________________ Last Name: __________________ Date of Birth: __________________

Gender: ________________

Billing Street Address: ______________________________ Apt./Unit #: ____________ City: ________________________ State: _____ Zip Code: ____________

Home Phone: ________________________ Mobile Phone: ________________________ Work Phone: _____________________________________

Email Address: ____ Employer: _____________________________________

2. Emergency Contact

Emergency Contact: ____ Relationship to Patient: _____________________________________

Emergency Contact Phone Number: ____

3. How did you hear about Freedom Behavioral Health Solutions?

- ❑ Healthcare Provider (Physician)
- ❑ Friend/Relative
- ❑ Google
- ❑ Other

4. Who referred you to our clinic?

____

5. Do you have Insurance?

- ❑ Yes
- ❑ No

6. Insurance Information:

Primary Insurance Provider: ______________________ Effective Date: ______________________

Policy Number:(Tricare will be the Benefits Number And VA will be your social) ______________________ Group Number: ______________________

Name of Subscriber: ______________________ Subscriber's Date of Birth: ______________________

Relationship to Patient: ____________ Subscriber's Gender: ____________ Subscriber's Social Security Number: ______________________

7. Secondary Insurance Information: (if applicable)

Secondary Insurance Provider: ______________________ Effective Date: ______________________

Policy Number: ______________________ Group Number: ______________________

Name of Subscriber: ______________________ Subscriber's Date of Birth: ______________________

Relationship to Patient: ____________ Subscriber's Gender: ____________ Subscriber's Social Security Number: ______________________

11. Pharmacy Information:

Pharmacy Name: ______________________ Pharmacy Phone Number: ______________________

Street Address: ____________ Apt./Unit #: ______ City: ____________ State: ____ Zip Code: ______

12. What services are you interested in?

- ❑ Therapy
- ❑ Psychiatry/Medication Management
- ❑ Deep Transcranial Magnetic Stimulation (DTMS)
- ❑ Esketamine (Spravato) Therapy
- ❑ VR/AR Therapy

13. What is your main concern?

____

____

14. Have you ever been diagnosed with Depression, Anxiety, or PTSD?

- ❑ Yes
- ❑ No

15. Have you ever been prescribed one or more anti-depressants?

- ❑ Yes
- ❑ No

16. Did you have inadequate response or intolerable side effects to the anti-depressant(s) medication?

- ❑ Yes

- ☐ No

17. Have you had any suicidal throughts or attempts? (past or present):

____

18. Have you been seen by past psychiatrists, mental health nurse practitioners and/or therapists in the past? If yes, please list and explain:

	Name of Professional	Date(s)	Reason/Diagnosis
1			
2			
3			

19. Have you ever been Psychiatrically hospitalized? If yes, please list and explain:

	Location	Date	Reason
1			
2			

Current Living Situation/Family Background

20. Marital Status: ____________________________________

Children/Ages: ____

Education Level: ___________________________________

Current Job Position: ____

Have you served in the U.S. Military? If yes, please list branch, how many years and how many deployments:____

____

Substances Used? (Please circle): Alcohol, THC/Marijuana, Opioids, Amphetamines, Cocaine, Hallucinations Ecstasy, LSD, PCP

21. Please list any medical diagnoses that you have been diagnosed with (present and past):

____

22. Do you have allergies to any medications? If so, please list your reaction: ___________________________

____

____

23. List ALL CURRENT Medications (list names and what for):

	Name of Medications	Dose/Frequency	Start Date	Reason for Use	Prescriber
1					
2					
3					
4					
5					
6					
7					

8					

24. Previous Psychiatric Medications (list names and what for):

	Name of Medications	Dose/Frequency	Start Date	Reason for Use	Prescriber
1					
2					
3					
4					
5					
6					

25. Dietary/Herbal Supplements (list names and what for):

	Name of Medications	Dose/Frequency	Start Date	Reason
1				
2				
3				
4				
5				
6				

26. Do you regularly see a Primary Care Physician? If so, who is your provider and when was you last visit:

____

CURRENT HEALTH FUNCTIONING

27. Sleep

What is your typical bedtime? ____________________

What is your typical wake time? ____________________

Do you have any concerns with your sleep?

____

____

28. Are there any accommodations that would assist in facilitating your visit: (for example: wheelchair accessibility, etc.):

____

****Please send a picture of your Photo ID and your Insurance Card (front and back) to info@freedombhs.com(for Manhattan Ks), inforER@freedombhs.com (for Eagle River), infoEP@freedombhs.com (for El Paso), and infokilleen@freedombhs.com (for Killeen)****

____ ____________________

Patient Signature Date

FREEDOM BHS TREATMENT CONTRACT FOR ADULTS

This document contains important information about our professional services and business policies. When you sign this document, it will represent an agreement between you and Freedom BHS.

Acknowledgment: I acknowledge that all information provided, whether verbal, in writing, or through any form of digital communication, will be utilized and binding to Freedom BHS.

Receipt of Privacy Practices: We are required by law to provide this notice to you and obtain your acknowledgment of this receipt before providing any services to you. I acknowledge receipt of Notice of Privacy Practices.

Consent to Treatment: After reading below, I consent to receive mental health care to include initial evaluation and ongoing treatment by staff from Freedom BHS.

Contacting your provider: ***Due to the nature of our outpatient clinic, your provider is often not immediately available by telephone.*** However, our providers are generally in the office between 8:00 AM and 6:00 PM Monday-Thursday and 8:00 AM to 12:00 PM on Fridays. If you have a treatment-related message during business hours, you can contact our office at 785-775-0221 and request to speak with a clinical nurse to discuss your needs. Someone from our staff will make every effort to talk to you when you call.

If you are ever experiencing an emergency and you are not able to speak with our nurse or other staff promptly, please follow the other guidelines in getting immediate help:

1. If you feel you are in imminent danger or feel unsafe, call **911.**

2. For all other emergency needs, call the Pawnee Mental Health Crisis Stabilization Unit. This emergency service can be contacted 24 hours a day, 7 days a week, 365 days a year. Call them at **1-800-609-2002**, or for non-emergency calls 785-587-4302 for anyone experiencing a mental health crisis. You can also contact The Crisis Stabilization Unit at **785-539-2785.** Both establishments have qualified staff to see you and make appropriate recommendations.

Scheduling and Attendance Policy

Scheduling appointments: The individual provider will determine your treatment plan at the initial evaluation. Your provider will recommend the number of treatment visits and visit frequency; this may vary patient to patient.

Our scheduling policy differs between medical staff and psychotherapy staff appointments and may vary between providers. Medical appointments with a psychiatry provider may be scheduled out as far as 3-6 months, and psychotherapy appointments are typically scheduled out 2-months at a time. After discussing your treatment plan with your provider at each visit, please stop at the front desk to schedule and confirm upcoming appointments. You can always add additional appointments to the schedule ahead of time to plan and hopefully get the appointment that works best for your schedule. Please understand that certain times are the most popular for all patients or families. Our providers and scheduling staff attempt to accommodate all our patients' needs to the best of our abilities. However, there may be some situations in which appointments times are only available at certain times of the day.

While we understand that things happen, attendance with both psychotherapy and medication management appointments is extremely important. Effective treatment is based on regular follow-ups for consistent progress to be made. In addition, our clinicians' time is valuable to other patients and financially to the clinic. Not attending your recommended appointments can limit your ability to progress in treatment and limit our clinic's ability to see other patients who could have benefitted from filling your missed appointment time. Maintaining scheduled appointments helps the clinic keep the cancellation and waitlists low or non-existent, helping us to provide care to as many patients as possible.

Rescheduling/Cancellation: If you become aware that you will miss an appointment or need to reschedule, please call the office at **785-320-7331**. Should you require the cancellation or rescheduling of an appointment, we respectfully request a minimum of 24 hours' notice. This advance notice allows us the opportunity to allocate your appointment slot to another patient in need. Maintaining a full schedule for our providers enhances our ability to deliver services more efficiently and promptly to you.

Late Notice: We ask that you call the office at **785-775-0221** and let us know if you are running late for your appointment. If you are more than 10 minutes late for an appointment, it is at each provider's discretion whether you can be seen that day. If you are seen, it will only be during the remaining allotted time of your appointment. There will unfortunately be times in which we will have to reschedule your appointment to another day and/or time in respect to the provider's schedule, as well as the patient who is also scheduled for that day. Getting you in for your appointment will always be a priority for Freedom BHS.

No-Show Policy: Due to these reasons Freedom Behavioral Health Solutions has instituted a 24-hour cancellation policy. In the event you are unable to make it to your appointment, we ask that you give us as much notice as possible. If you miss more than 2 appointments without giving 24-hour notice in a 6-month period, you will be put on scheduling probation. This probation period will last for 6 months from the time of the last missed appointment. During that time, you will only be able to schedule appointments for the week of the desired appointment, or to be placed on a cancellation list to be called if your provider has a cancellation during that week.

Exceptions can be made for unforeseen circumstances such as emergency sickness, or other emergency situations that are out of the client's control. However, even in these situations, it will be the responsibility of the patient to contact the clinic as soon as possible to communicate the reason for the missed appointment.

Medication Refills

If you need a refill for any medication, **please call your pharmacy first** to see if a prescription is already sent or ready. Please **allow 72 hours for a prescription to be refilled** by the Freedom BHS's staff. If you have not had an appointment within the last 3 months, you may be required to schedule an appointment or call in with requested vitals, to be seen before we refill your medication. Refills may be delayed if you do not schedule and attend regular appointments.

Freedom BHS's medical staff will not receive requests for medication refills on weekends, holidays, or outside regular office hours.

Confidentiality

The privacy of all communications between a patient and a psychotherapist is protected by law. Generally, our providers can only release information about you to others with your written permission. There are some important exceptions to confidentiality. Further information on this can be found in the Notice of Privacy Practices. Freedom BHS providers are required by law or by the guidelines of their profession to disclose information, whether they have your permission or not, in the following situations:

• In most legal proceedings, you have the right to prevent your mental health provider from releasing any information about your treatment. In some legal proceedings, a judge may order the release of records or testimony if he/she determines that the issues demand it, and our providers may be obligated to comply with that court order.

• There are some situations in which our providers are legally obligated to take action to protect others from harm, even if they must reveal some information about a patient's treatment. For example, if the provider believes that a child,

elderly person, or disabled person is being abused or has been abused, our provider must make a report to the appropriate state agency.

• If the provider believes that a patient is threatening serious bodily harm to another, they may be required to take protective actions. These actions may include notifying the potential victim, contacting the police, or seeking hospitalization for the patient. If the patient threatens to harm themselves, the therapist may be obligated to contact family members or others who can help provide protection and safety. If a similar situation occurs during your treatment, the provider will attempt to fully discuss it with you before taking any action.

• Adult patients still using parents' medical insurance: When a person receives services using medical insurance, the insurance company sends a statement called an Explanation of Benefits (EOB) that explains which services were used and paid for. If you use your parents' insurance for mental health services, your parents may receive an EOB outlining the services you used. However, they will not be able to access your records or find out what you discussed during your sessions with a provider.

• Your therapist may occasionally find it helpful to consult other professionals about a case. Within Freedom BHS, we belief strongly in team-based and integrated care. Therefore, if you see a psychiatry provider and a psychotherapy provider, they will consult with each other and share information about your treatment.

Fees for required court/legal proceedings

If a specific case in which a provider of Freedom BHS was required to be involved in legal proceedings, the following guidelines will be followed:

If Freedom BHS professionals were to receive a subpoena, the attorney or office staff needs to call Freedom BHS and set up a time for the subpoena to be served during office hours. We request a minimum of 72-hour notice of any court appearance so that schedule changes for the professional can be made within a reasonable time. **Please note:** If a subpoena or notice to meet attorney(s) is received without a minimum of 72-hour notice, there will be an additional $500.00 express charge, which must be paid prior to the professional's involvement in the court or legal situation. When it comes to court and legal actions required, the following fees are in effect so that our business is not harmed by the provider being pulled out of their regular duties:

1. Preparation time from the professional (including submission of records): $500.00/hr (billable in 15- minute increments)

2. Phone calls with attorneys or legal representatives: $500.00/hr (billable in 15-minute increments)

3. Depositions: $500.00/hour.

4. Time required in being available for a court appearance, needing to be present at the courthouse, or providing testimony: $500.00/hour

5. Mileage: Current Federal reimbursement rates.

6. All attorney fees and costs incurred by Freedom BHS professionals due to the legal action. This includes paying the Freedom BHS provider's legal representation to prepare for court responsibilities.

7. Paper copies of medical records: the fees allowed by the State of KS will be charged. If a Freedom BHS professional is subpoenaed, and the case is continued with less than 24 hours' notice before the beginning of the day of the scheduled court appearance- and/or the testimony is not given. The attorney will be charged $1,000.00. After reading through and

considering all of the conditions above and having the opportunity to ask questions please sign below to continue with treatment at Freedom BHS.

Telehealth Consent

I hereby consent to participate in telehealth with Freedom Behavioral Health Solutions as part of my treatment with my provider. I understand that telehealth is the practice of receiving clinical health care services via technology assisted media or other electronic means between the provider and the client via two differing locations.

I understand the following with respect to telehealth:

1. I have the right to withdraw consent at any time without affecting my right to future care, services, or program benefits to which I would otherwise be entitled.
2. There are risks, benefits, and consequences associated with telehealth, including but not limited to, disruption of transmission by technology failures, interruption, and/or breaches of confidentiality by unauthorized persona, and/or limited ability to respond to emergencies.
3. There will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. Freedom BHS follows the primary law that protects the confidentiality of my protected health information (PHI) when partaking in any telehealth appointment.
5. If I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telehealth services are not appropriate, and a higher level of care is required.
6. During a telehealth session, we could encounter technical difficulties resulting in service interruptions. If this occurs, end and restart the session. **If we are unable to reconnect within five minutes, please call our front desk at (785) 775-0221** to discuss options of completing your visit in full. Unfortunately, there may be times in which we may need to reschedule your appointment to a future time.
7. My provider may need to contact my emergency contact and/or appropriate authorities in case of an emergency.

Professional Fee Policy

We require that you provide a credit card on file with our office for all telehealth visits. Your payment information is stored on our EHR secure system. Office personnel will not have access to your card. For your protection, only the last 4 digits of your card will show in our system. Your credit card on file will be used to pay account balances after insurance adjustments. Once your insurance has processed your claims, they will send an Explanation of Benefits (EOB) to both you and our office showing what your total patient responsibility is. **You typically receive the EOB before we do, so if you disagree with the patient responsibility amount owed, it is your responsibility to contact your insurance carrier immediately.**

Payment Policy

1_____ I will pay my verified copayment of $_______ per visit.

2_____ I will pay $_______ per visit until the given deductible has been met.

3_____ I will pay $______ per visit as I do not have insurance to submit with. I will be a Self-Pay patient. I understand that Freedom BHS's Self-Pay costs are as listed: *Initial Evaluation (Therapy): $160.00, Initial Evaluation (Meds): $260.00, Follow Up Visit (Therapy): $155.00, Follow Up Visit (Meds): $135.00*

TMS Individual Treatment: $250.00   Full (36) TMS Treatment: $8,000.00   TMS Maintenance Treatment: $150.00

4_____ Other (Please explain): ____

Please understand that your insurance benefits information has been verified by your insurance carrier(s). Freedom BHS will establish your payment plan in accordance with the information they have been provided. The information provided by your insurance carrier(s) is not a guarantee of payment by your insurance carrier(s). The monetary responsibility for services rendered is the responsibility of the patient.

All copays must be paid at the time of service, and we also ask that an estimated amount be paid towards your deductible and/or co-insurance at each visit, until met. If you have chosen to be seen via Telehealth, we will reach out for payment within 24 hours after completing your appointment, via your credit card on file. This is put in place in order to keep patient balances low and manageable for all parties.

Upon receiving your monthly statement, we expect that you remit payment in full for your account balance. In the event that you are unable to pay in full, please understand that the balances of $0-500 much be paid in full within 60 days of receiving your statement. Balances of $500 or greater must be paid in full within 120 days (about 4 months) of receiving your initial statement.

I hereby assign all benefits directly to Freedom BHS and authorize release of any medical records necessary to facilitate my treatment to process medical claims and as otherwise permitted or required in the Notice of Privacy Practices. **I understand that if my insurance company or financially responsible party does not pay for the services I receive, I will be financially responsible for payment in full. I also understand that if any prior authorization is needed for any service with Freedom BHS per my insurance company, it is my responsibility to do so.**

Mental health treatment is based upon an individualized plan developed collaboratively between you and the mental health clinician. It may include psychotherapy, medication, TMS treatment, etc.

Please list any persons to whom protected health information may be released. Example: Spouse or Parent

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I have thoroughly read the information provided above and agree to the information explained throughout this consent form in full.

Patient or Guardian Printed:____________________________________ Date:________________

Patient or Guardian Signature____________________________________ Date________________