Exceeding your wellness expectations

INTAKE FORM – ADULT

Name: ____

Date of Birth: ______________ Sex: _____ Marital status:__________________________

Address:____

City, State, ZIP Code:____

Home phone: _________________________ Cell phone:__________________________

Work phone: ____________________ Email: ___________________________________

(Mark * next to the best number where we can reach you)

Employed By: ________________________ Occupation: __________________________

Business Address: ____

City, State, ZIP Code : ____

Emergency Contact Person (Name/Phone Number):

____

Insurance Company: ____________________________ ID#:________________________

Primary Care Doctor (Name/Practice): ____

Phone Number: _______________________ Fax Number: ___________________________

Would you like a letter sent to your primary care physician regarding today's visit: Yes / No

Referred by: _______________________________ May I thank them: Yes / No

Signature: ____ **Date**: _________________

PAST MEDICAL HISTORY

PAST MEDICATIONS	CURRENT MEDICATIONS
HOSPITALIZATIONS/SURGERIES	
DATE	REASON
MAJOR MEDICAL CONDITIONS (i.e. diabetes, hypertension, head traumas, cardiac problems, asthma, or other breathing problems, cancer, etc.)	
CONDITION	LENGTH OF TIME
PAST PSYCHIATRIC HISTORY (i.e. mental health and chemical dependency)	

FAMILY MENTAL HEALTH & CHEMICAL DEPENDENCY HISTORY

ALLERGIES: ____

SUBTANCE ABUSE HISTORY (COMPLETE FOR ALL PATIENTS 12 AND OVER)				
SUBSTANCE	**AMOUNT**	**DURATION**	**FIRST USE**	**LAST USE**
CAFFEINE				
TABACCO				
ALCOHOL				
MARIJUANA				
OPIOIDS/ NARCOTICS				
AMPHETAMINES				
COCAINE				
HALLUCINOGEN S				
OTHERS				

Exceeding your wellness expectations

AUTHORIZATION FOR RELEASE OF INFORMATION

____

Print Name of Client **Date of Birth**

If client is a minor:

____

Print Name of Parent/Guardian **Date of Birth**

I hereby authorize **Achieve Concierge Center**, to exchange information with:

Name of Agency/Person/Organization: ___________________________________

Address:____

City, State, ZIP Code: ____

Phone No: _______________________ **Fax No:** _________________________

With the knowledge that such contact discloses the fact that mental health services have been/are being provided.

This disclosure of information is required for the following purpose(s):
☐ Evaluation ☐ Treatment Planning/Course ☐ Other_______________________________

And will consist of the following types of information:

☐ Entire Record □ Medication History ☐ Results of Psychological Testing

☐ Discharge Summary ☐ Educational Information

☐ Legal Information ☐ Other ______________________________

☐ Dates / Results of Medical Assessments & Diagnoses

The information and records released pursuant to this consent will not be used for any other purpose.

This consent becomes effective immediately. This consent may be revoked by the undersigned at any time. If not revoked, it shall terminate at the end of treatment with **Achieve Concierge Center** I understand that I may receive a copy of this authorization. There is a risk that the person receiving information or documents pursuant to this authorization may re-disclose the information and documents in a manner that will no longer provide protection for the information and documents.

____**Date**: _______________________

Signature of Client

____**Date**: __________________

Signature of Parent, Guardian or Conservator

All requests for release of information must be in writing. If there are any parties to which you do not want to release this information. Please complete a Request for Special Privacy Protection (HF 04a).

CONSENT FOR TREATMENT

I hereby authorize and request **Achieve Concierge Center,** to carry out psychiatric and psychological examination, evaluation, treatment and/or diagnostic procedures which now, or during the course of my treatment, become advisable. I understand the purpose of these procedures will be explained to me upon my request and that these are subject to my agreement. I fully understand that while the course of my treatment is designed to be helpful, **Achieve Concierge Center,** can make no guarantees whatsoever about the outcome of my treatment. I also understand that the psychopharmacotherapeutic process can initiate and bring up uncomfortable feelings and reactions including, but not limited to anxiety, sadness, anger and physical side effects. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be jointly worked on between my therapist and me.

____

Patient/Guardian Signature **Date**

GENERAL CONSENT TO TREATMENT IN CASE OF DEPENDENT

I am the legal guardian and/or representative of the patient and on the patient's behalf legally authorize **Achieve Concierge Center** to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

____

Signature of Guardian/Legal Representative **Date**

____

Relationship to Patient

HIPPA NOTICE OF PRIVACY PRACTICES

A federal law, known as the "HIPAA Privacy Rule" requires that we tell you how we may use and give out personal health information about you to others. This summary will tell you what out Privacy Notice contains.

HOW WE MAY USE AND SHARE YOUR PROTECTED HEALTH INFORMATION
We may use and share personal health information that is protected (PHI) to you or your personal representative.
We may use and share this information:

For healthcare treatment that doctors, nurses and other clinicians give you for certain business activities called "health care operations" and for payment.

Some examples of how we may use and share PHI about you without your written permission including sharing information:

- To report abuse, neglect, or domestic violence
- To prevent a serious threat to your other's health or safety
- To prevent public health problems
- To agencies that audit, investigate and inspect health programs for the public's health
- For lawsuits and other legal proceedings
- For research
- To the Government for specialized purposes, such as military or national security; and
- For worker's compensation.

YOUR RIGHTS
You have the following rights as described in our Notice:

- The right to ask us if we will put more limits on the way we use and share PHI about you
- The right to share confidential communications from us
- The right to see and get a copy of PHI about you
- The right to ask us for a report that describes how and with whom we share PHI about you.

If you have any questions regarding your rights or privacy, please inquire with our office or reference http://www.hhs.gov/ocr/privacy.

I hereby acknowledge that I have read a copy of this HIPAA Notice of Privacy Practices. I further acknowledge that I may obtain a copy if requested.

____

Patient Name

____

Signature of Patient or Responsible Party **Date**

Exceeding your wellness expectations

OFFICE POLICIES

Confidentiality:

Confidentiality is essential for effective psychiatric treatment. No information will be released without your consent, except for the following situations: By law, I am required to report suspected child or elder abuse, domestic violence, and take action when a patient is considered to be danger to themselves or other.

Payment Policy:

Scheduled appointment times are reserved specifically for you. Failure to provide 48 hours cancellation notice or missed appointments will be billed and your credit card will automatically be charged. A credit card will be held on file to guarantee payment but will not be charged without notification.

Medication Policy:

You are responsible to make an appointment to see me in person at least once every 2 months to receive refills of your medications

Requests for refills may take up to 48 hours to be available at your pharmacy and are not done on weekends or holidays.

Notify Achieve Concierge Center of any side effects of your medication.

Notify Achieve Concierge Center if you suspect or know that you are pregnant or if you plan to become pregnant in the near future.

Notify Achieve Concierge Center any time another physician starts you on a new medication, or if there are significant changes in your psychiatric or medical condition.

Additional Services:

Services required outside of treatment session will be charged a fee. These will include consultations with other professionals, court appearances, and document preparation such as completing legal forms, conservatorship petitions, letters, etc.

I have read, understand and agree to the above policies.

____

Patient Name

____

Signature of Patient or Responsible Party **Date**

PATIENT ARBITRATION AGREEMENT

The contract below is an arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather that a suit in court. I believe the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between healthcare providers and their patients have long been recognized and approved by the California courts. By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings. Of course, my goal is to provide medical care in such a way as to avoid any such disputes. I know that most problems begin with communication. Therefore, if you have any questions about your care, please ask me.

By signing this agreement, the patient agrees with the provider that any dispute between you and Achieve Concierge Center and any dispute relating to medical services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whomever made (including, to the full extent permitted by applicable law, third parties who are not signatories to this agreement) shall be resolved by binding arbitration. Any award of the arbitrator(s) may be entered as a judgment in any court having jurisdiction. In the event a court having jurisdiction finds any portion of this agreement unenforceable, that portion shall not be effective and the remainder of the agreement shall remain effective. This agreement shall be governed by and interpreted under the Federal Arbitration Act, 9 U.S.C. Sections 1-16.

This agreement binds all parties whose claims may arise out of or relate to treatment or service provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term “patient” herein shall mean both the mother and the mother’s expected child or children. This provision for arbitration may be revoked by written notice delivered to the physician within 30 days of signature.

If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services.   Patient/Responsible Party Initials: ________________

The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the physician, cannot be brought as a lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as described in this section.

____

Patient Name

____

Signature of Patient or Responsible Party **Date**