Apex Psychiatric Services, LLC

A Place of Hope and Healing…

...Thrive—Don't Just Survive!

Intake Form

PLEASE PRINT CLEARLY Today's Date _____

PERSONAL INFORMATION

Client _____ **RESPONSIBLE PARTY** _____

Date of Birth _____ Gender _____ Responsible Party's SSN _____

Address _____ Address (if different) _____

_____ _____

City, State _____ Zip _____ City, State _____ Zip _____

Home Phone _____ Home Phone (if different) _____

Work Phone _____ Work Phone (if different) _____

Cell Phone _____ Cell Phone (if different) _____

Please indicate with an * which phone numbers we may NOT leave a message.

Clients' relationship to Responsible Party (check one): Self_____ Spouse_____ Child_____ Other _____

Relative or friend in case of emergency _____

Name Phone # Relationship

Source of referral _____ Reason for referral _____

How did you hear about Apex Psychiatric Services? _____

FINANCIAL

I understand that Apex Psychiatric Services, LLC **does not** accept insurance. I will be given a receipt/superbill that I may submit to my insurance for possible reimbursement. *Subject to the terms of your insurance plan* Apex Psychiatric Services, LLC is not responsible for any fees that your insurance does not reimburse to you. As well, I understand that if I cancel less than 48 hours before or do not show up for an appointment, I will be billed the entire amount of the session. I have been given the opportunity to ask questions regarding this statement.

_____ _____ _____

Signature of Responsible Party Printed Name Date

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PERSONAL MEDICAL AND PSYCHIATRIC HISTORY

Please mark any condition below that applies to your personal medical history and briefly explain in the space provided		
Diabetes	Hypertension	High Cholesterol
Migraines	Chronic Pain	GERD
Fibromyalgia	IBS/UC/Chron's	Thyroid Disease
Heart Disease	Head Injury/TBI	Cancer
Seizures	Sleep Apnea	Stroke
Alzheimer's	Parkinson's	Alcoholism/Drug Abuse
Anxiety	Depression	ADHD
Bipolar Disorder	Schizophrenia	OCD
Other:	Other:	Other:

Have you had any recent changes in any of the following areas?		
Weight	Energy Level	Ability to Sleep
Please list all of your prescribing physicians and their specialty: _____ _____		
Please list your most recent blood work tests and results: _____ _____		

Please list the dates of any Psychiatric Hospitalizations, name of the hospital, and reason for admission below.		

Please list the problems or concerns you'd like to discuss with your provider below.

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Have you ever been treated for emotional difficulties before (When and Where?) _____

_____

Physician: Name/Practice _____ Address_____ Phone _____

Date of last physical exam _____ Height _____ Weight _____

How is your general health now? _____

Have you had any serious illnesses? (List)_____

Have you ever had any surgeries? (List)_____

Are you presently being treated for any physical condition not already listed? _____

CURRENT MEDICATIONS

List ALL the medications currently prescribed to you by any doctor. Please include vitamins and herbal supplements

Medication Name *Example: Prozac*	**Dosage** *Example: 20 mg*	**Times Taken Per Day** *Example: 2 times a day*

PAST PSYCHIATRIC MEDICATIONS

Please list all past psychiatric medication taken, dosage, length of time you took the medication and why you stopped taking it.

Medication Name *Example: Prozac*	**Dosage** *Example: 20 mg*	**Length of Time Taken** *Example: 3 months*	**Why You Stopped Taking** *Example: It made me too drowsy*

ALLERGIES

Please list any medication allergies below or check the space below if you have no known allergies.

_____I Have no known drug allergies

Medication	Reaction

FAMILY PSYCHIATRIC HISTORY

Place a check to indicate any family members that have had or have any conditions below	Father	Mother	Son	Daughters	Brothers	Sisters	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles
Depression												
Anxiety												
Bipolar Disorder												
Schizophrenia												
ADHD												
OCD												

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FAMILY MEDICAL HISTORY

Place a check to indicate any family members that have had or have any conditions below	Father	Mother	Son	Daughters	Brothers	Sisters	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Aunts	Uncles
Diabetes												
High Blood Pressure												
Stroke												
Thyroid Disease												
Seizures												
Inherited Genetic Disease												
Cardiac Diseases (I.e. arrythmias, heart attacks before age 40, cardiac defects at birth)												
Kidney Disease												
Cancer												
Alcoholism/Drug Abuse												
Other:												

Please complete the information below for each family member notated above.

Living or Deceased (L/D)												
If deceased, age of death												

SOCIAL HISTORY

Current Employment:	Highest Level of Education Completed:

If any, please describe your military background.

Living Situation: With Spouse/Partner With Parents With Children # of children_____ Other:_____

Exercise Habits (Describe the type and amount of exercise you do regularly and how often).

Caffeine Intake (Indicate the number of caffeine drinks per day)

Coffee:_____ Tea:_____ Soda:_____ Energy Drinks:_____ Other:_____

Are you currently sexually active?	If yes, are you trying for pregnancy?
Do you use alcohol?	If yes, please indicate type and mount consumed per week.
Do you use tobacco?	If yes, please indicate type and mount used per week.

Do you, or have ever taken drugs, legal or illegal, other than over-the-counter medications that were not prescribed for you?
If yes, please list and describe.

Please use this space to provide any additional information for your clinician to review regarding your medications, medical history, or concerns you'd like to address.

Privacy Practices Form – CLIENT COPY – KEEP THIS FORM FOR YOUR RECORDS

You, or a member of your family, are about to become involved in psychiatric services which might include medication management, counseling or psychotherapy with a trained and licensed APRN or therapist. We wish to take this opportunity to welcome you and also to state some basic principles we believe essential in establishing a good therapeutic relationship between us. Please read through this information, asking questions as needed.

1) INITIAL INTERVIEW: Your first visit is considered a diagnostic or evaluation interview. At the time of this appointment, the following decisions will be made with you:
   a) Therapy Evaluation:
      i) Type of therapy needed (individual, group, medication referral, etc.)
      ii) Frequency of therapy sessions (weekly, biweekly, etc.)
      iii) Goals of therapy (what you hope to gain from this process.)

   b) Medication Management Evaluation
      i) Are medications appropriate to treat my condition
      ii) What medications options are available to treat my symptoms
      iii) Risk vs benefits of pharmacological intervention
      iv) Potential Side Effects

2) FOLLOW-UP APPOINTMENTS: Each medication management appointment is approximately 20 minutes long and therapy appointments are approximately 45-60 minutes. At the end of each appointment you can discuss future appointments with your clinician.

3) PAYMENTS: Payment for initial evaluations is due at the time of scheduling and subject to the cancellation policy. Payment is due in full at the time of service prior to seeing the clinician. Services will not be rendered unless payment is received. Charges for other services (i.e., involvement in client litigation, document preparation, etc.) may be levied. These fees will be negotiated individually with your therapist and are subject to change. We accept cash, debit, and credit card

4) CANCELLATIONS: If you find that you need to cancel an appointment, please give as much notice as possible so that we can schedule people that are on our waiting list. The initial evaluation fee is non-refundable if client no-shows. Failure to cancel 48 hrs prior to or not showing for a Medication Management or Therapy Follow-up appointment will result in a No-Show Fee equal to the full amount of the appointment. The fee must be paid before any new appointments will be scheduled.

5) INSURANCE: Insurance is an agreement between you and your insurance company as to how our services will be paid for. We will assist you in any way possible by providing receipts and documentation. We currently do not directly participate with insurance plans. However, we will assist you in contacting your insurance, giving you receipts to submit, and follow up contacts. Many insurance companies will pay for a portion or all of the outpatient mental health services received. You should check with your insurance company representative to find out specific requirements and limitations of this coverage. We will be happy to assist you in the preparation of insurance forms if you feel there is a chance your insurance company will pay for these services. Rates may apply. Payments for services received through Apex Psychiatric Services, LLC are ultimately your responsibility. If your insurance company requires that outpatient mental health services be preauthorized, it is your responsibility to initiate the preauthorization process, i.e. contacting your primary care physician, insurance company, or a third party "gate keeper". Failure to obtain required preauthorization for outpatient mental health services will result in you being held 100% responsible for all charges.

6) CONFIDENTIALITY: All information regarding the specific nature of your services received is maintained at Apex Psychiatric Services, LLC and is considered confidential within the office unless specified by you in writing. However, each clinician at this office reserves the right to use specialty consultation with other clinicians at the office as deemed necessary. We follow HIPAA and maintain confidentiality. We are bound to report suspected abuse/neglect towards a child or vulnerable adult, intended harm to self/others, or follow a court-issued subpoena.

By signing I agree to the following:

- I acknowledge that I have read and understand all of the foregoing statements and that my signature below indicates that I agree to abide by all of the above conditions and I consent to treatment.
- I have received a copy of the Privacy Practices Form.
- I consent to the exchange of treatment information between Apex Psychiatric Services, LLC and my primary care physician.
- I consent to the exchange of treatment information between Apex Psychiatric Services, LLC and my insurance company for the purpose of facilitating my service fee reimbursement. *If you choose to not disclose any information to your insurance for enhanced privacy, you can always change your mind later.*