



Emotional Wellness Center
of Valdosta

Please Print Information

Last Name _____ First _____ Middle _____

Mailing Address _____ Street _____

City/State _____ County _____ Zip _____

SSN _____ Birthdate _____ Age _____ Sex _____ Race _____

Phone (home) _____ (work) _____ (other) _____

Patient Employer/School _____ Occupation _____

Address _____ How long/grade _____

City/State _____ Zip _____ Place of Birth _____

Marital Status: Single _____ Married _____ Divorced _____ Separated _____ Widow _____

Parent/Guardian Name & Contact Information (If under 18)

Children/Siblings _____ Ages: _____

Accompanied By _____ Phone _____

Referred By _____ Phone _____

Family Doctor _____ Phone _____

Reason for Referral _____

NOTIFY IN CASE OF EMERGENCY

Name _____

Address _____

Phone _____

City/State _____

Relationship _____



Emotional Wellness Center
of Valdosta

INSURANCE INFORMATION

	<u>Primary</u>	<u>Secondary</u>
Name of Insurance Comp	_____	_____
Policy Number	_____	_____
Group Name	_____	_____
Group Number	_____	_____
Name of Insured	_____	_____
Insured D.O.B	_____	_____
SS# of Insured	_____	_____
Employer of Insured	_____	_____

PLEASE READ CAREFULLY

The patient is responsible for ALL fees, regardless of Insurance Coverage. All charges are due at time of service unless other arrangements have been made in advance. I understand that I am responsible for any amount NOT covered by insurance. I hereby authorize payment directly to Emotional Wellness Center of Valdosta, all insurance benefits not to exceed the Center’s regular charges. I hereby authorize Emotional Wellness Center of Valdosta to release the information needed to any physician and/or third party responsible for payment of such services.

APPOINTMENTS- Schedule, change and cancel appointments through the office manager. If you find that you cannot keep your appointment, notify our office as soon as possible. A charge may be made for all appointments not cancelled 24 hours in advance, and this charge will be the responsibility of the patient.

AUTHORIZATION FOR TREATMENT/ACKNOWLEDGEMENT OF PATIENT RIGHT

I, the undersigned, hereby request treatment by the staff of Emotional Wellness Center of Valdosta. I understand that this office does not discriminate on the basis of race, creed, religion, age, sex, political affiliation, physical or mental handicap. I realize that such treatment will be conducted by a treatment team which may include therapists, social workers, psychologists, medical doctors and under appropriate supervision. In addition, I understand that I have rights as a patient and realize procedures exist to file any grievances that may arise during treatment. This authorization will continue in effect until revoked in writing.

NOTICE OF PRIVACY PRACTICES

This _____ Day of _____ 20__

(Patient’s signature or legal guardian)

(Date)

(Staff’s signature)



Emotional Wellness Center of Valdosta

Notice of Privacy Practices

This Notice Describes How Medical Information About You May Be Used and Disclosed and How You Can Get Access To This Information. Please Review It Carefully.

Uses and Disclosures

Treatment: Our Staff members may disclose your health information to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, laboratory test results and treatment will be available in your medical record to all health professionals who may provide treatment or who may be consulted to treat you.

Payment: Your health information may be used to seek payment from your insurance plan or from other sources such as credit card companies that you may use to pay for services. For example, your health plan may request and receive information on dates of services, the service provided, and the medical condition being treated.

Health Care Operations: Your health information may be used as necessary to support the day-to-day-activities and management of Emotional Wellness Center of Valdosta. For example, we may allow access to your medical information to students working with us; we may call you by name from the waiting room.

Law Enforcement: Your health information may be disclosed to Law Enforcement agencies, without your permission, to support government audits and inspections, to facilitate law enforcement investigations, and to comply with government mandated reporting.

Public Health Reporting: We may disclose your health information to public health agencies as required by law. For example, we are required to report certain communicable diseases to the State's Public Health Department.

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed above requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation or the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision.

Additional Uses of Information: Your health information may be used to send you information on the treatment and management of your medical condition that you may find to be of interest. We may also send you information describing other health-related goods and services that we believe may interest you.

Rights to Revise Privacy Practices: As permitted by law, we reserve the right to amend or modify our privacy, policies and practices. These changes may be required by changes in Federal or State law and regulations. Whatever the reason for these revisions, we will provide you with a revised notice on your next office visit. The revised policies and practices will be applied to all protected health information that we maintain.

Individual Rights

You have certain rights under Federal Privacy Standards. These include:

- The right to request restrictions on the use and disclosure of your health information.
- The right to receive confidential communications concerning your medical condition and treatment.
- The right to inspect and copy your protected health information. (Patient Access is limited with regard to psychotherapy notes.)
- The right to amend or submit corrections to your protected health information.
- The right to receive an accounting of how and to whom your protected health information has been disclosed.
- The right to receive a printed copy of this notice.

Requests to Inspect Protected Health Information

As permitted by Federal Regulations, we require that requests to inspect or copy protected health information be submitted in writing. You may obtain a form to request access to your records by contacting the Privacy Officer.

A COPY OF THE ENTIRE PRIVACY PRACTICE POLICIES IS AVAILABLE UPON REQUEST.

I have been given and read the notice of Privacy Practices for Emotional Wellness Center of Valdosta.

(Patient Signature)

(Date)

(Parent/Guardian Signature If under 18)

(Date)



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Name: _____

Date: _____

Do you have any problems at this time? _____

Please check any symptoms that describe how you feel, think, or behave currently or during the past few weeks:

- | | |
|---|---|
| <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Aggressive/abusive towards others |
| <input type="checkbox"/> Agitation | <input type="checkbox"/> Attempts to harm self |
| <input type="checkbox"/> Avoidance of public places | <input type="checkbox"/> Back pain |
| <input type="checkbox"/> Change in ability to walk | <input type="checkbox"/> Chest pain |
| <input type="checkbox"/> Chest tightness | <input type="checkbox"/> Chronic sadness |
| <input type="checkbox"/> Confused/worried about sexual behavior | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Crying episodes | <input type="checkbox"/> Diarrhea |
| <input type="checkbox"/> Difficulty at work | <input type="checkbox"/> Difficulty completing tasks |
| <input type="checkbox"/> Difficulty concentrating | <input type="checkbox"/> Difficulty focusing |
| <input type="checkbox"/> Difficulty functioning socially | <input type="checkbox"/> Difficulty making decisions |
| <input type="checkbox"/> Difficulty waiting your turn | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Easily startled | <input type="checkbox"/> Excessive gambling |
| <input type="checkbox"/> Excessive spending | <input type="checkbox"/> Excessive worry |
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Fear of dying |
| <input type="checkbox"/> Fear of leaving home | <input type="checkbox"/> Fear of loss of control |
| <input type="checkbox"/> Fearfulness | <input type="checkbox"/> Frequent forgetfulness |
| <input type="checkbox"/> Frustration | <input type="checkbox"/> Hard to stay with job very long |
| <input type="checkbox"/> Hopelessness | <input type="checkbox"/> Intrusive thoughts of bad memories |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Legal problems |
| <input type="checkbox"/> Loss of appetite | <input type="checkbox"/> Low energy/fatigue |
| <input type="checkbox"/> Marital conflict | <input type="checkbox"/> Memory problems |

- | | |
|--|--|
| <input type="checkbox"/> Muscle stiffness | <input type="checkbox"/> Withdraw from others |
| <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Nausea/vomiting |
| <input type="checkbox"/> Neck pain | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Not well organized | <input type="checkbox"/> Overeating |
| <input type="checkbox"/> Panic attacks | <input type="checkbox"/> Physical abuse |
| <input type="checkbox"/> Pounding heart/palpitations | <input type="checkbox"/> Problems with co-workers |
| <input type="checkbox"/> Racing thoughts | <input type="checkbox"/> Reduced interest in activities |
| <input type="checkbox"/> Re-living bad experiences | <input type="checkbox"/> Restlessness |
| <input type="checkbox"/> School problems | <input type="checkbox"/> Seeing things others don't |
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Snoring | <input type="checkbox"/> Staying up for days without sleep |
| <input type="checkbox"/> Taking on too many tasks | <input type="checkbox"/> Tendency to act impulsively |
| <input type="checkbox"/> Thoughts of physically hurting others | <input type="checkbox"/> Thoughts of suicide |
| <input type="checkbox"/> Trembling/shaking | <input type="checkbox"/> Vision changes |

Please describe why you are seeking help at this time _____

Has any member of your family been hospitalized for mental health concerns? _____

If yes, please list who, when and for what reason: _____

Do/did you have any family members who have/had problems with drinking alcohol or using drugs? _____

If yes, please list who, when and if it is still a problem: _____

Has any member of your family attempted/committed suicide? _____

If yes, please list who, when, and what happened: _____

What is your best memory about your family when growing up? _____

If you could change anything about your family situation right now, what would it be? _____

Have you ever seen a counselor, psychologist, psychiatrist, or other mental health professional for any mental health or drug/alcohol concerns? _____

If yes, please list who, when and why: _____

Have you ever been hospitalized for mental health or drug/alcohol concerns? _____

If yes, please list when and for what reason: _____

Do you have thoughts of harming yourself? _____ If so, how often does this happen? _____

Have you ever tried to harm yourself? _____ If so, when did this happen? _____

Did you receive medical help at the time? _____

Current Medications

(Please include prescription, over the counter, herbs, vitamins, and other remedies)

<i>Medication</i>	<i>Dosage/when taken</i>	<i>Reason taking</i>	<i>Prescribing Doctor</i>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Allergies to medications: _____

Please list any current medical problems or concerns: _____

Please list any past serious illnesses, surgeries or health concerns: _____

Exercise and Physical Recreational Activity

Type of activity

How often

Would describe yourself as physically active? _____

Do you currently have a primary care physician? If so, please list his/her name:

Are you currently under the care of any other physicians? If so, please list names:

Use of substances (on average) If none, please leave blank.

	<i>Current amount</i>	<i>Most used in past</i>
<i>Alcohol</i>	_____ glasses per day _____ glasses per week	_____ glasses per day _____ glasses per week
<i>Tobacco</i>	___ cigarettes _____ per day ___ cigars _____ per day ___ smokeless ___ cans per day	___ cigarettes _____ per day ___ cigars _____ per day ___ smokeless ___ cans per day
<i>Caffeine (tea, coffee, soda)</i>	_____ servings per day	_____ servings per day
<i>Marijuana</i>	_____ per day _____ per week	_____ per day _____ per week
<i>Cocaine</i>	_____ times per day _____ times per week	_____ times per day _____ times per week
<i>Diet pills</i> Name: _____	_____ pills/doses per day _____ pills/doses per week	_____ pills/doses per day _____ pills/doses per week

Marital status: _____ *Children:* _____

Education: _____ *Living arrangements:* _____

Employment: _____

Military service: _____



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RELEASE OF INFORMATION

Release Information To:	Please Initial for Authorization:	Other:
_____ Outside Physician	_____	_____
_____ Court	_____	_____
_____ Probation Officer	_____	_____
_____ Lawyer	_____	_____
_____ Family Physician	_____	_____
_____ Referral Source	_____	_____
_____ Social Service Agency	_____	_____
_____ Spouse/Significant Other	_____	_____
_____ Family Member	_____	_____
_____ Employer	_____	_____
_____ School	_____	_____
_____ Patient's Signature/Guardian	_____	Date
_____ Office Staff	_____	Date