Emerald Behavioral Health Services LLC
3201 East Pioneer Parkway
Suite 40 B ,Arlington, TX 76010.
Email: Support@emeraldbehavioralhealth.com
Phone: +1 214-919-0147 Fax: 214-306-6384

Welcome to Emerald Behavioral Health Services.

We are board certified mental health Nurse practitioner. We evaluate, diagnose and manage various mental health conditions such as ADHD, personality disorders, mood disorders and anxiety in both children and adults. Our goal is to bridge the gap and enhance access to treatment. As a community, we will break barriers to treatment as well as stigma affecting individuals from seeking treatment. We are dedicated to the wellbeing of our generation, therefore we are dedicated to both young and old with needs for mental health treatment.

Our purpose is to provide a safe environment for our patients and empower people to discuss their mental health needs freely.

Our vision is to provide culturally competent, holistic, and wellness focused services that will promote your social-emotional wellbeing and address social-emotional problems that currently exist in our society.

Thank you for allowing us to serve you!

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EMERALD BEHAVIORAL HEALTH SERVICES LLC

Patient Demographic & Insurance Verification

Date:_____ Contact number: _____
Name (Last)_____(First)_____
DOB:_____/_____/_____Current Age _____
Sex (please check one) Male_____Female _____

Address:_____City_____State___
Zip _____

Email: _____
Patient Status □ student □ single □ married
Race □ Asian/Vietnamese □ Black □ White □ Other
Ethnicity □ Hispanic □ Not Hispanic □ Decline
Preferred Language □ English □ Spanish □ Other_____

Primary Parent:_____

Pharmacy name:_____

Pharmacy phone_____

Pharmacy Address:_____City:_____State:___Zip:_____

Health Insurance Information

Name of Primary Insurance	
Patient ID#	
Group #	
Insurance Phone Number	

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EMERALD BEHAVIORAL HEALTH SERVICES LLC

Authorization for Use & Disclosure Release of Protected Health Information

Autorización para el Uso y Revelación (lanzamiento o de una solicitud) de Información de salud protegida

□ **I do not at this time give my consent for my health records to be release or obtain** /En este momento no doy mi consentimiento para que mis registros de salud sean liberados u obtenidos.

Patient/Paciente:_____Date of Birth/Fecha de nacimiento _____

Doctor/Facility or Family Member: _____

Address:_____City:_____State_____Zip code _____

Phone_____ Fax _____

I hereby authorize the □ release of □ obtaining of the medical records to/from: Por la presente autorizo la □ liberación de □ la obtención de los registros médicos para:

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The specific purpose(s) for the disclosure of records is (check your selection): □ sharing with healthcare providers as needed □ sharing with psychologist □ other (describe)_____. This request/ authorization applies to Healthcare information relating to treatment and conditions.

The Information to be released includes/Please check specific information needed
(Por favor, compruebe la información específica necesaria)

El propósito específico para la divulgación de los expedientes es (verifique su selección): □ compartir con los proveedores de atención médica según sea necesario □ compartir con el psicólogo □ otro (describir) _____. Esta solicitud / autorización se aplica a la información de salud relacionada con el tratamiento y las condiciones. La información que debe publicarse incluye:
□ Progress Notes/ Notas de progreso □ Medication Records/ Registros de medicamentos □ Treatment Plan/Plan de tratamiento □ Lab Data /Datos de laboratorio □ Verbal Communication /Comunicación verbal □ Other/Otros: _____

This Release of Information demonstrates compliance with the Health Insurance Portability and Accountability Act (HIPAA); and all federal regulations and interpretive guidelines there under. **I**f the requestor or receiver is not a health care or plan provider, the released information may no longer be protected by Federal Privacy Regulation. **I** understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. **I** understand that the specified information to be released may include, but is not limited to: history, diagnoses, and or treatment of drug or alcohol abuse, mental illness, or communicable disease including HIV and AIDS. **I** agree that a facsimile or photocopy of this authorization is as valid as the original. **I** understand this authorization is voluntary, that I may revoke this authorization in writing at any time except to the extent that actions have been taken in reliance upon the authorization.

**Esta Divulgación de Información demuestra el cumplimiento con la Ley de Portabilidad y Responsabilidad del Seguro Médico (HIPAA); Y todas las regulaciones federales y las pautas de interpretación allí debajo. Si el solicitante o el receptor no es un proveedor de atención médica o plan, la información liberada puede no estar protegida por el Reglamento Federal de Privacidad. Entiendo que mis registros son confidenciales y no pueden revelarse sin mi autorización por escrito, excepto cuando la ley lo permita. Entiendo que la información especificada para ser liberada puede incluir, pero no está limitada a: historia, diagnósticos y / o tratamiento de abuso de drogas o alcohol, enfermedades mentales o enfermedades contagiosas, incluyendo el VIH y el SIDA. Estoy de acuerdo en que un facsímil o fotocopia de esta autorización es tan válido como el original. Entiendo que esta autorización es voluntaria, que yo revocar esta autorización por escrito en cualquier momento excepto en la medida en que se

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EMERALD BEHAVIORAL
HEALTH SERVICES LLC

CONSENT FOR TREATMENT FOR MENTAL/BEHAVIORAL SERVICES

Patient Last name, First Name **Date of Birth**

I_____(*patient/ guardian name*) hereby give my authorization and consent for the above name to receive treatment for mental and behavioral services at Emerald Behavioral Health Services LLC by a *Board Certified Family Psychiatric Mental Health Practitioners.* Treatment consists of psychiatric examinations, diagnosis, and medication management. I understand that complete and accurate information is needed to help provide the best treatment plan and care. Moreover, during my care as a patient, I understand that the purpose of treatments and procedures will be explained to me and that while the course of medication management is designed to be helpful at times undesirable side effects may occur and it is my responsibility to communicate these occurrences to my provider. I understand that I may end treatment at any time. I understand that my mental health provider may want to discuss this with me, but that I reserve the right to stop treatment. I understand that all information regarding diagnosis and/or treatment is confidential and will not be released to any other agency or individual without my knowledge and written consent, except when required by law.

_____
Patient Name:

_____
(Patient/Guardian Signature) Guardian

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EMERALD BEHAVIORAL
HEALTH SERVICES LLC

_____
(Date)

Member Acknowledgement of Insurance Benefits

FINANCIAL AGREEMENT AND INSURANCE BENEFITS

I hereby assign all medical benefits, to which I am entitled, including Medicare, Medicaid, private insurance and any other health plans to Emerald Behavioral Health Services LLC. This assignment will remain in effect until revoked by myself in writing. A photocopy of charges whether or not paid by said insurance. I hereby authorize said assignee to release all information necessary to secure this payment. I understand that failure to notify Emerald Behavioral Health Services LLC of any changes or insurance coverage will result in the financial obligation to rest fully on myself regardless of any contract between the insurance company and Emerald Behavioral Health Services LLC clinic.

_____ _____
(Patient/Guardian Signature) Guardian (Date)

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EMERALD BEHAVIORAL
HEALTH SERVICES LLC

HIPAA DISCLOSURE NOTICE

I_____UNDERSTAND THAT, UNDER THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPPA), I HAVE CERTAIN RIGHTS TO PRIVACY REGARDING MY PROTECTED HEALTH INFORMATION. PROTECTED HEALTH INFORMATION (PHI) MAY ORIGINATE IN YOUR MEDICAL RECORD AT Emerald Behavioral Health Services LLC OR MAY BE RECEIVED FROM OUTSIDE HEALTH ENTITIES AND FILED IN YOUR MEDICAL RECORD. I UNDERSTAND THAT THIS INFORMATION CAN AND WILL BE USED BY Emerald Behavioral Health Services LLC TO:

A) CONDUCT, PLAN AND DIRECT MY TREATMENT AND FOLLOW-UP AMONG THE MULTIPLE HEALTHCARE PROVIDERS WHO MAY BE INVOLVED IN THE TREATMENT DIRECTLY OR INDIRECTLY

B) OBTAIN PAYMENT FROM THIRD-PARTY PAYERS

C) CONDUCT NORMAL HEALTHCARE OPERATIONS SUCH AS QUALITY THROUGH CHATEL BEHAVIORAL HEALTHCARE CLINIC OR NETWORKING OORGANIZATION AND

D) CONSENT TO PROPERTY TRANSFER OF SPECIMEN (TISSUE OBTAINED DURING MEDICAL TESTING TO Emerald Behavioral Health Services LLC.

I HAVE BEEN INFORMED BY YOU OF YOUR NOTICE OF PRIVACY PRACTICES CONTAINING A MORE COMPLETE DESCRIPTION OF THE USES AND DISCLOSURES OF MY HEALTH INFORMATION.

I UNDERSTAND THAT THIS ORGANIZATION HAS THE RIGHT TO CHANGE ITS NOTICE OF PRIVACY PRACTICES FROM TIME TO TIME AND THAT I MAY OBTAIN A CURRENT COPY OF THE NOTICE OF PRIVACY PRACTICES FROM MY OFFICE OR BY CONTACTING THEM AT

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I UNDERSTAND THAT I MAY REQUEST IN WRITING THAT YOU RESTRICT HOW MY PRIVATE INFORMATION IS USED OR DISCLOSED FOR TREATMENT, PAYMENT OR HEALTH CARE OPERATIONS.

I ALSO UNDERSTAND THAT YOU ARE NOT REQUIRED TO AGREE TO MY REQUESTED RESTRICTIONS, BUT IF YOU DO AGREE THEN YOU ARE BOUND TO ABIDE BY SUCH RESTRICTIONS.

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT IN WRITING AT ANY TIME, EXCEPT TO THE EXTENT THAT YOU HAVE TAKEN ACTION RELYING ON THIS CONSENT.

_____
_ PATIENT NAME (PLEASE PRINT)

_____/_____/
_____(DATE OF BIRTH IN (MM/DD/YYYY)

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EMERALD BEHAVIORAL HEALTH SERVICES LLC

FINANCIAL POLICY PATIENT CONSENT FORM

Emerald Behavioral Services LLC. RECOGNIZES THE NEED FOR A CLEAR UNDERSTANDING BETWEEN PATIENT AND MEDICAL PROVIDER REGARDING PROTECTED HEALTH INFORMATION AND FINANCIAL ARRANGEMENTS FOR HEALTHCARE. THE FOLLOWING INFORMATION IS PROVIDED TO AVOID ANY MISUNDERSTANDING CONCERNING PROTECTED HEALTH INFORMATION AND PAYMENT FOR PROFESSIONAL SERVICES.

I. PAYMENT: PAYMENT IS EXPECTED AT THE TIME OF SERVICE.
If your deductible has not been met, or a percentage is your responsibility, we expect payment when services are rendered. Even though insurance will be filed, you are responsible for any balance after insurance processes your claim. All charges for treatment become due and payable sixty (60) days after the date of service. These periods allow sufficient time to process insurance and make payment in full of any remaining balance. There will be a $25.00 charge for returned checks. If not paid within sixty (60) days, Emerald Behavioral Services LLC will begin various collection activities including, but not limited by submitting the past due account to a collection agency.

II. SELF PAYMENT (PRIVATE, CASH PAYMENT):
If you have no insurance coverage, we ask that you coordinate your care with our business office prior to your evaluation, follow-up, and treatment. We require an advance payment for professional services.

III. MANAGED CARE: ALL MANAGED CARE (MH, PPM, etc.) CO PAYMENTS ARE DUE AT THE TIME OF SERVICE. By signing below, patient acknowledges that it is the patient responsibility to be aware of what services are covered and agrees to pay for any services deemed to be non-covered or not authorized by the plan.

IV. MEDICARE: Emerald Behavioral Services LLC is a participating provider with the Medicare Program and accepts as payment, the Medicare allowable, patient deductible and/or 20% co-insurance. If you have supplemental insurance (Medigap) to cover the portion of the charges that Medicare does not pay, please provide us with a copy of your insurance card. Medicare or secondary carriers do not cover some procedures and supplies. Please make certain you understand which aspects of your treatment are covered before proceeding. In this rare case you may be asked to sign a waiver form, which states that you understand that you will be responsible for these charges.

V. CHILDREN OF DIVORCED PARENTS: Responsibility for payment for treatment of minor children, whose parents are divorced, rests with the parent who seeks the treatment. Any court ordered responsibility judgment must be determined between the individuals involved, without the inclusion of Emerald Behavioral Services LLC.

VI. SECONDARY INSURANCE: The Texas Department of Insurance requires the patient to provide secondary insurance coverage to the provider if applicable. You agree to provide such information as outlined below. You agree to notify the provider in the future immediately of any additions, changes or deletions in primary or secondary coverage.

Initial/Complete as applicable:
_____I have NO SECONDARY INSURANCE COVERAGE

_____I have SECONDARY INSURANCE COVERAGE AS DESCRIBED ON THE ATTACHED PATIENT DEMOGRAPHIC FORM

It is our hope that the above policies will allow us to provide the highest quality of care to our patients. If you have any questions or need clarification regarding these policies please call us at (214-919-0147).

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EMERALD BEHAVIORAL HEALTH SERVICES LLC

OFFICE POLICIES & PROCEDURES

_____
PRINT PATIENT NAME

OUR DISCLAIMER

BY LAW WE COLLECT COPAY, CO-INSURANCE OR DEDUCTIBLE BEFORE WE CAN PROVIDE SERVICE. IT IS CONSIDERED INSURANCE FRAUD IF WE DON'T COLLECT AND BILL YOUR INSURANCE. THANK YOU IN ADVANCE!

_____ I AM RESPONSIBLE FOR MY OR MY CHILD'S COPAYS, CO-INSURANCE OR DEDUCTIBLES FEES AT THE TIME SERVICE IS RENDER BEFORE SEEING THE DOCTOR.

_____ ***FOR STANDARD OFFICE VISITS***, I UNDERSTAND THAT THERE WILL BE A CHARGE OF $35 for **NO CALL NO SHOW** APPOINTMENT THAT I DO NOT GIVE 48 HOUR ADVANCE NOTICE TO CANCEL OR RESCHEDULE.

_____ ***FOR THERAPY VISITS***, I UNDERSTAND THAT THERE WILL BE A CHARGE OF $55 for **NO CALL NO SHOW** APPOINTMENT THAT I DO NOT GIVE 48 HOUR ADVANCE NOTICE TO CANCEL OR RESCHEDULE.

_____ ***FOR STANDARD OFFICE VISITS***, I UNDERSTAND THAT THERE WILL BE A CHARGE OF $20 FOR **LAST MINUTE CANCELLATIONS GIVEN LESS THAN 48 HOURS.** I AM RESPONSIBLE FOR CALLING THE CLINIC OR SENDING A TEXT MESSAGE TO TIMELY CANCEL MY OR MY CHILD'S APPOINTMENT.

_____ ***FOR THERAPY VISITS***, I UNDERSTAND THAT THERE WILL BE A CHARGE OF $40 FOR **LAST MINUTE CANCELLATIONS GIVEN LESS THAN 48 HOURS.** I AM RESPONSIBLE FOR CALLING THE CLINIC OR SENDING A TEXT MESSAGE TO TIMELY CANCEL MY OR MY CHILD'S APPOINTMENT.

_____ I UNDERSTAND THAT AN APPOINTMENT THAT IS SCHEDULED FROM 330PM UNTIL CLOSING IS GUARANTEED APPOINTMENTS. IF AN APPOINTMENT IS SET AND NOT KEPT, THEN YOU WILL CHARGED THE APPROPRIATE NO-SHOW CANCELLATION FEE DESCRIBED ABOVE.

_____ IF YOU OR YOUR CHILD HAS FIVE OR MORE NO-SHOW APPOINTMENTS WITHIN ONE YEAR YOU WILL BE, AT THE CLINIC'S DISCRETION, DISCHARGED/DISMISSED FROM THE PRACTICE.

_____ I UNDERSTAND THAT THERE WILL BE A $10 FEE TO REPLACE EXPIRED PRESCRIPTION. WE CANNOT BILL YOUR INSURANCE COMPANY FOR THIS AMOUNT AS IT WILL BE SOLELY YOUR RESPONSIBLE TO PAY IN FULL.

_____ I UNDERSTAND THAT IT IS THE CLINIC'S POLICY AND DISCRETION TO REQUEST A POLICE REPORT TO REPLACE LOST OR STOLEN PRESCRIPTION.

_____ ALL OUTSTANDING PAYMENTS (AMOUNT DUE, NS/LC FEES OR FINANCIAL RESPONSIBILITY) MUST BE PAID. PAYMENT ARRANGEMENTS MUST BE MADE BEFORE SEEING DOCTOR.

_____ I UNDERSTAND AND AGREE THAT I AM FINANCIALLY RESPONSIBLE FOR ALL APPOINTMENTS NOT KEPT. (YOUR INSURANCE DOES NOT COVER LAST MINUTE, NO SHOWS, OR PAPERWORK FEES YOU MAY INQUIRE)

_____ I UNDERSTAND THAT BY CANCELLING AND/OR RESCHEDULING MY APPOINTMENT I AM RESPONSIBLE FOR MAKING SURE I (PARENT/PATIENT) HAVE ENOUGH MEDICATION TIL THE DOCTOR CAN SEE ME.

_____ I UNDERSTAND THAT IT IS THE PATIENT'S RESPONSIBILITY TO INFORM THE OFFICE OF ANY CHANGES IN INSURANCE. IF I FAIL TO NOTIFY THE OFFICE, I WILL BE RESPONSIBLE AND CHARGED FOR ANY OUTSTANDING VISITS MY INSURANCE DOES NOT COVER.

_____ CELLULAR DEVICES, CAMERAS, CAMCORDERS OR ANY RECORDING /PHOTO DEVICES OR PROHIBITED. (TO REDUCE THE POTENTIAL RISK OF FEDERAL HIPPA VIOLATION RECORDING/PHOTO TAKING DEVICES ARE PROHIBITED)

_____ IF THE CLINIC HAS TO CALL IN OR SUBMIT AN E-RX DUE TO YOUR INABILITY TO KEEP YOUR ORIGINAL APPOINTMENT DUE TO NO-SHOW OR LAST-MINUTE CANCELLATIONS, YOU WILL BE CHARGED $10 PER PRESCRIPTION.

HERE ARE NO EXCEPTIONS TO THE ABOVE OFFICE POLICIES. I UNDERSTAND THE OFFICE POLICY MAY BE AMENDED OR MODIFIED FROM TIME TO TIME BY THE PRACTICE

Signature (Patient/Guardian)_____ Date_____

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EMERALD BEHAVIORAL HEALTH SERVICES LLC

DISCLOSURE OF FEE SCHEDULE

Most fees are for office and/or hospital procedures. However, fees will also be incurred when you request services in addition to your regular services.

******Our office is not contracted and we are not legally obligated to complete additional paperwork requested by your employer or other entity.***

Brief, non-comprehensive listing of such services:

1. Medical records copied/transferred - ***$30 and up***
2. Medical FMLA paperwork - ***$75 and up***
3. . Return or NSF Checks - ***$25*** ***Please note, one returned check warrants our discretion to not accept any future checks for the patient or parent of patient***
4. We do not complete Disability/Workers' Comp forms or letters
5. Missed or no-show scheduled appointments with no notification incurs a fee of ***$30 for standard appointments and $75 for therapy visits***.
6. Last minute cancellation of a scheduled appointment **with less than 48hr notification** will incur a fee of $25. Last minute cancellations of therapy appointments will incur a fee of $50. NO SHOW FEE $55.
7. Lost/Stolen/Expired Prescription to be replaced will incur a $10 fee.
8. Our office under no circumstance will fill out forms or letters for CHL (Concealed handgun permit) or Handicap Stickers.
9. We are not contracted by any government, commercial or medical entity therefore we may refuse to sign any form or letter you may bring in. This is solely the discretion of the clinic.

The above fees are not covered through your insurance plan and are payable at the time of service rendered.

Patient Name_____ Date:___/___/_____

Patient/Guardian Signature _____

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EMERALD BEHAVIORAL
HEALTH SERVICES LLC

CONTROLLED SUBSTANCE POLICY

___Controlled Stimulants prescriptions **EXPIRE 21 DAYS** after the appointment date, please make an effort to fill them in the appropriate time frame.

___ If you feel your child's medication needs to be increased, please discuss this during your office visit, not over the phone as the practitioner will not increase meds via phone calls.

___ If your medication is lost/stolen, we will not rewrite any prescription without **A POLICE REPORT**. We encourage you to turn in or fill all prescriptions when they are issued.

___If you or your child is using ILLICIT DRUGS OF ANY KIND we will no longer prescribe your medication.

___If you alter the original prescription in any way, we will no longer prescribe your medication.

___If we discover you are getting the same prescription drugs from multiple pharmacies and/or physicians, we will no longer prescribe your medication.

___We do not do medication refills (especially controlled substances). You are required to make and keep your appointments as recommended in order to obtain these medications. If you know you will have to miss an appointment due to illness or another obligation, it is **your responsibility** to call and reschedule in order to avoid a disruption in your medication.

___We reserve the right to stop prescribing your medication if we feel there is a legitimate reason to include but not limited to: suspicious behavior, reports of misuse of medication, reports of illegal drug use/alcohol via urine/toxic screen.

___We reserve the right to terminate our service with you, if we feel there is a legitimate reason to include: Verbal abuse to our providers/staff, Threatening of any kind to the providers/staff, etc.

The guidelines in this policy are non-negotiable.

Patient name _____

Patient/Guardian Signature_____ Date___/____/_____

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EMERALD BEHAVIORAL HEALTH SERVICES LLC

Evaluations for Litigation Purposes

Dear Clients,

Please be advised that Texas Advance Behavioral Health does not provide evaluations (diagnosing) for litigation purposes. Litigation purposes would include criminal cases, divorce, personal injury and emotional distress types of cases, among others. If you are looking to get an evaluation for a litigation purpose and or disability, we recommend that you get a physician and/or psychologist who specializes in performing such legal evaluations and treatment.

The providers at Emerald Behavioral Services LLC do not provide litigation evaluations; our purpose is strictly to assist you.

I acknowledge that I have read and understand the above statement.

Patient name _____

Patient/Guardian Signature_____ Date___/____/_____

Grievance Procedure

We are committed to you and your mental health needs here at Texas Advance Behavioral Health. If you have concerns, feedback, or complaints we would like to know. The process for patient who has a complaint, or a question is to:

1. Begin by discussing the concern with our front office Patient Care staff. This will often clear up any misunderstanding.

2. If your concern is not dealt with to your satisfaction, you may inform our **Clinical Manager at 214-919-0147** or by emailing at **Support@emeraldbehavioralhealth.com.**

3. If your concern still is not addressed to your satisfaction, you may speak directly to your provider or email your provider so they may assist you.

_____ _____/_____/_____
(Patient/Legal Guardian signature) (Date)

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EMERALD BEHAVIORAL HEALTH SERVICES LLC

Telemedicine Informed Consent

Telemedicine services involve the use of secure interactive videoconferencing equipment and devices that enable health care providers to deliver health care services to patients when located at different sites.

1. I understand that the same standard of care applies to a telemedicine visit as applies to an in-person visit.
2. I understand that I will not be physically in the same room as my health care provider. I will be notified of and my consent obtained for anyone other than my healthcare provider present in the room.
3. I understand that there are potential risks to using technology, including service interruptions, interception, and technical difficulties.
    a. If it is determined that the videoconferencing equipment and/or connection is not adequate, I understand that my healthcare provider or I may discontinue the telemedicine visit and make other arrangements to continue the visit.
4. I understand that I have the right to refuse to participate or decide to stop participating in a telemedicine visit, and that my refusal will be documented in my medical record. I also understand that my refusal will not affect my right to future care or treatment.
    a. I may revoke my right at any time by contacting [PRACTICE NAME] at [PHONE NUMBER].
5. I understand that the laws that protect privacy and the confidentiality of health care information apply to telemedicine services.
6. I understand that my health care information may be shared with other individuals for scheduling and billing purposes.
    a. I understand that my insurance carrier will have access to my medical records for quality review/audit.
    b. I understand that I will be responsible for any out-of-pocket costs such as copayments or coinsurances that apply to my telemedicine visit.
    c. I understand that health plan payment policies for telemedicine visits may be different from policies for in-person visits.
7. I understand that this document will become a part of my medical record.

By signing this form, I attest that I (1) have personally read this form (or had it explained to me) and fully understand and agree to its contents; (2) have had my questions answered to my satisfaction, and the risks, benefits, and alternatives to telemedicine visits shared with me in a language I understand; and (3) am located in the state of Texas and will be in Texas during my telemedicine visit(s).

_____ _____ _____
Patient/Parent/Guardian Printed Name Patient/Parent/Guardian Signature Date

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EMERALD BEHAVIORAL HEALTH SERVICES LLC

INITIAL INTAKE QUESTIONNAIRE

PATIENT'S NAME:_____ **Date of Birth:**_____ **Todays Date:**_____

Who referred you to the clinic?_____

What brings you to the clinic? (CHIEF COMPLAINT):_____

PSYCHIATRIC HISTORY: Do you have any Psychiatric problems/ History:

☐ No past psychiatric history ☐ Eating d/o ☐ depression ☐ anxiety ☐ ADHD ☐ bipolar ☐ schizophrenia ☐ Excessive Crying

☐ Excessive Sleeping during the Day ☐ High irritability ☐ Mood Swings ☐ Nightmares ☐ Hallucinations ☐ Sleep Disturbance

☐ Feeling Nervous ☐ Weight Gain ☐ Weight Loss

PSYCHIATRIC MEDICATION:Are you taking any psychiatric medications? ☐ None ☐ Yes. Please list all medications:

_____

_____

Have you been hospitalized? ☐ None. ☐ Yes: Where have you been hospitalized and when?

_____

Have you ever attempted suicide: ☐ No attempts. ☐ Yes: When:

_____

Do you have any legal issues? ☐ None. ☐ Yes. Please list issue(s):_____

PATIENT'S MEDICAL HISTORY: ☐ No medical history

☐ High blood pressure (HTN) ☐ Diabetes (DM) ☐ Seizure (SZ) ☐ Sexually Transmitted Diseases (STD's)

☐ head trauma ☐ high cholesterol (dyslipidemia) ☐ anemia ☐ hypo or hyperthyroidism ☐ liver problems

[ ]kidney problem ☐ cardiac problems ☐ surgeries:_____

LMP:_____

FAMILY PSYCHIATRIC HISTORY: [☐ No past family psychiatric history ☐ ☐]

☐ Eating d/o ☐ depression ☐ anxiety ☐ ADHD ☐ bipola ☐ schizophrenia ☐ Who in the family has psychiatric disorders:_____

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FAMILY MEDICAL HISTORY: ☐ No family medical history

☐ High blood pressure (HTN) Diabetes (DM) ☐ Seizure (SZ) Sexually Transmitted Diseases (STD's)

[[☐ ☐] ☐ ☐ ☐

☐ head trauma ☐ high cholesterol (dyslipidemia) anemia hypo or hyperthyroidism ☐ liver problems

☐ ☐

☐ kidney problem [ ] cardiac problems surgeries:_____

☐ Other problems:

_____

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EMERALD BEHAVIORAL HEALTH SERVICES LLC

PREVENTIVE CARE: Who is your Primary Care Provider: [ ] None.
Name:_____Last seen:_____

SOCIAL HISTORY:
Who does the patient currently lives with:_____
_____
Have you had any CPS cases: ☐None ☐ Yes. When:_____
☐ ☐ [ ] [ ]
Employment: None Where do you work:_____

_____
Education: Highest School Grade:_____Name of school_____
Learning Disabilities: ☐ None ☐Yes reports: _____
_____
Special education placement: ☐ None Yes reports:_____
☐

ABUSE HISTORY: Have you been abused physically, emotionally, or sexually? ☐ No. Yes reports:
☐

_____

SUBSTANCE ABUSE: Do you use any drugs or alcohol? Do you smoke? ☐No.

☐Yes reports: What you use and when you used last._____

DEVELOPMENTAL HISTORY (Child & Adolescents Only): Was the patient born premature? When did they walk and talk?
Patients Birth Weight?

REVIEW OF SYSTEMS -Circle if you have had any of these symptoms in the last month:

Constitutional: ☐fever, night sweats, fatigue, daytime, somnolence, polydipsia, polyphagia, *See Vitals*
☐ ☐ ☐ ☐ ☐ ☐

Eyes and Ears: (-)change in vision, loss of vision, blurred vision, diplopia, Denies any hearing problems.
☐ ☐ ☐ ☐

Respiratory: dyspnea, cough, cough productive of sputum
☐ ☐

Cardiovascular: chest pain, palpitations, dyspnea at rest, dyspnea with activity, orthopnea
☐ ☐ ☐ ☐ ☐

Gastrointestinal: ☐abdominal pain, nausea, vomiting, constipation, diarrhea
☐ ☐ ☐ ☐ ☐

Urinary: dysuria, increased urinary frequency, urinary incontinence
☐ ☐ ☐

Dermatologic/Integumentary: ☐dry skin, rash, bruising
☐ ☐ ☐ ☐ ☐

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Musculoskeletal: ☐ muscle pain, ☐ muscle cramps, ☐ muscle weakness, ☐ decreased muscle strength, ☐ difficulty walking

Neurological: ☐ HA, ☐ vertigo, ☐ lightheadedness ☐ tremor, ☐ difficulty speaking, ☐ memory loss, ☐ difficulty concentrating