Patient Information

Patient Information

Patient Name: _____ DOB: _____ Sex: _____

Driver's License: _____ SSN: _____

Home Phone: _____ Cell: _____

Address: _____

Employer: _____ Position: _____

Employer Address: _____ Phone No. _____

Emergency Contact Information

Dependent? _____ If yes, Guardian's Name: _____

Guardian's Phone: _____ Cell: _____

Marital Status: _____ Spouse's Name: _____

Spouse's Employer: _____ Work Phone No. _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

Emergency Contact: _____ Relationship: _____

Home Phone: _____ Cell: _____

Insurance

Insured Party: _____ Relationship to Patient: _____

Insurance Company: _____ Phone No. _____

Address: _____

Policy No. _____ Group No. _____

Dual Coverage? _____ 2nd Insurance Company: _____

Insured Party: _____ Relationship to Patient: _____

Phone No. _____ Address: _____

Policy No. _____ Group No. _____

Payment Method: _____ Card/Check No. _____

I verify that the above information is factual and true to the best of my knowledge. I authorize the doctor to employ X-Rays, photographs, anesthetics, medicines, surgeries, and other equipment or aids as he/she deems necessary in order to provide the proper patient care. I understand that payment, proof of insurance, and/or copay is due at the time of service.

I authorize this office to apply benefits on my behalf for the covered services rendered. I certify that the insurance information I have provided is factual and correct.

_____ Patient

_____ Date

HIPAA Disclosure Form

Hospital: _____ Doctor: _____

Patient Name: _____ Date: _____

Listed Address: _____

Preferred Correspondence Address: _____

Listed Phone No. _____ Preferred Phone No. _____

Listed Email Address: _____

Preferred Email Address: _____

Would you like our correspondence with you to be marked "Confidential"? ❑ Yes ❑ No

May we identify ourselves over the phone? ❑ Yes ❑ No May we leave messages? ❑ Yes ❑ No

I, the Patient, hereby authorize the doctor and/or hospital listed above to release my medical information (appointments, lab/x-ray results, diagnoses, treatments, medications, surgeries, etc.) via postal mail, telephone, fax, or email to the following family members:

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

Name: _____ DOB: _____ Relationship: _____

I further release my medical information to the following physicians, clinics, and/or hospitals:

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

Doctor: _____ Clinic: _____ Phone: _____

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

VERNU MEDICAL
TREATMENT CONSENT FORM / PRACTICE POLICIES

MEDICATION

_____When a mental illness and/or addiction issue markedly impacts your ability to work, maintain interpersonal relationships, or properly care for your basic needs, medication may offer much needed relief. If it is agreed that medications are indicated, I will discuss with you several the medication options that are available to treat your current condition. I will present information in language that you can understand. You will learn how the medication works, its dosage, and frequency, its expected benefits, possible side effects, drug interactions, and any withdrawal affects you may experience if you stop taking the medication abruptly. By the end of the discussion you will have all the information you need to make a rational decision as to which medication is right for you. Not everyone is a good candidate for medication therapy. Such therapy requires strict adherence to dosage, and frequency, close follow-up, and sometimes regular blood tests. Your ability to adhere to medication treatment will be taken into consideration in making the decision to start such therapy. Overall, I am a strong proponent of the bio-psycho-social model of medical treatment. Treatment that considers your biological status, genetics, your psychological development, and social issues together will yield the best chance for success in achieving your goals.

FREQUENCY AND DURATION OF VISITS

_____At your initial visit, we will decide together the structure of your treatment. If medications are prescribed, or changed, I prefer to conduct a follow-up visit in two weeks. This is necessary to ensure proper administration and minimize any side effects you may experience. If your symptoms improve, follow-up visits can be spaced out at monthly intervals. For clients on maintenance therapy, most follow-up visits can be held at three-month intervals.

FEES

_____For an initial evaluation, my fee is $300.00. The fee for a follow up, med management visit is $150.00. Other miscellaneous services such as telephone correspondence, prior authorizations, letters for school work or court hearings, etc. requiring more than ten minutes of time, will cost $65.00 per ten-minute interval. If you are filing for FMLA/Disability or School Leave of Absence. I charge a $150.00 charge for each incident paperwork is needed. Prior authorizations for medications and medication refills without an appointment are $45.00. Fees may be subject to change.

CANCELLATIONS AND NO-SHOWS

_____If you must cancel or reschedule an appointment, I require at least 24-hour notice. Please leave a message if after hours or on weekends. Cancellations that occur with less than 24-hour notice or failure to show to an appointment will be charged the $50.00 for the session. No exceptions.

PAYMENTS

_____I will expect payment at the beginning of each session, unless we have agreed on other arrangements. I accept cash or personal check, and major credit cards. If you choose to use any type of card there is a $2.00 Convenience Charge. If a check is returned for "Insufficient Funds", there is a $50.00 charge. If payment is 60 days past due, I reserve the right to utilize legal resources such as collection agencies or small claims court to obtain payment for my services.

INSURANCE POLICIES

_____ If you seek my services for an addiction issue, I do not accept insurance. I currently accept a few insurance policies. It is your responsibility to verify if I am "In-Network" or "Out of Network" for your insurance. I file claims with insurance companies as a courtesy. If the insurance company returns a claim as denied or unpayable, you are responsible for payment. Many insurance companies have limitations on the number and frequency of visits, and types of medications that will be covered. Occasionally, certain forms of treatment, or large number of sessions require a prior authorization. If this is the case, I may need to provide information about your diagnosis, history, and treatment plan to your insurance company. Once this information is provided, it will be subject to the privacy policies of the insurance provider and is out of my control.

MEDICAL RECORDS

_____I am required by law to keep complete medical records. Most of my medical records will be electronic, encrypted, and under fingerprint security. Any written records including the initial consent forms, letters, outside medical records, will be kept locked. If you wish to view your records, I recommend that we review them together to minimize any confusion or misinterpretation of medical terms. Time spent collecting, printing, copying, and summarizing the medical record will be charged the appropriate fee.

CONFIDENTIALITY

_____The security of your sensitive information is of utmost importance to me, and I am bound by law to protect your confidentiality. Any disclosure of your treatment to others will require your explicit written consent. As described above, basic information about your treatment may be disclosed to your insurance company for purposes of prior authorization if necessary. There are exceptions to this confidentiality, where disclosure is mandatory. These include the following: -If there is a threat to the safety of others I will be required by law to take protective measures including reporting the threat to the potential victim, notifying police, and seeking hospitalization - When there is a threat of harm to yourself, I am required to seek immediate hospitalization, and will likely seek the aid of family members or friends to ensure your safety. - In legal hearings, you do have the right to refuse my involvement in the hearing. There are rare circumstances, however, in which I will be required by a judge to testify on your emotional, or cognitive condition. - In situations where a dementing illness, epilepsy or other cognitive dysfunction prevent you from operating a motor vehicle in a safe manner, I will be required to report this to the DMV - If a mental illness prevents you from providing for your own basic needs such as food, water, shelter, I will be required to disclose information to seek hospitalization. These situations rarely occur in an outpatient setting. If they do arise, I will do my best to discuss the situation with you before acting.

THE PRACTICE

_____My medical records are kept secure and separate from theirs. No person operating in my office suite will have access to your records without your written consent. I am fully responsible for the services I provide you. If I refer you to a community therapist/physician, we may find it helpful to collaborate and coordinate your care, and this will require your written consent. Any clinician to whom I refer you will be responsible for the care they provide to you.

TREATMENT CONSENT

By signing below, you certify that you have read and understand the terms stated in the Treatment Consent Form. You indicate that you understand the scope of my services, session structure, fees, cancellation/no-show policies, payment policy, insurance reimbursement, confidentiality, the nature of my practice, and my contact information, and that you agree to abide by the terms stated above during the course of our therapeutic relationship.

Client name (please print): _____ Date: _____

Client's signature: _____

Provider: _____ Date: _____

Authorization to Bill Insurance

Client: _____ Guardian (if Minor): _____

Phone: _____ Email: _____

Address: _____

Insurance Company: _____ Policy No. _____

Doctor: _____ Clinic: _____

Phone: _____ Location: _____

I, the undersigned, hereby certify and attest that I have sought evaluation, treatment, or medical advice from the staff at the clinic named above. I therefore authorize the medical staff and personnel to release my or my minor child's medical information to the insurance company listed above for the purpose of determining and receiving benefits for medical bills.

I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required.

I understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided above. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for non-payment.

_____ _____

Signature Date

PATIENT WAIVER FOR NON-COVERED SERVICES

Patient's Name: _____ Date: _____

Your insurance does not pay for all of your healthcare costs. Some items and services are not considered "covered benefits" under your health insurance plan and as such, your insurance will not pay for these services.

Your physician believes that the following service(s), although not covered by your health insurance, are an important part of your chiropractic care and recommends that you receive these services as part of your current treatment plan. However, since the services listed here are not considered to be a covered benefit under your health insurance, should you choose to receive these services; you will be personally responsible for the payment of such services. The purpose of this notice is to help you make an informed choice about whether or not you want to receive these items or services.

The services recommended by your physician are listed below:

_____	$_____
_____	$_____
_____	$_____
_____	$_____
_____	$_____

The total cost for the services/items recommended by your physician are:

$_____

I acknowledge that I have been informed in advance of receiving these services, that these services are not covered by my health insurance plan. I have chosen to receive these services and understand that I will be financially responsible for the charges indicated above.

Print Patient Name _____

Patient Signature _____

Name of Parent or Legal Guardian (if applicable)_____

Signature of Parent or Legal Guardian (if applicable)_____

Date_____

This form must be signed by the patient or legal guardian PRIOR to receiving any non-covered services or items and *must be maintained in the patient's medical record.*

Health Risk Assessment Form

General

Name: _____
DOB: _____ Gender: _____
Height: _____ Weight: _____
Race: _____

Medical History

Date of last check-up: _____
Allergies: _____
Medications: _____
Previous Medications: _____
Injuries: _____
Surgeries: _____
Blood Pressure: _____
Cholesterol: _____

History of…

Cancer: ❑ Me ❑ Relation: _____
Diabetes: ❑ Me ❑ Relation: _____
Stroke: ❑ Me ❑ Relation: _____
Heart Disease: ❑ Me ❑ Relation: _____
Heart Attack: ❑ Me ❑ Relation: _____
Depression: ❑ Me ❑ Relation: _____
Bipolar Disorder: ❑ Me ❑ Relation: _____

Females

Last date of most recent cycle: _____
Date of last PAP Smear: _____
Date of last breast exam: _____
Date of last rectal exam: _____
Year of last pregnancy: _____
Did the pregnancy come to term? ❑ Yes ❑ No

Males

Date of last prostate exam: _____

Well-Being

Rate your overall well-being: ❑ Great ❑ Good ❑ Fair ❑ Poor ❑ Bad

Rate your health: ❑ Great ❑ Good ❑ Fair ❑ Poor ❑ Bad

How safe do you feel? ❑ Very ❑ Not Very ❑ Not at all

How satisfied are you with your life? ❑ Very ❑ Not Very ❑ Not at all

How often do you feel depressed? ❑ Always ❑ Often ❑ Occasionally ❑ Never

Current therapist: _____
Frequency of sessions: _____
Starting date: _____

Nutrition

How many daily servings of vegetables do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of fruit do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of grains do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of meat do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

How many daily servings of sugar/carbs do you eat? ❑ None ❑ 1 – 2 ❑ 3 – 4 ❑ 5 – 6 ❑ More

Drug Use

How often do you smoke tobacco? ❑ Never ❑ Occasionally ❑ Often ❑ Daily ❑ Used to

How often do you chew tobacco? ❑ Never ❑ Occasionally ❑ Often ❑ Daily ❑ Used to

When did the tobacco use start? _____
How many cigarettes do you have per day? _____

How many alcoholic drinks do you have per week? _____
How often do you binge drink (5+ drinks in 1 hour)? ❑ Occasionally ❑ Weekly ❑ Daily ❑ Never
Have you ever been treated for alcoholism? _____
How often do you black out/lose time? _____

Have you ever used recreational drugs? _____
Which drugs? _____
Have you ever abused prescription drugs? _____
Which drugs? _____
Have you ever been treated for drug use? _____
How often do you use recreational drugs? ❑ Daily ❑ Weekly ❑ Often ❑ Occasionally ❑ Rarely ❑ Never

Exercise

How many days per week do you work on cardio? _____
Length of time spent on cardio each session: _____
How many days per week do you work on strength? _____
Length of time spent on strength each session: _____
Injuries/conditions that interfere with exercise: _____

Other

Volunteer Activities: _____
Who do you live with? _____
Do you require…? ❑ Hearing Aid ❑ Walker ❑ Cane ❑ Oxygen Tank ❑ Glasses
How often do you get headaches? _____
Food Sensitivities: _____
How many hours of sleep do you get per night? _____
How restful is your sleep? ❑ Restful ❑ I wake up once or twice ❑ I wake up often ❑ Fitful

ADULT HEALTH HISTORY

Date _____

Name _____
Date of birth _____ Age _____
General health _____

Are you currently or have you ever been treated for

Yes	No	Condition	Explain
☐	☐	Asthma	
☐	☐	Bleeding disorders	
☐	☐	Blood Pressure	
☐	☐	COPD	
☐	☐	Diabetes	
☐	☐	Ear/sinus	
☐	☐	Fainting	
☐	☐	Gastro-intestinal problems	
☐	☐	Heart disease	
☐	☐	Kidney disease	
☐	☐	Learning disorders	
☐	☐	Menstrual problems	
☐	☐	Musculo-skeletal	
☐	☐	Psychological/psychiatric	
☐	☐	Seizures	
☐	☐	Sickle cell disease	
☐	☐	Sleep disorders	
☐	☐	Stroke	
☐	☐	Surgery	
☐	☐	Thyroid disease	
☐	☐	Serious injury	
☐	☐	Other	

List all medications you are currently taking, include over-the-counter drugs and herbal supplements

Medication	Dosage	Reason

Allergies

Signature _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

The above named person must indicate when this authorization is to expire:

- ☐ When information is received
- ☐ In six months
- ☐ On date _____
- ☐ In one year
- ☐ In three years

The person named above is or has been a patient of

Name of Person, Provider, or Facility _____

Address _____

Phone _____

Fax _____

The person named above hereby authorizes _____ **to**

Name of Person, Provider, or Facility

- ☐ Request health information from
- ☐ Discuss health information with
- ☐ Send health information to
- ☐ Discuss health information with

The person named above authorizes information to be requested or released by representatives of

Name Of Person, Provider, Or Facility _____

Address _____

Phone _____

Fax _____

Scope

- ☐ All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify): _____
- ☐ All information regarding care received by patient between the dates of _____ (Starting Date) and _____ (Ending Date)
- ☐ Other information (specify): _____

Authorization

_____
Printed name of Patient or Authorized Representative

_____ Signature of Patient or Authorized Representative

_____ Date

_____ Signature of witness

_____ Date

If not signed by the patient, indicate relationship of authorizing person to patient:

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient
- ☐ Beneficiary or personal Representative of a deceased individual