For Office Use Only

☐ Original Intake
☐ Updated Info. _____

Provider Name_____
Today's Date _____

Patient Information Form

(PLEASE PRINT LEGIBLY)

Patient Information

Last Name:_____ First:_____ Middle:_____

Birth Date: _____ Social Security #: _____ Gender: ❒ M ❒ F

Primary Phone: (___) ___ - ___ Cell Home Work Secondary Phone: (___) ___ - ___ Cell Home Work

E-mail Address:_____ ❒ Decline to give

Mailing Address:
Street: _____

City: _____ State: _____ Zip Code: _____

Primary Language: _____ Ethnicity: _____ ❒ Decline to give

Marital Status

❒ Single ❒ Married ❒ Separated ❒ Divorced ❒ Widowed ❒ Domestic Partner ❒ Other

Responsible Party

Name (if not 18): _____ Phone: (_____) _____ - _____

Address:_____ ❒Same as above

City: _____ State: _____ Zip Code: _____

Emergency Contact

Name: _____ Phone: (_____) _____ - _____

Address: Street: _____ ❒ Decline to give

City: _____ State: _____ Zip Code: _____

Primary Care Physician (PCP)

PCP Name:_____ ❒ Decline to give
PCP Address: _____
City: _____ State: _____ Zip Code: _____
Phone Number: (____) ____ - _____ Fax Number: (____) ____ - _____

Referral Source

❒ Healthcare Professional ❒ Family/Friend ❒ Flyer ❒ Book ❒ Internet Search ❒ Insurance
❒ Workshop ❒ Walk in ❒ Hospital _____ ❒ Other_____

****If you would like to release information to a provider or other individual, please ask for a Release of Information Form****

INSURANCE INFORMATION

Please fill out all information for insurance. If CPS cannot receive payment due to insufficient insurance information, the patient will be responsible for the amount in full. Remember, it is the patient's responsibility to verify their insurance benefits before their appointment.

Authorization and EAP Information

Does your insurance require a referral or pre-authorization PRIOR to your first visit? ❒ Yes ❒ No
EAP Company:_____ Employer: _____ Authorization #:_____
Number of Sessions Authorized: _____ Dates Authorized:_____
Claims Address: _____

Primary Insurance

Does the back of your card indicate a phone number to call for Mental Health (MHSA)? ❒ Yes ❒ No
Insurance Company: _____ Copay Amount: _____
Insurance Phone #: _____ Group #: _____ ID #: _____
Policy Holder Name: _____ Social Security #: _____
Relation to Patient: _____ Date of Birth: _____ Gender: ❒ M ❒ F
Address (if different from patient): _____
Effective Date:_____ Policy Holder Employed by: _____

Additional Insurance

Does the back of your card indicate a phone number to call for Mental Health (MHSA)? ❒ Yes ❒ No
Insurance Company: _____ Copay Amount: _____
Insurance Phone #: _____ Group #: _____ ID #: _____
Policy Holder Name: _____ Social Security #: _____
Relation to Patient: _____ Date of Birth: _____ Gender: ❒ M ❒ F
Address (if different from patient): _____
Effective Date:_____ Policy Holder Employed by: _____

Worker's Comp/Auto Accident

Insurance Name: _____ Claim #: _____
Claims Address: _____
City: _____ State: _____ Zip Code: _____
Adjuster Name: _____ Adjuster Phone #: _____
Date of Accident: _____ State Accident Occurred In: _____

Medicare Information

If insured with Medicare, how do you qualify? ❒ Retirement ❒ Long-term Disability ❒ ESRD
Do you currently have a spouse that is employed? ❒ Yes ❒ No
If you marked yes above, are there more than 20 employees at their place of work? ❒ Yes ❒ No

Signature of Responsible Party: _____ **Date:** _____

Please Print Name of Responsible Party: _____

Please Print Name of Patient: _____ **DOB:**_____

Professional Service Agreement

Acknowledgement

I understand that my clinician is an independent professional who operates a practice that is separate from Comprehensive Psychological Services; CPS provides billing and scheduling services for the clinician.

Insurance Benefits

I understand that it is my responsibility to check with my insurance company regarding my benefits before my appointment begins. I also understand that I need to inform CPS if authorization is needed to be seen for my initial visit or for follow-up appointments. If my insurance does not pay because I did not obtain authorization, I will be responsible for the amount in full.

Fees, Payment, and Insurance Billing

I agree to make my respective payment at the time of service. I agree to pay my copay, coinsurance, contracted rate for my insurance deductible, or the full fee if I am a self-pay client. If I do not make payment at the time of service, I understand that I may be denied service and receive a $60 late cancelation fee. My provider may refuse to provide services unless payment is made at the time of service.

I understand that appointments not kept or canceled 24 hours in advance will result in a charge of $60 and cannot be billed to my insurance. My provider may choose to terminate treatment temporarily or permanently based on my attendance. Additional fees may be billed for services such as written reports, completion of paperwork, and other professional services at the discretion of my provider when deemed necessary.

By listing my email on the Patient Information Form, I understand that I may receive email correspondence regarding my statement.

I understand that each provider, as an individual practitioner, sets his or her own rates for services. I understand that a list of service fees will be provided to me upon request.

Finance Charges

In the event that my account is not paid as agreed or is delinquent, I agree to pay a collection fee of 35% of my unpaid balance in addition to my balance. In the event that it is necessary to commence legal action to collect this bill, I agree to pay reasonable attorney's fees and court costs and to submit to the jurisdiction of Comprehensive Psychological Services, Inc. If any portion of this bill or the provider's services is disputed, I agree to submit myself to mediation or arbitration and in so doing will pay the associated costs.

Authorizations and Release of Information

I authorize the professional staff at Comprehensive Psychological Services to exchange information relevant to my care (written and/or verbal) with my Primary Care Physician, whom I may list on the Patient Information Form, and with any other provider from whom I receive services within CPS. I understand that if I fail to list my Primary Care Physician's information on the Patient Information form, continuity of care may not be complete.

I authorize the release of any medical, psychiatric, and/or substance abuse information necessary to process fees for service claims to my insurer. I authorize payment of insurance benefits to Comprehensive Psychological Services or any facility authorized by Comprehensive Psychological Services. By signing this form, I am requesting that Comprehensive Psychological Services open an account in my name. My insurance, employer, or other third party company may offset the expense I incur. If not, I accept the financial responsibility to settle whatever balance is generated when payment is not received following 90 days from the billing date.

I understand that my healthcare provider will keep all information about me confidential unless I give my written consent through a release of information or as otherwise stated in the CPS Privacy Practices and Consumer Rights Policy & Procedures. I understand that my health care provider is required by law to report clear and present danger to human life or any suspicion of child abuse. I also understand that it may be necessary to furnish information to a court of law if a subpoena is issued (in cases of child custody, accidents, divorce, or otherwise).

Consent for Treatment

I understand that, while most people benefit by participating in mental health services, there is no guarantee that my family members or I will be helped and in some cases symptoms may worsen.

In signing for services for a minor, I certify that I am the legal guardian and I have the legal right to approve of the evaluation, treatment, and release of information. As the legal guardian, I understand that I (or another guardian) must be present for services to be rendered with an underage child.

Privacy Practices & Consumer Rights

I acknowledge that I have access to a copy of CPS affiliates Privacy Practices and Consumer Rights Policy & Procedures upon request. I acknowledge that I have been offered information regarding privacy rights and HIPPA guidelines.

Emergencies

If you are in an emergency or crisis situation, please call 911 or visit your local emergency room. If you need to reach your clinician after hours, we have a live answering service available. Please call (801) 483-1600, option 9 and wait for a representative.

Program Rules

I understand that each clinician at CPS is an independent entity and may set forth his or her own rules and guidelines surrounding treatment and client conduct requirements.

I understand that I am not permitted to bring weapons of any kind onto CPS property at any time. I understand that I am not permitted to bring any animals onto CPS property, with the exception of a service animal.

I understand that clients at CPS are expected to maintain respectful and lawful conduct while on the premises and while communicating with CPS providers and staff either on the premises or over the phone. I understand that I may be asked to temporarily or permanently leave treatment if they do not maintain respectful and lawful conduct during treatment or while communicating with CPS providers and staff. This will be at the discretion of providers and administrative staff.

If my provider is asked to testify about me or my case then I am ultimately responsible for the financial bill for time spent by my provider, whether or not my provider is called to testify. Retainers for testimony need to be paid up front. My provider determines his or her own fee schedule for these services. It is important in retaining my confidentiality that I not have my provider subpoenaed to the extent that I am able.

Grievance Policy

If I wish to file an official grievance with CPS or any of its individual providers, I may contact the Office Manager and/or the CEO, whose contact information will be given to me upon request. Upon the initiation of this process, the matter will be brought before the CPS Quality Assurance Committee and a resolution will be decided upon. If CPS does not provide me with a satisfactory resolution, I may then file my grievance with the external agency of my choice.

Treatment and Services

I understand that CPS offers a variety of outpatient mental health treatment options, including but not limited to psychotherapy, psychiatric medication management, and psychological testing. I understand that a comprehensive list of services can be provided to me upon request. I understand that a treatment plan including services recommended for me by my provider may include a variety of different treatment options; I understand that if CPS does not offer mental health treatment options that I desire or that my provider recommends for me, a referral to an outside facility can be obtained upon request at the discretion of my provider.

I understand that I can expect the following from my treatment at CPS: outpatient mental health treatment as outlined in our list of services; confidentiality and secure records keeping; professionalism and competency from providers and office staff; scheduling support; referrals to outside sources if necessary and in keeping with my treatment plan. I understand that my information is confidential and may be withheld from third parties requesting my information if deemed necessary by my provider or administrative staff at CPS. I understand that CPS does not provide inpatient mental health services.

I understand that, because therapy and psychiatry services are typically ongoing, CPS does not implement a formal discharge plan as part of the treatment process. I understand that treatment may end voluntarily at any time; I also understand that treatment may end involuntarily at the sole discretion of my provider(s).

I understand that I can access prescription refill support from my CPS medication management provider and/or CPS office staff, given that I provide at least five business days' notice when requesting a prescription refill.

I understand that, because CPS provides outpatient services by appointment only, I should visit an emergency room if my provider is not available for an appointment and I feel that I need immediate assistance or medical advice; I understand that I can obtain advice regarding prescription drug interactions from my pharmacist if my provider is not available.

Maximum Sanctions and Consequences

Your CPS provider(s) and/or administrative staff reserve the right to refuse treatment and services to any person who does not comply with CPS program rules. Consequences for non-compliance with program rules may include dismissal from treatment and/or CPS property.

I, by virtue of my signature below, understand the risks and responsibilities noted above and agree to the inherent conditions implied or stated.

Signature of Responsible Party: _____ **Date:** _____

Please Print Name of Responsible Party: _____

Please Print Name of Patient: _____ **DOB:** _____

Medical History Form

Directions: Please answer the following questions to the best of your knowledge.

Patient Information			
Last Name	**First Name**	**MI**	**Birthdate**

Children: ☐ Yes ☐ No How many?	Number of persons living in your home?

Primary Therapist(s) or Physician(s)		
Name:	**Name:**	**Name:**
Address:	**Address:**	**Address:**
Phone:	**Phone:**	**Phone:**

Are you allergic to any medications? ☐ Yes ☐ No If yes, what medication (s)? _____
Are you allergic to any substances or foods? ☐ Yes ☐ No If yes, what substance (s)? _____

Family History

☐ Diabetes ☐ Mental Illness ☐ Epilepsy/Seizure ☐ Cancer ☐ Alzheimer's ☐ History Unknown

Any other neuropsychological or psychiatric conditions? _____

If you answered "Yes" to any of the above, please explain: _____

Are you currently being treated for any medical conditions? ☐ Yes ☐ No If yes, please list: _____

Medications (List more on separate page if necessary)

Current Medication	For what condition?	Dosage	Frequency	Date Started	Comments/Problems/Concerns

Past Medications/For what condition? (List sedatives, pain medications, sleeping pills, antidepressants, etc.)

Other

☐ Yes ☐ No	Do you smoke? If yes, how many cigarettes per day?
☐ Yes ☐ No	Do you use alcohol? If yes, how often, how much?
☐ Yes ☐ No	Do you or your partner(s) use drugs? If yes, how much, how often? Ever injected drugs? (explain)

REVIEW OF SYMPTOMS		
Check	**Symptom**	**Explain**
	Prolonged Mood Changes	
	Changes in Sleep	
	Changes in Appetite	
	Problems Concentrating	
	Death Wishes/Suicidal Ideations	
	Hopelessness/Helplessness	
	Lack of Enjoyment	
	Unworthiness	
	Sluggishness	
	Excessive Guilty Feelings	
	Anxiety	
	Irritability	
	Racing Thoughts	
	Hallucinations	
	Bizarre Ideations	
	Paranoia	
	Phobias(specify)	
	Eating Disorders	
	Repetitive Thoughts/Behaviors	
	Bodily Complaints	
	Changes of Libido (sex drive)	
	Sexual Problems	
Other Conditions/problems not listed:		

Pharmacy Information:		
Pharmacy Name:		
Pharmacy Phone:	Pharmacy Fax:	
Pharmacy Address:		
City:	State:	Zip:

I certify that I have answered these questions to the best of my knowledge.

Signature of Responsible Party: _____ **Date:** _____

Please Print Name of Responsible Party: _____

Please Print Name of Patient: _____ **DOB:** _____