FAMILY WELLNESS CENTER OF NORMAN

2760 Washington Drive, Suite 110 Norman, OK 73069
Phone (405)360-2827 Fax (405)283-1124
www.FamilyWellnessNorman.com

Welcome to Family Wellness Center of Norman. We strive to provide compassionate behavioral health care for children, adolescents, and their families.

New patients must complete and return paperwork to our office two business days in advance or appointment will be cancelled, with no notice, you will be charged a no-show fee of $50, and the office will schedule someone else in the appointment slot instead. It is encouraged to verify your completed packet was received and nothing else was needed by calling our office to confirm your appointment two business days prior to your appointment. A late or now show fee of $50 will be made if paperwork is not completed in time, the appointment is missed, the patient and parent/guardian is not available at appointment time, or 24 hours' notice was not given for cancellation. Consecutive missed appointments (two or more in a row) will result in further being dismissed as a patient, and you will not be able to reschedule with our office or receive any medication refills. We ask that if you are having problems filling out the paperwork and sending the completed paperwork back to us two days prior to your appointment, please let our office know when you arrive to pick up a packet or to fill out a packet in person; the packet is expected to be completed two business days prior to the appointment. For in person appointments, we expect your arrival 10 minutes before your appointment to allow time to get vitals, payments, and anything else needed upon your arrival.

Please email completed paperwork to info@fwcnorman.com along with the following additional items needed for your first appointment:

- ID or driver's license
- Insurance cards (front and back copies) and subscriber information (primary subscriber's full legal name, date of birth and social security number)
- Payment for your deductible or copay
- DHS, custody, or adoption papers
- Medication list
- Previous provider's contact information for record requests (Office name, provider name, address, phone number, fax number, and estimated dates seen there)

TELEMEDICINE:
Telemedicine is highly acclaimed by providers and patients across the world, as the provider can provide quality care through virtual or video visits as they would be able to if they were here in person. This also offers patients the benefit of being seen from home in cases of convenience, emergency, health concerns, transportation, or other issues that may make coming to our office difficult for the patient. **You will receive an email with the Zoom link from TelemedReminder@mail.insynchcs.net. When your patient portal account is created, you can also log in to your patient portal, go to appointments, and click on the telemedicine link next to the appointment to start zoom video. Keep in mind that the Zoom link is only available 15 minutes before the visit. You will click on the link just before your appointment time and wait to be admitted to the Zoom meeting by the provider. Please call our office at or before your appointment time if you have any technical problems connecting virtually with your provider or receiving the zoom link by email. We highly encourage trying Zoom.com before the visit.**

Family Wellness Center of Norman **Adult Intake Form**

CLIENT NAME: _____

PLEASE FILL OUT FORMS IN BLACK INK ONLY

Patient's first name: _____ MI: ____ Last name: _____
Nick name: _____ Alternative/Maiden name: _____
Date of birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____
Sex: ( ) Male ( ) Female ( ) Transgender Race: _____

Primary address: _____ City: _____ Zip Code: _____
Secondary address: _____ City: _____ Zip Code: _____
PO Box/Mailing address: _____ City: _____ Zip Code: _____
Patient's home phone number: _____ Patient's cell phone number: _____
Is it okay for us to leave a detailed voice message? Yes / No
Patient's email: _____

Primary Provider: _____ When was your last appointment? _____
Therapist: _____ When was your last appointment? _____
Referred by: _____ Referred for: _____

Interested in: ( )Medication management ( )TMS treatments for depression ( )Therapy -not offered at FWCN currently

Preferred pharmacy name: _____
Pharmacy address: _____ City: _____ Zip Code: _____

Primary guardian name: _____
Relationship: ( ) Mom ( ) Dad ( ) Foster Parent ( ) Other: _____
Home phone number: _____ Cell phone number: _____
Email: _____
Secondary guardian name: _____
Relationship: ( ) Mom ( ) Dad ( ) Foster Parent ( ) Other: _____
Home phone number: _____ Cell phone number: _____
Email: _____

We ask that written permission to be given to our office for anyone that will be bringing patients under 18 years old or under guardianship. This person or persons will need to be aware of the patient's current state and medical history, and be able to make medical decisions, or the parent will need to be available during the appointment or be at the appointment. If there is a guardianship or custody arrangement (court ordered or not), we ask that a copy be provided to our office before your first appointment. Please let us know if there are any changes or provisions to that arrangement that we need to be aware of. In addition to this, there is a release of information to a designee and authorization for release of information to receive or disclose information to previous or future providers located towards the end of the packet.
Who is the primary parent/guardian/caregiver responsible for making medical decisions? _____
Is there anyone else responsible for making medical decisions? _____
Is there anyone else responsible for making medical decisions when parent/guardian/caregivers are not available?
_____
Current custody or guardianship arrangement (sole, partial, etc.): _____
Has custody or guardianship changed in the past? If yes, what was the previous arrangement?:
_____
Caseworker name and phone number: _____

Primary emergency contact: _____ Relationship: _____
Home phone number: _____ Cell phone number: _____
Secondary emergency contact: _____ Relationship: _____
Home phone number: _____ Cell phone number: _____

Family Wellness Center of Norman **Adult Intake Form**

CLIENT NAME: _____

Primary insurance subscriber's full name: _____ Relationship: _____
Subscriber's date of birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____
Primary insurance name: _____ Copay: _____
Policy #: _____ Group #: _____

Secondary insurance name: _____ Copay: _____
Secondary insurance subscriber's full name: _____ Relationship: _____
Subscriber's date of birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____
Policy #: _____ Group #: _____

Tertiary insurance name: _____ Copay: _____
Tertiary insurance subscriber's full name: _____ Relationship: _____
Subscriber's date of birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____
Policy #: _____ Group #: _____

If you would like to join our patient portal to have access to the patient's visit notes, lab results, requesting medication refills, appointment reminders, asking your provider a question, receiving health reminders, notifications from your provider, and much more, please print your email address below. **Sign up for Patient Portal?** Yes / No

If yes, print email address: _____

What are the problem(s) for which you are seeking help?
1. _____
2. _____
3. _____

What are your treatment goals?
1. _____
2. _____
3. _____

Current Symptoms Checklist
(check once for any current regular symptoms, check twice for any current major symptoms)

[ ] [ ] Depressed mood
[ ] [ ] Unable to enjoy activities
[ ] [ ] Sleep pattern disturbance
[ ] [ ] Loss of interest
[ ] [ ] Concentration/forgetfulness
[ ] [ ] Racing thoughts
[ ] [ ] Impulsivity
[ ] [ ] Increase risky behavior
[ ] [ ] Increased libido
[ ] [ ] Decreased need for sleep
[ ] [ ] Excessive energy
[ ] [ ] Increased irritability
[ ] [ ] Crying spells
[ ] [ ] Excessive worriedness
[ ] [ ] Anxiety attacks
[ ] [ ] Avoidance
[ ] [ ] Repetitive behaviors
[ ] [ ] Thoughts of harming someone else
[ ] [ ] _____
[ ] [ ] _____
[ ] [ ] _____

Family Wellness Center of Norman **Adult Intake Form**

CLIENT NAME: _____

Review of Systems

What symptoms are you experiencing? If yes, please circle or underline the symptom.

- YES / NO Constitutional: Weight loss, weight gain, fever, poor appetite, fatigue, insomnia, night sweats
- YES / NO Eyes: Blurry vision, eye pain, discharge, redness, decrease in vision, dry eyes, double vision
- YES / NO ENT: Sore throat, hoarseness, ear pain, hearing loss, nose bleeds, tinnitus, sinus problems
- YES / NO Cardiovascular: Chest pain, palpitations, rapid heart rate, swelling in legs or feet, fainting
- YES / NO Respiratory: Shortness of breath, cough, coughing blood, tuberculosis, excess sputum production
- YES / NO Gastro: Nausea, vomiting, diarrhea, constipation, blood in stool, heartburn, trouble swallowing
- YES / NO Genitourinary: Frequent urination, blood in urine, loss of bladder control, painful urination, urinary retention, frequent UTI's
- YES / NO Musculoskeletal: Joint pain, muscle pain, frequent leg cramps, weakness, bone pain, joint swelling, back pain
- YES / NO Skin: Rash, hives, hair loss, skin sores or ulcers, itching, skin thickening, nail changes, mole changes
- YES / NO Endocrine: Goiter, heat intolerance, cold intolerance, increased thirst, excess sweating
- YES / NO Neurological: Seizures, tremors, migraines, numbness, dizziness, loss of balance, slurred speech, stroke
- YES / NO Hem/Lymphatic: Low blood count, easy bruising, swollen lymph nodes, transfusions, prolonged bleeding, blood clots
- YES / NO Allergy/Immune: Allergic reactions, hay fever, frequent infections, hepatitis, HIV positive, positive TB
- YES / NO Psychiatric: Anxiety, depression, panic attacks
- YES / NO Other Complaints: _____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? [ ] Yes [ ] No

If YES, please answer the following.

If NO, please skip to the next section.

Do you currently feel that you don't want to live? [ ] Yes [ ] No

How often do you have these thoughts? _____

When was the last time you had thoughts of dying? _____

Has anything happened recently to make you feel this way? _____

Would anything make it better? _____

Have you ever thought about how you would kill yourself? _____

Is the method you would use readily available? _____

Have you planned a time for this? _____

Is there anything that would stop you from killing yourself? _____

Have you ever tried to kill or harm yourself before? _____

Do you have access to guns? [ ] Yes [ ] No

If yes, please explain: _____

Family Wellness Associates **Adult Intake Form**

CLIENT NAME: _____

Past Medical History

Allergies: _____

_____

_____

List all **current prescription medications** and how often you take them:

_____

_____

_____

_____

List all **current over-the-counter medications or supplements** and how often you take them:

_____

_____

_____

_____

Current medical problems:

_____

_____

_____

Past medical problems, non-psychiatric hospitalizations, or surgeries:

_____

_____

_____

Additional Information:

Is there anything else you would like us to know?

_____

_____

For Women Only

Are you currently pregnant or do you think you might be pregnant? [ ] Yes [ ] No

Are you planning to get pregnant in the near future? [ ] Yes [ ] No

Birth control method: _____

Family Medical/Psychiatric History Please list any major medical or psychiatric history for your immediate family

_____

_____

_____

_____

_____

Past Psychiatric History

Have you ever had outpatient treatment? [ ] No [ ] Medication management [ ] Therapy

[ ] Ketamine [ ] Spravato [ ] TMS [ ] Other: _____

If yes, please describe when, by whom, and reason for treatment

_____

_____

_____

_____

Psychiatric Hospitalization? [ ] Yes [ ] No

If yes, please describe when, where, and reason for treatment

_____

_____

_____

_____

Family Wellness Center of Norman **Adult Intake Form**

CLIENT NAME: _____

Past Psychiatric Medications

Please check all, if any, of the following medications. Please indicate the dates, dosage, and how helpful they were to the best of your ability, including all the details you can remember.

ANTIDEPRESSANT Medication name	Works well	Helped some	Did not work	Bad reaction or side effect	When? (Month/Year)	Taken more or less than 6 weeks	Maximum dose taken?
Prozac (fluoxetine)						More/Less	
Zoloft (sertraline)						More/Less	
Luvox (fluvoxamine)						More/Less	
Paxil (paroxetine)						More/Less	
Celexa (citalopram)						More/Less	
Lexapro (escitalopram)						More/Less	
Effexor (venlafaxine)						More/Less	
Cymbalta (duloxetine)						More/Less	
Wellbutrin (bupropion)						More/Less	
Remeron (mirtazapine)						More/Less	
Anafranil (clomipramine)						More/Less	
Pamelor (nortriptyline)						More/Less	
Elavil (amitriptyline)						More/Less	
Trintellix (vortioxetine)						More/Less	
Viibryd (vilazodone)						More/Less	
Emsam(selegiline transdermal patch)						More/Less	
Spravato nasal spray (esketamine)						More/Less	
Ketamine IV infusion						More/Less	
Other-						More/Less	
ANTIANXIETY Medication name	**Works well**	**Helped some**	**Did not work**	**Bad reaction or side effect**	**When? (Month/Year)**	**Taken more or less than 6 weeks**	**Maximum dose taken?**
Xanax (alprazolam)						More/Less	
Ativan (lorazepam)						More/Less	
Klonopin (clonazepam)						More/Less	
Valium (diazepam)						More/Less	
Tranxene (clorazepate)						More/Less	
Buspar (buspirone)						More/Less	
Vistaril (hydroxyzine, atarax)						More/Less	
Other-						More/Less	

Family Wellness Center of Norman **Adult Intake Form**

CLIENT NAME: _____

ANTISEIZURE/ MOOD STABILIZER Medication name	Works well	Helped some	Did not work	Bad reaction or side effect	When? (Month/Year)	Taken more or less than 6 weeks	Maximum dose taken?
Tegretol (carbamazepine)						More/Less	
Lithium (lithium carbonate)						More/Less	
Depakote (valproate)						More/Less	
Lamictal (lamotrigine)						More/Less	
Tegretol (carbamazepine)						More/Less	
Topamax (topiramate)						More/Less	
Other-						More/Less	
ANTIPSYCHOTIC/ MOOD STABILIZER Medication name	**Works well**	**Helped some**	**Did not work**	**Bad reaction or side effect**	**When? (Month/Year)**	**Taken more or less than 6 weeks**	**Maximum dose taken?**
Seroquel (quetiapine)						More/Less	
Zyprexa (olanzapine)						More/Less	
Geodon (ziprasidone)						More/Less	
Abilify (aripiprazole)						More/Less	
Abilify Maintena injection (aripiprazole)						More/Less	
Aristada injection (aripiprazole lauroxil)						More/Less	
Clozaril (clozapine)						More/Less	
Latuda (lurasidone)							
Risperdal (risperidone)						More/Less	
Rexulti (brexpiprazole)						More/Less	
Vraylar (cariprazine)						More/Less	
Invega (palperidone)						More/Less	
Invega injection- Sustenna or Trinza (palperidone)						More/Less	
Saphris (asemapine)						More/Less	
Caplyta (lumateperone)						More/Less	
Haldol (haloperidol)						More/Less	
Prolixin (fluphenazine)						More/Less	
Other-						More/Less	
SEDATIVE/ HYPNOTICS	**Works well**	**Helped some**	**Did not work**	**Bad reaction or side effect**	**When? (Month/Year)**	**Taken more or less than 6 weeks**	**Maximum dose taken?**
Ambien (zolpidem)						More/Less	
Sonata (zaleplon)						More/Less	
Rozerem (ramelteon)						More/Less	

Restoril (temazepam)						More/Less	
Trazodone (desyrel)						More/Less	
Melatonin (OTC)						More/Less	
Other-						More/Less	
ADD/ADHD Medication name	**Works well**	**Helped some**	**Did not work**	**Bad reaction or side effect**	**When? (Month/Year)**	**Taken more or less than 6 weeks**	**Maximum dose taken?**
Adderall (amphetamine)						More/Less	
Mydayis (amphetamine)						More/Less	
Vyvanse (lisdexamfetamine)						More/Less	
Focalin (dexmethylphenidate)						More/Less	
[ ] Concerta [ ] Ritalin [ ] Aptensio [ ] Metadate [ ] Quillachew [ ] Quillivant [ ] Jornay PM [ ] Daytrana patch (methylphenidate)						More/Less	
Strattera (atomoxetine)						More/Less	
Intuniv (guanfacine)						More/Less	
Kapvay (clonidine)						More/Less	
Qelbree (viloxazine)						More/Less	
Other-						More/Less	

Substance Use

Have you ever been treated for alcohol or drug use or abuse? [ ] Yes [ ] No
If yes please explain: _____
How many days per week do you drink any alcohol? _____
What is the least number of drinks you will drink in a day? _____
What is the most number of drinks you will drink in a day? _____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____
Have you ever felt you ought to cut down on your drinking or drug use? [ ] Yes [ ] No
Have people annoyed you by criticizing your drinking or drug use? [ ] Yes [ ] No
Have you ever felt bad or guilty about your drinking or drug use? [ ] Yes [ ] No
Have you ever had a drink or used drugs first thing in the morning to steady your nerves? [ ] Yes [ ] No
Have you ever had a drink or used drugs first thing in the morning to get rid of a hangover? [ ] Yes [ ] No
Do you think you may have a problem with alcohol or drug use? [ ] Yes [ ] No
Have you used any street drugs in the past 3 months? [ ] Yes [ ] No If yes, which ones?
_____
Have you ever abused prescription medication? [ ] Yes [ ] No
If yes, which ones and for how long? _____
Have you ever used marijuana? [ ] Yes [ ] No
Do you currently use marijuana? [ ] Yes [ ] No
If yes, for how long? _____ How many packs, cartridges, or cans per day on average? _____

Family Wellness Center of Norman **Adult Intake Form**

CLIENT NAME: _____

Tobacco History

Have you ever smoked, vaped, or chewed tobacco? [ ] Yes [ ] No
Do you currently smoke, vape, or chew tobacco? [ ] Yes [ ] No
If yes, for how long? _____ How many packs, cartridges, or cans per day on average? _____
Have you tried quitting? [ ] Yes [ ] No Are you interested in quitting? [ ] Yes [ ] No [ ] Maybe

Trauma History

Have you experienced trauma of any kind, or do you have a history of being abused (emotionally, sexually, physically or by neglect)? [ ] Yes [ ] No [ ] Maybe
If yes, please explain briefly: _____
_____

Educational History

What is the highest grade level you completed? _____
Did you attend college? [ ] Yes [ ] No
What is the highest education level or degree you attained? _____

Occupational History

Are you currently: [ ] Working [ ] Student [ ] Unemployed [ ] Disabled [ ] Retired
How long have you been in your present position? _____
What is/was your occupation? _____
Where do/did you work? _____

Relationship History and Current Family

Are you currently: [ ] Married [ ] Partnered [ ] Divorced [ ] Single [ ] Widowed
How long have you been in your present relationship status? _____
If not married, are you currently in a relationship? [ ] Yes [ ] No If yes, how long? _____
Are you sexually active? [ ] Yes [ ] No
How would you identify your sexual orientation?
[ ] Straight/Heterosexual
[ ] Lesbian/Gay/Homosexual
[ ] Bisexual
[ ] Transsexual
[ ] Unsure/Questioning
[ ] Asexual
[ ] Other
[ ] Prefer not to answer
Have you had any prior marriages? [ ] Yes [ ] No If yes, how many and for how long? _____
Do you have children? [ ] Yes [ ] No If yes, how many? _____
Who do you live with? _____

Legal History

Have you ever been arrested? [ ] Yes [ ] No
If yes, why? _____
Have you ever been to jail? [ ] Yes [ ] No
If yes, when and for how long? _____
Do you have any pending legal problems? [ ] Yes [ ] No
If yes, what? _____

Spiritual Life

Do you belong to a particular religion or spiritual group? [ ] Yes [ ] No
If yes, please explain what/where: _____
If yes, how long have you been a part of it? _____
If yes, what is the level of your involvement? _____

Family Wellness Center of Norman **Adult Intake Form**

CLIENT NAME: _____

NOTICE OF PRIVACY PRACTICES

This Notice of Privacy Practice describes how we may use and disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to address and control your protected health information. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future mental health or condition and related health care services.

USES AND DISCLOSURES OF HEALTH INFORMATION

Your protected health information may be used by our physician or other providers of services, our office staff and others outside of our office that is involved in your care and treatment or providing health care services to you, to pay your health care bills, to support the operations of the physician's practice and any other use required by law.

TREATMENT: We will use and disclose your protected health information to provide, coordinate, or manage your health are and any related service.

PAYMENT: Your protected health information will be used, as needed, to obtain payment for your health care services.

HEALTH CARE OPERATION: We may use and disclose, as needed, your protected health information in order to support the business activities of your provider's practice. These activities include, but are not limited to quality assessment activities, employee review activities and conducting or arranging for other business activities. We may call you by name in the waiting room when your provider is ready to see you. We may use or disclose your protected health information, as necessary, to contact you to remind you of your appointments.

We may use or disclose your protected health information in the following situations without your authorization. These situations include as required by law, public health issues such as Communicable Disease, Health Oversight: abuse or neglect, Food and Drug Administration requirements: Legal Proceedings, Law Enforcement: Coroners, Funeral Directors and Organ Donation Research; Criminal Activity, Military Activity and National Security; Worker's Compensation; Inmates, Required Uses and Disclosures; Under the law, we must make disclosures to you and when required by the secretary of the Department of Health and Human Services to investigate or determine our compliance with the requirements of Section 164.500

Other Permitted and Required Uses and Disclosures are made only with your consent, authorization or opportunity to object unless required by law. You may revoke this authorization at any time in writing, except to the extent that your physician, provider of service or the office staff has taken an action in reliance on the use or disclosure indicated in the authorization.

PATIENT'S RIGHTS: The following is a statement of your rights with respect to your protected health information.

You have the right to inspect and copy your protected health information. Under federal law however, you may not inspect or copy the following records: psychotherapy notes, information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment, or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in the Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

You have the right to request and receive confidential communications from us by alternate means or at an alternative location. You have the right to obtain a paper copy of this notice from us upon written request, even if you have agreed to accept this notice alternatively, i.e., electronically.

You have the right to have your physician or provider amend your protected health information. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to amend the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice.

COMPLAINTS: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our privacy contact of your complaint we will not retaliate against you for filing a complaint.

This notice was published and becomes effective on April 14, 2003. We are required by law to maintain the privacy of and provide individuals with this notice of our legal duties and privacy practice with respect to your protected health information.

Signature below only acknowledges that you have received this Notice of Privacy Practices

Print Patient or Guardian's Name: _____

Patient or Authorized Guardian's Signature: _____

Relationship to Patient: _____ Date Signed: _____

Family Wellness Center of Norman **Adult Intake Form**

CLIENT NAME: _____

RELEASE OF INFORMATION TO DESIGNEE

I authorize Family Wellness to release any information acquired in the course of my treatment to the following designated person. I authorize the following designated person to access or change any information regarding my treatment. A designated person would be someone who is not myself or my legal parent/guardian. This release will automatically expire if guardianship has changed and any information given will be by provider's discretion if appropriate or client is in potential danger. **Please list restrictions, if any:**

____ *I do not authorize release of any information to any designee*

____ I do authorize release of information to a designee

____ I do authorize release of information to a designee except the following:

____ Appointments ____ Medications

____ Lab, X-rays, ECG ____ Progress Notes

____ Financial Statement, Billing, Receipts, or Payments

____ Other: _____

Name of designee: _____ Relation: _____

Phone number: _____ Date Release Expires, if any: _____

CONSENT FOR USE OF TELEMEDICINE AND REMOTE INTERVIEW LISTENING

I understand that Telemedicine (video communication) is an optional feature that I can choose to use or not to use at the provider and I's discretion to communicate with the provider for my appointments. I understand that if the provider thinks my case is too severe that they may require me to be seen in person rather than by video. I understand that if I consent, an employee of Family Wellness may be listening to my psychiatric evaluation or medication check visit, for the sole purpose of transcribing the visit into my medical record. I understand that no other persons will be listening, and no recording will be made of the interview. I understand that all Family Wellness employees have signed confidentiality agreements and are required to keep all client information private. I understand that I have the right to refuse remote listening and transcribing, and I will still be able to receive medication management in person.

I hereby acknowledge that I have read or have been given these authorizations and fully understand the nature of the agreements.

Patient or Guardian's Signature: _____ Date Signed: _____

Family Wellness Center of Norman **Adult Intake Form**

CLIENT NAME: _____

Authorization for Release of Information

Client Name: _____

Date of birth: _____ / _____ / _____ Social Security #: _____ - _____ - _____

Name of Company to Receive and Disclose PHI	**Name of Individual/Company/Facility to Receive and Disclose PHI**
Family Wellness Center of Norman	**Business _____**
and Mobile Medical Solutions	**Attn _____**
2760 Washington Drive Suite 110	**Address _____**
Norman, OK 73069	**City/State/Zip _____**
Phone: 405-360-2827	**Phone # _____**
Fax: 405-283-1124	**Fax # _____**

Purpose of Release: _____Treatment_____

Information to be released /obtained for dates of treatment: _____ to _____PRESENT_____

__X__ Lab, X-rays, ECG __X__ Progress Notes _____ History and Physical

_____ Medication Record __X__ Discharge Summary _____ Other _____

I am requesting information be:

__X__ Faxed to the above requestor _____ Mailed to the above requestor _____ Other: _____

This consent for release of information may be revoked in writing at any time. Any release of information made between the time authorized and the time revoked shall not constitute a breach of confidentiality. Unless otherwise indicated, this release expires one year from date of signature. Date this release expires: _____

I release the entities listed above, their agents and employees from any liability in connection with the use or disclosure of the protected health information covered by the authorization. The entity authorized to disclose the information will not be compensated by the recipient for the disclosure, except for the cost of copying and mailing as authorized by law. Information used or disclosed pursuant to this authorization may be subject to re disclosure by the recipient and no longer protected by federal law. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

Reproduction of this authorization is as authentic as the original signed authorization.

I understand the information authorized for release may include records which may indicate the presence of a communicable or non-communicable disease.

I, the undersigned, hereby acknowledge that I have read this authorization prior to its execution and fully understand the nature of the release.

Client signature: _____ Date _____

Parent/Legal Representative: _____ Date _____

Description of Legal Representative's Authority: _____

Witness signature: _____ Date _____

Family Wellness Center of Norman **Adult Intake Form**

CLIENT NAME: _____

Informed Consent for Treatment with Psychoactive Medications

If you have any questions, you may request reviewing the following with the provider before starting medication.

By reading the following conditions and signing my name at the bottom of this document, I acknowledge that I understand all the following about the risks that are associated with psychoactive medications.

- The nature and seriousness of my mental condition for which the medication is recommended, and the reason for using the medication.
- Psychoactive medications have the potential for side effects. These side effects may involve the heart, nervous system, muscles, glands, urinary tract, bowels, blood, eyes, skin, and allergic responses. (This list is not all inclusive.) Most side effects are minor and reversible. However, some side effects are serious and may not be reversible such as tardive dyskinesia, which is a movement disorder. I also understand that sudden death has been reported in association with stimulants in children with structural cardiac abnormalities.
- Monitoring serum concentrations of some medications (e.g., lithium, valproic acid, etc.) may be necessary. Also for patients receiving second-generation antipsychotics, baseline and follow–up monitoring of serum lipid and glucose concentrations is recommended.
- Some medications have dependence and/or abuse potential (e.g., stimulants, sedatives, anxiolytics) and may produce serious withdrawal symptoms upon abrupt discontinuation.
- Antidepressants increased the risk of suicidal thinking and behavior (suicidality) in short-term studies in children and adolescents with Major Depressive Disorder and other psychiatric disorders. (See Medication Guide About Using Antidepressants in Children and Teenagers.)
- The improvement associated with psychoactive medications may be permanent or temporary. The medication will not cure the illness, but is recommended to help control the symptoms. Without medication the present mental condition may improve spontaneously, continue with little or no change, or worsen.
- The medication recommended and/or dosage used may not be approved by the Food and Drug Administration for the assigned psychiatric diagnosis or for all the age groups. However, data does exist to support the use for which medication is recommended.
- Alternatives to treatment with medications are no treatment, psychotherapy, and/or electro-conclusive therapy (the last is not available at this facility.) I understand the prognosis with and without the recommended medication treatment.
- I have the right to accept or refuse this medication treatment and the right to revoke consent at any time prior to or during treatment. This consent is being granted without threat or coercion expressed or implied. No guarantees or assurances have been made concerning the results of treatment with this medication.
- I have been informed that if I have any questions or concerns about my mental health condition and/or medication I may I may discuss them with my psychiatrist or nurse practitioner at our next visit.
- I understand that the patient is to take the prescribed medication only as prescribed and only for the condition for which it is prescribed.
- I understand that it is the responsibility of the patient or guardian of the patient to contact the provider prescribing the psychoactive medication for questions or concerns regarding the effect, or side effects of the prescribed drug or, in the event of medical emergency, emergency personnel.

I have read, or the provider has read and explained to me, and I do understand the foregoing risks that are associated with psychoactive medications. I have had the opportunity to have my questions answered. I understand the nature, purpose, and expected benefit of the recommended medication, the diagnosis and prognosis of the condition for which the medication is recommended, the alternatives to medication treatment including no treatment, and the significant risks and common side effects of the recommended medication. I do hereby give informed consent to the agreed upon treatment for the medications prescribed by the provider. *I understand that this release expires a year from the signed date.*

Signature of Client or Parent/Guardian: _____

Relationship to Client: _____ Date signed: _____ /_____ /_____

Family Wellness Center of Norman **Adult Intake Form**

CLIENT NAME: _____

PAYMENT POLICY, VERIFICATION OF APPOINTMENT PROCESS, AND CANCELLATION AGREEMENTS

I authorize Family Wellness to release any information acquired during my treatment to my insurance company and assign the insurance payments due to Family Wellness Center of Norman or Mobile Medical Solutions. I understand that Family Wellness files my insurance as a courtesy, but the bill is my responsibility. I understand that my insurance may not cover my entire visit and that co-payment may be required upon checking in or checking out at each appointment. I understand that notice of cancellation must be given 24 hours in advance so that I will not be charged a fee of $50. I understand that by not providing the office with verification of my appointment 24 hours prior to my appointment that the office may schedule someone else in my appointment slot instead. I understand that if I have consecutive missed appointments (two or more missed appointments in a row) that I may not receive my medication refills and I may further be dismissed as a patient. I understand that I may be charged $1 for providers filling out paperwork (FMLA, Disability, Driver's License, etc.) or may be required to make an appointment to have such paperwork filled out by the provider. I understand that if I have an outstanding balance of over $150, I need to pay the outstanding balance prior to being seen or my appointment will be cancelled until a payment or payment plan is made. I understand that after sending multiple statements regarding an unpaid balance, I will not be able to be seen or get medication refills as all service will be terminated, and the balance will be sent to collections.

Payment Plan Options

Payment plans are available for large balances of over $100, to schedule payments being ran monthly or bi-monthly by our office, to pay off a balance within six months. Any further services must be paid in full. A payment plan does not allow patient to carry over any further services rendered. Services were rendered and now payment is due, this is the patient's responsibility. Working with our patients is top priority; please contact our office (405)360-2827 or billing department if you need further assistance with your bill (405)310-2720.

Please circle the payment plan you have chosen to pay off the balance of your medical bill.

Option One **Pay 50%** on 1st or 15th of the month _____/_____/_____ $ _____
Pay remainder on 1st or 15th of the month _____/_____/_____ $ _____

Option Two **Pay 25%** by 1st and/or 15th of one month $ _____ on _____/_____/_____
Pay 25% by 1st and/or 15th of two months $ _____ on _____/_____/_____
Pay 25% by 1st and/or 15th of three months $ _____ on _____/_____/_____
Pay remainder by 1st or 15th of four months $ _____ on _____/_____/_____

Option Three **Pay $50.00 a month**, 1st or 15th of every month, until balance is paid off
Pay remainder by 1st or 15th of six months $ _____ on _____/_____/_____

Option Four **Pay $_____** every 1st and/or 15th of every month until balance is paid off
Pay remainder by 1st or 15th of six months $ _____ on _____/_____/_____

If a payment plan is chosen, a credit card must be given so that it can be charged each due date. By signing below, you give permission to our office to charge your card automatically according to your payment plan or when payment is due. If any dates fall on a holiday, weekend, or day that the practice is closed, it will be charged the following business day. Your card will be kept on file and only used when payment has not been made. We will charge the amount due if we cannot get a hold of you and payment has not been made in a timely manner or when a no show/ late cancellation fee is charged. Please let us know if you have any further questions.

Type of credit card (Visa, Mastercard, etc.) _____
Name on credit card: _____
Numbers on credit card:_____
Expiration Month/Year: _____/_____ CVV#:_____ Zip Code: _____
Receipts can be sent by email: _____

CLIENT'S Name: _____ CLIENT'S Date of Birth: _____/_____/_____
Client or Guardian Signature: _____ Date: _____

Office Manager or Billing Signature: _____ Date: _____