Patient Information and Professional Services Agreement

Original Intake_____ Provider Name_____Today's Date:_____

Patient Last Name:_____First:_____Middle:_____

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

Primary Phone: (____)_____-_____ Secondary Phone: (____)_____-_____

E-mail Address:_____

Address: _____ Apt. #:_____

City: _____State: _____Zip Code: _____

Responsible Party if patient not 18: _____Phone: (____)_____-_____

Address:_____❒ Same as above

City: _____State: _____Zip Code: _____

Emergency Contact: _____Ph: (____)_____-_____

Address: _____Email:_____

City: _____State: _____Zip Code: _____

❒ Declined to give Emergency Contact Information

Insurance: Does your insurance require a "referral" or "pre-auth" PRIOR to first visit? ❒ 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:_____

Secondary Insurance: Do you have a second insurance that covers health care? ❒ Yes ❒ **N**o
Are your services to be paid by Worker's Comp or Auto Accident Insurance? ❒ Yes ❒ No
Are you using an EAP Employee Assistance Program to pay for services: ❒ Yes ❒ No
If YES to any of the above, request and complete additional insurance information form.

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
Acknowledgement. ***I understand that the clinician providing services to me is independent from CPS and that CPS provides billing and scheduling services for the professional.***

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Insurance Benefits. I understand that it is my responsibility to check with my insurance company regarding my benefits before receiving services and that I should advise CPS of any required authorization procedures.

Fees, Payment, and Insurance Billing. I agree to pay my copay, contracted rate, or the full fee if I am a self-pay client or if my insurance fails to pay. Appointments canceled less than **2 BUSINESS DAYS** in advance will result in a charge of **$60** which cannot be billed to insurance (Example: Monday appointments need to be cancelled on the previous Thursday). Additional fees may be billed for services such as written reports, completion of paperwork, etc. A Co-insurance payment is due on the day of service and a $10 billing fee will charged when this is not paid accordingly. ***Collections Fee.*** A collections fee of 35% of my unpaid balance will be added to the unpaid amount over due. Services may be denied, if payments are not received on the day of service.

Authorizations and Release of Information. Professional staff at CPS may exchange information relevant to my care. CPS professional staff may share information with your Primary Care Physician, and your health care insurers. I understand that my health care provider is required by law to report any threat 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. While most people benefit by participating in mental health services, in some cases symptoms or problems 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 under aged child.

Emergencies. Please call 911 or go to a local emergency room. CPS provides its services by appointment only. If you need to reach your clinician after hours, please call (801) 483-1600, option 9 and wait for a representative. Prescription medication interaction and side effects information is available through your pharmacy.
Program Rules and Grievances . I understand that weapons or pets unless certified as support animals and vested are not allowed in the CPS facility. ***Grievance Policy. To file a grievance*** contact the CPS staff representative and/or the CEO. Then the matter will be reviewed and you will be notified of CPS' resolution.

Treatment and Services. I understand that CPS offers a variety of outpatient mental health services, including but not limited to psychotherapy, psychiatric medication management, and psychological testing. I understand that I can expect outpatient mental health services 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; and prescription refill support if CPS is given 5 days advance notice.

Telehealth Consent. I agree to participate in telehealth appointments when necessary. Tele health can include text, emails, phone calls and secure video calls. I understand that telehealth may (although unlikely) compromise privacy.

I have been given information regarding behavioral health diagnosis and treatment and best practices as described by the American Psychiatric Association section on Patients and Families; information regarding local support groups, information about CPS privacy policies and client rights, and this Patient Services Agreement.

I understand that the services provided are ongoing and scheduled on an as needed basis. CPS does not document a formal discharge unless requested or required by an agency. Services may end voluntarily and resume at any time.

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

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

Please Print Name of Responsible Party: _____

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

Patient Health Information

Patient: _____ DOB:_____ Provider: _____ Date of Service: _____

Person completing this form: _____

Main reasons and problems for which you are now seeking services? _____

_____

Please list diagnoses that you were previously given and the treatment that you received: _____

_____

Primary Care Physician (PCP) name: _____

PCP Address: _____

City: _____State: _____Zip Code: _____

Phone Number: _____Fax Number: _____Email: _____

Who referred you to us? _____

Do we have your permission to communicate with your primary care physician? ___ Yes ___No

Name of your Pharmacy: _____Phone: _____

1. Please indicate below the medical conditions that you have had:
   - ❒ None
   - ❒ Arthritis
   - ❒ Bronchial Asthma
   - ❒ Cerebrovascular Accident
   - ❒ Coronary Artery Disease
   - ❒ Diabetes
   - ❒ Acid Reflux or other stomach problems
   - ❒ Head Trauma
   - ❒ Hepatic Disease
   - ❒ HIV/AIDS
   - ❒ Hypertension
   - ❒ Heart Condition or Heart Attack
   - ❒ Migraines
   - ❒ Kidney Disease
   - ❒ Seizures
   - ❒ Chronic Pain/Injuries
   - ❒ Crones Disease
   - ❒ Multiple Sclerosis

   ❒ Other: _____
   ❒ Note: _____

2. Past Surgeries Relevant to the Current Services that you are seeking?
   ❒ None
   ❒ Details of relevant surgeries: _____
   _____

3. Mark below, the behavioral health conditions that your close biological family members have been diagnosed or have been suspected of having?
   - ❒ ADHD
   - ❒ Addictions
   - ❒ Alzheimer's
   - ❒ Anxiety
   - ❒ Bipolar
   - ❒ Depression
   - ❒ Eating Disorders
   - ❒ OCD
   - ❒ Positive in biological relatives
   - ❒ Schizophrenia
   - ❒ Other: _____

4. What medications and dosages are you currently taking for behavioral health reasons (i.e. anxiety; depression; bipolar disorder): _____

_____

5. What medications and dosages are you taking for physical health reasons? _____

_____

6. Which medications have you or your family members taken for similar conditions for which you are seeking services and have they been effective? _____

_____

7. Are you allergic to any medications, substances or foods? Which? _____

_____

8. Do you use tobacco or alcohol or drugs that are not prescribed? What and how often? _____

_____

9. Marital Status:
   - ❒ Married
   - ❒ Divorced
   - ❒ Separated
   - ❒ Single
   - ❒ Widowed
   - ❒ Domestic Partner

10. Children:
    - ❒ The Patient is a child
    - ❒ None
    - ❒ Names/Ages: _____

11. Developmental Symptoms:
    - ❒ None
    - ❒ Participated in special programs at school
    - ❒ Learning Disorder
    - ❒ Tics
    - ❒ Developmental Disorder
    - ❒ Mental Retardation
    - ❒ Note: _____

12. Developmental History: Did you have problems in health or development during birth, infancy, childhood?
    - ❒ Normal, Unremarkable
    - ❒ Not Relevant
    - ❒ Relevant
    - ❒ Note: _____

13. Please indicate your current Social Support:
    - ❒ Family/Friends local
    - ❒ Family out of area are/involved
    - ❒ Minimal Family/Friends contact
    - ❒ Note: _____

14. Please note a little about your family, employment, education, religion, etc. or life events (deaths, births, divorce, job loss, etc.) which you have experienced that you believe are important for your provider to know: _____

_____

15. Please list what you believe are your Strengths/Abilities:
    - ❒ Average or above intelligence
    - ❒ Capable of independent living
    - ❒ Communication skills
    - ❒ Supportive family and/or friends
    - ❒ Work skills
    - ❒ Financial means
    - ❒ Religious affiliation
    - ❒ Special hobby/interest
    - ❒ Motivation for treatment/growth
    - ❒ Active sense of humor
    - ❒ Ability for insight

16. Please list your Weaknesses/Challenges which may hinder your progress:

- ❒ Loss (deaths; break-ups; other)
- ❒ Legal issues
- ❒ Marital or family conflict
- ❒ Financial difficulties
- ❒ Traumatic event
- ❒ Educational concerns
- ❒ Substance abuse
- ❒ Medication change or non-compliance
- ❒ Occupational concerns
- ❒ Health problems

Survey of Mental Illness Symptoms Related to Diagnostic Categories.

Please Mark your current symptoms with a checkmark.

17. Depression Symptoms:

- ❒ None
- ❒ Depressed Mood
- ❒ Appetite Disturbance
- ❒ Insomnia (can't sleep)
- ❒ Hypersomnia (sleeps too much)
- ❒ Fatigue
- ❒ Decreased Concentration
- ❒ Loss of Interest in Usual Activities
- ❒ Significant Weight Loss or Gain
- ❒ Restlessness/ Psychomotor
- ❒ Agitation
- ❒ Sluggishness
- ❒ Feelings of Worthlessness or Guilt
- ❒ Thoughts of Death or Suicidal Ideation (*Complete Risk Assessment*)
- ❒ Irritability
- ❒ Note: _____

18. Suicide Risk Assessment:

- ❒ None
- ❒ I have attempted suicide in the past
- ❒ I do not have suicidal thoughts
- ❒ I have suicidal thoughts, but would not act on them and have no plan.
- ❒ I have suicidal thoughts and think about ways I would kill myself, I often have intent
- ❒ I agree to contact a Crisis Line, relatives or 911, if my suicidal intent activates.
- ❒ Note: _____

19. Mania Symptoms:

- ❒ None
- ❒ Elevated, expansive, or irritable mood
- ❒ Talkative or pressure to keep talking
- ❒ Distractibility
- ❒ Can't stop an activity or my agitation
- ❒ Can't stop thinking about grand plans
- ❒ Racing thoughts
- ❒ Excessive involvement-pleasurable activities
- ❒ Become unaware of my behavior and circumstances

20. Anxiety Symptoms:

- ❒ None
- ❒ Worry about the same things again and again/ruminations
- ❒ Rapid heartbeat, sweats, shakes, or chest pains
- ❒ Shortness of breath, nausea, dizziness, derealization
- ❒ Fear of dying or losing control, depersonalization
- ❒ Anxiety about being in a place where exiting is difficult
- ❒ Avoidance of such places
- ❒ Fear of animals, nature, blood, injections

21. Obsessive Compulsive Symptoms:

- ❒ None
- ❒ Recurrent and persistent thoughts; urges
- ❒ Major effort to suppress thoughts and urges
- ❒ Repetitive behaviors: handwashing, counting, etc.
- ❒ Above patterns engaged in to reduce distress

22. Conduct Disorder Symptoms:

- ❒ None
- ❒ Aggression to people or animals
- ❒ Deceitfulness; Theft
- ❒ Destruction of property in fine setting
- ❒ Serious Violations of rules (Truant, Running)

23. Trauma/PTSD Symptoms:

- ❒ None
- ❒ Avoids events that remind of trauma, unable to recall event, detachment
- ❒ Deja-vu
- ❒ Distressing recollections or dreams
- ❒ Distress/fear related to an event
- ❒ Repeated thoughts about traumatic event
- ❒ Trouble with sleep, irritable, hypervigilance
- ❒ Experienced traumatic event(s)
- ❒ Repeat exposure to traumatic events, learned about trauma with loved ones
- ❒ Re-exposure trauma or intrusion symptoms: dreams, nightmares, flashbacks
- ❒ Avoidance: Efforts to avoid thoughts, feelings or events
- ❒ Hyperarousal: Aggressive behavior, irritability, reckless behavior
- ❒ Negative distortions in cognitions, thoughts, moods, or feelings
- ❒ Dissociative symptoms: Amnesia/memory gaps, derealization, depersonalization

24. Schizo-Affective Symptoms:

- ❒ None
- ❒ See things that others don't
- ❒ Hear things that others don't
- ❒ Delusions
- ❒ Grandiose Ideas that others think impossible
- ❒ Persecutory: Feel like people or agencies are out to do me wrong
- ❒ Disorganized speech
- ❒ Isolated, no friends.
- ❒ Loss of ability to speak/ mutism
- ❒ With postpartum onset

❒ Note: _____

25. Cognition Symptoms:

- ❒ None
- ❒ Impaired Thinking and Planning
- ❒ Disturbance of sight or balance or perception
- ❒ Disturbance fluctuates or develops over short period of time
- ❒ Memory Impairment
- ❒ Aphasia: Can't comprehend or find words or phrases to speak
- ❒ Can't coordinate my physical body movements
- ❒ Disturbance in ability to plan and organize

❒ Note: _____

26. Substance Abuse Symptoms and/or Concerns:

- ❒ None
- ❒ Substance abuse or alcohol abuse/addictions are a concern

❒ Note: _____

27. ADHD Symptoms:

- ❒ None
- ❒ Planning problems
- ❒ Hyperactivity
- ❒ Poor concentration
- ❒ Follow through problems
- ❒ Distractibility

❒ Eating Disorder Symptoms: _____

❒ Conduct/Behavior Symptoms: _____

28. Please write about what you believe to be important regarding your symptoms: _____

_____

_____

29. If you would like to release information about your care to another agency, professional or person please complete a specific RELEASE OF INFORMATION FORM. Request this form.

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