Serenity Concepts

Patient Information

Please Print

Today's Date:______________________________________

First Name:____ M.I.___________

Last Name:____

Address:____

City:____State:_________Zip:__________________

Home Phone: (____)_______________________________Birth Date:__________________________

Work Phone: (____)_______________________________Sex: Male____ Female____

Other Phone: (____)________________________________Can we a leave message for a reminder call ? (Yes)_____(No)_______

Marital Status: Single____ Married____ Divorced____ Other____

Employer:____

Student: Full-time____ Part-time____ N/A____

In the event of an emergency, my Therapist may contact______________________________

Relationship: __________________________ at phone number: (____)______________________

This section to be completed by the Therapist	
Authorization Number:	
Effective Dates:	
Number of Sessions:	
Co-Payment:	
Percentage covered by Insurance:	
Deductible:	
Out of Pocket:	
Diagnosis 1:	Diagnosis 2:
Notes and Comments:	

PRIMARY INSURANCE INFORMATION

<u>You must present a copy of your card in order for us to bill your insurance</u>

Insurance Company: ____

Phone #: ____

INSURED PERSONAL INFORMATION

Relationship to patient: ____

I.D. #: ____________________________ Group #: ________________________

First Name: ____

Last Name: ____

Address: ____

City: ______________________ State: _________ Zip: _______________

Home Phone: (________)________________________ Birth Date: __________________

Work Phone: (________)________________________ Sex: ______Male ______Female

Other: (________)________________________ S.S. #: ____________________________

Employer: ____

I authorize the release of any information necessary to process claims with my insurance company and I authorize my insurance company to make payments for my treatment directly to my therapist. I understand that I am responsible at the time of service for paying my co-insurance and/or co-pay. I also acknowledge I am fully responsible for any charges not covered by any other sources.

Signature of responsible party: ____

Date: ____________________

Your records are confidential. Your records will not be released without written consent. **MEDICAL HISTORY FORM**

Name: ______________________________ Birth date: ________________ Date:____________________
Street Address: _________________________City: ____________________State: _____ Zip: ___________
Primary Phone: ___________________________ Marital Status: __________________________________
Children: YES NO How many? ___ # of persons living in your home? ___ Race/Ethnicity: ________
Emergency Contact: ____________________ Phone #:____________________ Relationships: ___________
Smoke? ________ Drink Alcohol?________ Drink cola/coffee?___________
Packs per day: _____ Drinks per day: _______ How much per day? _________
Years smoked ____

Current Medications - For what condition?- Dosage Frequency- Date Started- Comments/Concerns

____
____
____
____List any allergies you have to drugs, food, or other items:
____

Are you currently under medical care for any reasons? YES NO
If yes, please explain:
____
____

Primary Care Physician- Name: ____
Address and City:____ Phone: (_____)_____________

Past Psychiatric/Mental Health Care:
Therapist's Name: _____________________________________ For How Long and When?_____________

List all times you have been admitted to a hospital overnight (except for childbirth)

Reason Hospitalized	Year	Hospital	Doctor

Please check if any relative (parents, siblings, grandparents, children) have had any of the conditions listed below:

High blood pressure: ____
Kidney Disease: ____
Asthma: ____
Stroke: ____
Bleeding Tendencies: ____
Tuberculosis: ____
Cancer: ____

Seizures: ____
Colitis: ____
Emphysema: ____
Heart Disease: ____
Anemia: ____
Ulcers: ____
Sugar Diabetes: ____

Gout: ____
Mental Illness: ____
Other Serious Illness:
____
____
____
____

If you answered yes to any of the above, please explain: ____
____

It should be noted that medications may have unwanted side effects. You are strongly urged to bring to our attention any problem that you may be having with your medications.

____ ____________________________
Signature Date

Please describe primary issues that brought you in today: ____

____

Please rate the following life areas which currently cause issues of concern/problems for you on a 1-5 scale. 1= No concern and 5= Primary, strong concern. Circle appropriate response.

Martial or partner relations	1	2	3	4	5	n/a
Family relations with your parents and/or siblings	1	2	3	4	5	n/a
Special family issues (step and blended families, adoption)	1	2	3	4	5	n/a
Other interpersonal relationships (friend, peer, partner, co-worker)	1	2	3	4	5	n/a
General mental and emotional health (anxiety, depression)	1	2	3	4	5	n/a
Alcohol and/or substance abuse and/or dependence Self __________ Family member_________	1	2	3	4	5	n/a
Job/career and related job/career issues	1	2	3	4	5	n/a
School and/or school related issues	1	2	3	4	5	n/a
Financial and/or legal situations	1	2	3	4	5	n/a
Concern for physical state of health	1	2	3	4	5	n/a
Physical, verbal, emotional, and/or sexual abuse	1	2	3	4	5	n/a
General lifestyle (life stage) changes	1	2	3	4	5	n/a
Other	1	2	3	4	5	n/a

Overall, rate the degree to which these areas of concern have affected your life.
Use a 1-10 point scale. 1= very little and 10= great deal.
1 2 3 4 5 6 7 8 9 10

Please place a check next to all that apply below:

Tremors, shaking		Increased sweating		Feeling restless/trapped	
Headaches		Hives		Feeling afraid	
Muscle pains		Confusion		Feeling irritable	
Nausea		Inability to concentrate		Loss of appetite	
Stomach pain		Feeling anger/rage		Weight loss	
Diarrhea		Feeling of sadness		Overeating	
Constipation		Desire to cry		Weight gain	
Tension in chest		Insomnia		Increased alcohol/drug use	
Dizziness/fainting		Increased sleeping		Increased smoking	
Fatigue/weakness		Numb emotionally/physically		Fights or arguments	
Sexual dysfunction		Inability to communicate		Other	

Rate your overall health:
Poor____ Fair____ Good____ Excellent____

Please check the statements which describe your recent experience related to work or school:

Received verbal warning(s)		Had an accident		Leaving early	
Received written warning(s)		Conflicts with boss/teacher		Taken sick days	
Placed on problem		Conflicts with peers		Used disability	
Suspended		Arriving late		No problems	

Rate your overall job/school satisfaction:
No satisfaction:____ A little:____ Moderate:____ Very:____ Extremely satisfied:____

Has your job performance been affected by the above stated problems? YES NO

If so, how: ____

____

Client Information and Policy Statement

Welcome:

Thank you for choosing Serenity Concepts. We [I] would like to take this opportunity to acquaint you with information relevant to treatment, confidentiality and office policies. Your therapist will answer any questions you have regarding any of these policies.

Aims and Goals:

The major goal is to help you identify and cope more effectively with problems in daily living and to deal with inner conflicts which may disrupt your ability to function effectively. This purpose is accomplished by:

- Increasing personal awareness.
- Increasing personal responsibility and acceptance to make changes necessary to attain your goals.
- Identify personal treatment goals.
- Promoting wholeness through psychological and spiritual healing and growth.

You are expected to play an active role in you r treatment, including working with your therapist to outline your treatment goals and assess your progress. You may be asked to complete questionnaires or to do homework assignments. Your progress in therapy depends much more on what you do between sessions than on what happens in the session.

Appointments:

Appointments are usually scheduled for 45 minutes. The practice's hours are 9:00 a.m. to 8:00 p.m. Patients are generally seen weekly or more/less frequently as acuity dictates and you and your therapist agree. You may discontinue treatment at any time, but please discuss any decisions with your therapist. **In an event of an emergency**, community crisis phone numbers are: Netcare (24 hours) 614-276-2273, Suicide Hotline (24 hours) 614-221-5445. If you have a mental emergency, go to the nearest emergency room.

Confidentiality:

Issues discussed in therapy are important and are generally legally protected as both confidential and "privileged." However, there are limits to the privilege of confidentiality. These situations include: 1) possible abuse or neglect of a child, elderly person or a disable person, 2) when your therapist believes you are in danger of harming yourself or another person or you are unable to care for yourself, 3) if your report that you intend to physically injure someone the law requires your therapist to inform that person as well as the legal authorities, 4) if your therapist is ordered by a court to release information as part of a legal involvement in company litigation, etc., 5) when your insurance company is involved, e.g. in filling a claim, insurance audits, case review or appeals, etc., 6) in natural disasters whereby protected records may be exposed, or 7) when otherwise required by law. You may be asked to sign a Release of Information so that your therapist may speak with other mental health professionals or to family members. This office is compliant with the HIPPA Privacy Act. It is located in the building, if you would like to read it. Emails and fax transmissions are not guaranteed confidential.

Record Keeping:

A clinical chart is maintained describing your condition and your treatment and progress in treatment, dates of and fees for sessions, and notes describing each therapy session. Active chars are locked and kept on site. Inactive charts are locked and kept in medical records.

Fees:
Fee for the initial visit, the Diagnostic Interview, is $75.00. Each 45-50 minute therapy session thereafter is $60.00 **for our self pay patients.** If you have insurance, your out of pocket costs will be determined by your policy terms. Please contact your insurance provider if you have not already done so to get your mental health benefits. All paperwork/reports are $40.00 and is not covered by insurance.

Payments:
Payment is due at the time of the session unless other arrangements have been made. Your therapist will file your insurance claim, but you are responsible for deductibles, co-insurance, and co-payments. **It is your responsibility to familiarize yourself with your insurance benefit.**

Cancellations and Missed Appointments:
You will be billed for a session that you cancel with less than 24 hours notice. You may leave messages 24 hours per day. You will be billed at the full rate of $25.00- $50.00 for late cancellations and missed appointments. **Insurance companies do no reimburse for failed appointments.**

Consent for Treatment:
I have read and understand this policy statement and I have had my questions answered to my satisfaction. I accept, understand and agree to abide by the contents and terms of this agreement and further, consent to participate in evaluation or treatment. I understand that I may withdraw from treatment at any time.

Complaints:
You have a right to have your complaints heard and resolved in a timely manner. If you have a complaint about your treatment, your physician, or any office policy please inform us immediately and discuss the situation. If you do not feel the complaint has been resolved, you may also inform your insurance carrier and file a complaint if you so choose. And finally, you have the right to file a complaint with the state licensing board "The State of Ohio Counselor and Social Worker Board."

Rights and Responsibilities:
I also acknowledge I have received and read a copy of my patient rights and responsibilities.

Name of Patient (Please Print): ____

Signature: ____

Date: ________________________