NEW PATIENT INTAKE DOCUMENTATION - Outpatient

CLIENT INFORMATION

Client Name: _____ Client SSN: _____

Client Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: _____ Alternate Phone: _____

Email Address: _____

DOB: _____ Age: _____ Sex at Birth: _____ Current Gender: _____

Race: _____ Marital Status: _____

Preferred Language: _____Any Special Communication Needs?: _____

Any Mobility Concerns?: _____

Legal Representative (POA, Conservator, Guardian): _____

INSURANCE INFORMATION

Name of Insurance: _____ Insured Name (Policyholder): _____
Policy Number: _____ Group Number: _____
Insured DOB: _____ Relationship to Client: _____
Insured SSN: _____ Insured Employer: _____

Is there a secondary policy? ☐ Yes ☐ No
Secondary Insurance: _____ Insured Name (Policyholder):_____
Policy Number: _____ Group Number: _____
Insured DOB: _____ Relationship to Client: _____
Insured SSN: _____ Secondary Insured Employer: _____

PHARMACY INFORMATION

Pharmacy Name: _____

Pharmacy Address: _____

Pharmacy Phone Number: _____

FINANCIALLY RESPONSIBLE PARTY INFORMATION

Guarantor Name: _____ Guarantor SSN: _____
Guarantor Address: _____ Preferred Phone: _____

I, _____, consent to be treated at Blues & Soul Psychiatry.

I, _____, certify that all of the above information is accurate and up-to-date. In the event that any of this information changes, I will notify the Blues & Soul Psychiatry and update my information.

PAYMENT/INSURANCE AUTHORIZATION-AUTHORIZATION TO SEND REIMBURSEMENT INFORMATION

I accept responsibility for payment of charges for services rendered to the above named patient. I understand that full payment and/or my co-payment and/or deductibles are expected at the time services are rendered unless the doctor agrees otherwise. I understand that unless the named patient has coverage under a managed healthcare plan (i.e. HMO, PPO, EAP) to which I subscribe and in which the doctor is a participating provider, I am personally responsible for the payment of all charges. I understand that as a courtesy they will have my insurance claims filed but that it does not release me of responsibility for payment of these charges. Payment for any charges denied or not covered by my insurance company becomes my responsibility and I agree to pay these charges. I understand that any court order I have is an agreement between the courts and I – not the doctor and I am still responsible for all payments. I also understand that I may be charged for and required to pay for missed appointments not canceled at least 24 hours in advance. I further understand and agree that a collection agency and/or courts may be used in the event of delinquent payments and that I realize that such action could require the doctor release to the collection parties involved information which identifies me, diagnosis, dates, services rendered and charges as well as any other information needed on the claim filed. In addition, if I have requested the doctor have my charges filed with my insurance company, I understand that securing benefits under health insurance or other health plans will require that the doctor provide plan management with confidential patient information including diagnosis, service dates and type of services rendered. Further, I understand that for utilization review, quality assurance and other claim review purposes, it may require the doctor to provide my confidential information. I fully and freely consent to the release of any and all such patient information as is necessary for the processing and review of health claims made by or on behalf of the named patient. This consent shall remain in effect unless all claims have been fully processed and all review procedures completed.

_____ _____
Client Signature Date Parent/Legal Guardian Signature Date

FINANCIAL RESPONSIBILITY AGREEMENT

By signing below, you are certifying that you have read and understand the Financial Responsibility Agreement as a patient at Blues & Soul Psychiatry.

_____ _____
Client Signature Date Parent/Legal Guardian Signature Date

Staff Signature: _____ Date: _____

COORDINATION OF CARE AND RELEASE OF INFORMATION FORM

Client Name: _____ DOB: ____/____/_____

I, the undersigned client, hereby authorize Blues & Soul Psychiatry to release and/or obtain information with respect to any physical, psychiatric, or substance abuse related condition obtained during the course of diagnosis and treatment of the following:

Emergency Contact: (client must list at least one emergency contact): **Client's Initials**
Name: _____ Relationship: _____
Phone Number(s): _____ _____
▢ *Please check if you would allow this individual to have access to medical records.*

Additional Family/Support Person (if applicable): **Client's Initials**
Name: _____ Relationship: _____
Phone Number(s): _____ _____

PCP: Name: _____ **Client's Initials**
Address: _____
Phone Number(s): _____ _____

Outpatient Psychiatrist: Name: _____ **Client's Initials**
Address: _____
Phone Number(s): _____ _____

Outpatient Therapist: Name: _____ **Client's Initials**
Address: _____
Phone Number(s): _____ _____

School/Employer: Name: _____ **Client's Initials**
Address: _____
Phone Number(s): _____ _____

Health Insurance Company: Name: _____ **Client's Initials**
Address: _____
Phone Number(s): _____ _____

Legal Representative (**POA, Conservator, Guardianship**): Name: _____ **Client's Initials**
Address: _____

Phone Number(s):_____ _____

I understand that the purpose of this form is to exchange information pertinent to my treatment. The above consents are subject to revocation or change at any time except to the extent that Blues & Soul Psychiatry has acted in reliance thereon. This information which is being disclosed is confidential and is protected by Federal Law.

_____ _____

Client Signature Date Parent/Legal Guardian Signature Date

Staff Signature: _____ Date: _____

PERSONAL HISTORY

Were there problems with your birth? ☐Yes☐ No
Where were you born & raised? _____
What is your highest education? ☐High School ▢ Some College ▢ College Graduate ▢ Graduate Degree
Marital status: ▢ Never married ▢ Married ▢ Divorced ▢ Separated ▢ Widowed ▢Partnered/Sign. Other
What is your current or past occupation?_____
Are you currently working? : ▢ Yes ▢ No Hours/week_____
If not, are you: ▢ Retired ▢ Disabled ▢ Sick Leave?
Do you receive disability or SSI? ▢ Yes ▢ No
If yes, for what disability & how long?_____
Have you ever had legal problems? (specify)_____

FAMILY HISTORY

	Age(s)	Health & Psychiatric	Age(s) at Death	Cause of Death
Father				
Mother				
Siblings #:				
Children #:				

EXTENDED FAMILY PSYCHIATRIC PROBLEMS - PAST & PRESENT:

Maternal Relatives:_____

_____

Paternal Relatives:_____

_____

PSYCHIATRIC HISTORY

Describe briefly your present symptoms:

Please list the dates and names of other practitioners you have seen for this problem:

List hospitalizations, IOP, PHP:

Have you had psychotherapy? ☐ Yes ☐ No

Do you have a history of being abused emotionally, sexually, physically or by neglect? ☐ Yes ☐ No
If yes, please describe:

CURRENT PSYCHIATRIC MEDICATIONS

Drug allergies: ☐ Yes ☐ No If yes, please list:_____

Name	Dose (include strength and number of pills per day)	Outcome

OTHER CURRENT MEDICATIONS *(Medical and etc.)*

PAST PSYCHIATRIC MEDICATIONS

PAST MEDICAL HISTORY

Do you have or have you ever had:

▢ Diabetes	▢ Heart murmur	▢ Crohn's disease
▢ High blood pressure	▢ Pneumonia	▢ Colitis
▢ High cholesterol	▢ Pulmonary embolism	▢ Anemia
▢ Hypothyroidism	▢ Asthma	▢ Jaundice
▢ Goiter	▢ Emphysema	▢Hepatitis
▢ Cancer (type) _____	▢ Stroke	▢ Stomach/peptic ulcer
▢ Leukemia	▢ Epilepsy (seizures)	▢ Rheumatic fever
▢ Psoriasis	▢ Cataracts	▢ Tuberculosis

▢ Angina	▢ Kidney disease	▢ HIV/AIDS
▢ Heart problems	▢ Kidney stones	

Other medical conditions (please list): _____

SUBSTANCE USE

Drug Category:	**Age when you first used this:**	**How many years did you use this?**	**Date you last used:**	**Do you currently use this?**
ALCOHOL				▢ Yes▢ No
CANNABIS: Marijuana, THC, Hash oil, CBD oil				▢ Yes▢ No
STIMULANTS: Cocaine, Crack, Meth				▢ Yes▢ No
BENZO:Valium,Librium, Klonopin, Xanax				▢ Yes▢ No
OPIOIDS: Percocet, Opium, Morphine, Demero				▢ Yes▢ No
HALLUCINOGENS: LSD, PCP, STP, MDA, DAT				▢ Yes▢ No
INHALANTS: Glue, gasoline, aerosols, paint				▢ Yes▢ No
OTHER: _____				▢ Yes▢ No

SYSTEMS REVIEW

In the past month, have you had any of the following problems?

GENERAL	NERVOUS SYSTEM	MUSCLES/JOINTS/BONES
▢ Recent weight gain; how much ____ ▢ Recent weight loss; how much ____ ▢ Fatigue	▢ Headaches ▢ Dizziness ▢ Fainting or loss of consciousness	▢ Numbness ▢ Joint pain ▢ Muscle weakness

▢ Weakness ▢ Fever ▢ Night Sweats	▢ Numbness or tingling ▢ Memory loss	▢ Joint swelling Where? _____ _____
EARS ▢ Ringing in ears ▢ Loss of hearing	EYES ▢ Pain ▢ Redness ▢ Loss of vision ▢ Double or blurred vision ▢ Dryness	SKIN ▢ Redness ▢ Rash ▢ Nodules/bumps ▢ Hair loss ▢ Color changes of hands or feet
THROAT ▢ Frequent sore throats ▢ Hoarseness ▢ Difficulty in swallowing ▢ Pain in jaw	BLOOD ▢ Anemia ▢ Clots	KIDNEY/URINE/BLADDER ▢ Frequent or painful urination ▢ Blood in urine
HEART AND LUNGS ▢ Chest pains ▢ Palpitations ▢ Shortness of breath ▢ Fainting ▢ Swollen legs or feet ▢ Cough	STOMACH AND INTESTINES ▢ Nausea ▢ Heartburn ▢ Stomach pain ▢ Vomiting ▢ Yellow jaundice ▢ Increasing constipation ▢ Persistent diarrhea ▢ Blood in stools ▢ Black stools	PSYCHIATRIC ▢ Depression ▢ Excessive worries ▢ Difficulty falling asleep ▢ Difficulty staying asleep ▢ Difficulties with sexual arousal ▢ Poor appetite ▢ Food cravings ▢ Frequent crying ▢ Sensitivity ▢ Thoughts of suicide/attempts ▢ Stress ▢ Irritability ▢ Poor concentration ▢ Racing thoughts ▢ Hallucinations ▢ Rapid speech ▢ Guilty thoughts ▢ Paranoia ▢ Mood swings ▢ Anxiety ▢ Risky behavior
WOMEN ONLY ▢ Abnormal Pap smear ▢ Irregular periods ▢ Bleeding between periods ▢ PMS	OTHER PROBLEMS ▢ _____ ▢ _____ ▢ _____ ▢ _____ ▢ _____ ▢ _____ ▢ _____ ▢ _____	

WOMEN'S REPRODUCTIVE HISTORY

Age of first period: _____
# of Pregnancies: _____
# of Miscarriages: _____
# of Abortions: _____
Have you reached menopause? ▢ Yes☐ No If yes, at what age? _____
Do you have regular periods? ▢ Yes☐ No

_____ _____
Client Signature Date Parent/Legal Guardian Signature Date

PATIENT ACKNOWLEDGMENTS

*****ALL INFORMATION REGARDING THE ACKNOWLEDGEMENTS BELOW IS LOCATED IN THE BSP NEW PATIENT INFORMATION BINDER.*****

CLIENT RIGHTS AND RESPONSIBILITIES

By signing below, you are certifying that you have read and understand your Rights and Responsibilities as a patient at Blues & Soul Psychiatry.

_____ _____
Client Signature Date Parent/Legal Guardian Signature Date

Staff Signature: _____ Date: _____

NOTICE OF HIPAA COMPLIANCE & YOUR HEALTH INFORMATION RIGHTS

By signing below, you are certifying that you have read and understand the Notice of HIPAA Compliance and Health Information Rights as a patient at Blues & Soul Psychiatry.

_____ _____
Client Signature Date Parent/Legal Guardian Signature Date

Staff Signature: _____ Date: _____

LIABILITY WAIVER

By signing this waiver, I release Blues & Soul Psychiatry from all liability for personal injuries (including death), property losses or damage while participating in treatment services at Blues & Soul Psychiatry.

The undersigned further agrees to follow all rules and regulations while participating in treatment at Blues & Soul Psychiatry.

_____ _____

Client Signature Date Parent/Legal Guardian Signature Date

Staff Signature: _____ Date: _____

ACKNOWLEDGEMENT OF CONFIDENTIALITY

By signing below, you are certifying that you have read and understand the Statement of Confidentiality as a patient at Blues & Soul Psychiatry.

_____ _____

Client Signature Date Parent/Legal Guardian Signature Date

Staff Signature: _____ Date: _____

CONSENT TO SUBSTANCE ABUSE SCREENING

To ensure program effectiveness, please be mindful that you may be asked to complete a drug screen or submit lab work to achieve optimal treatment success. This may be done on-site if it is a UDS and/or at an off-site laboratory.

_____ _____

Client Signature Date Parent/Legal Guardian Signature Date

Staff Signature: _____ Date: _____

CONTROLLED SUBSTANCE AGREEMENT

By signing below, you are certifying that you have read and understand the Controlled Substance Agreement as a patient at Blues & Soul Psychiatry.

_____ _____

Client Signature Date Parent/Legal Guardian Signature Date

Staff Signature: _____ Date: _____

VERIFICATION OF NOTICE OF PRIVACY POLICY

Blues & Soul Psychiatry's Client Notification of Privacy Rights, which provides a detailed description of the potential uses and disclosures of your Protected Health Information, as well as your rights on these matters is attached in this paperwork. Copies of these rights are made available upon request.

_____ _____

Client Signature Date Parent/Legal Guardian Signature Date

Staff Signature: _____ Date: _____

TELEPSYCHIATRY/TELEHEALTH DISCLOSURE AGREEMENT

In the event that you are unable to attend an appointment/program in-person, Blues & Soul Psychiatry providers/clinicians can utilize telepsychiatry/telehealth services via Zoom (a HIPAA compliant platform) on a case-by-case basis. By signing below, you are acknowledging you are in agreement with utilizing Zoom, if needed.

_____ _____

Client Signature Date Parent/Legal Guardian Signature Date

Staff Signature: _____ Date: _____

ACKNOWLEDGEMENT OF INFORMATION

Please initial next to applicable statements.

Consent to Treat/Medication Management

____I, client/guardian, consent to medication evaluation, prescription and monitoring as recommended by the provider.

____As a legal guardian, I understand the client will not be given any medication without my prior knowledge/consent.

Coordination of Care and Release of Information

____ I acknowledge information pertaining to my treatment at Blues & Soul Psychiatry will only be shared with those listed on the Release of Information.

Health Assessment Agreement

____ I agree to fulfill all medical requirements within the required time frame.

____ As legal guardian, I understand and will assure that the client will fulfill all medical requirements within the required time frame.

Treatment Guidelines

____I, client or legal guardian, take full responsibility for my/the client's actions while receiving services at Blues & Soul Psychiatry.
____I, client/guardian, acknowledge that in the event an urgent need or crisis arises, I will contact 988/911 for immediate assistance.

Advanced Directives

Indicate below whether you do, or do not, currently obtain an advanced directive. If you do have a current advanced directive, it is your responsibility to provide Blues & Soul Psychiatry with a copy. If you terminate or modify your advanced directive, it is your responsibility to notify BSP or provide an updated copy.

☐ Yes, I have an active advanced directive. ☐ No, I do not currently have an advanced directive.

Declaration of Mental Health Treatment (Stating someone can make decisions for you if you are not able)
https://www.tn.gov/content/dam/tn/mentalhealth/documents/Declaration_for_Mental_Health_Treatment-Form.pdf

____I have executed a Declaration of Mental Health Treatment.

____I have not executed a Declaration of Mental Health Treatment.

____I will review the information on the site provided above for more information about making a Declaration of Mental Health Treatment.

_____ _____
Client Signature Date Parent/Legal Guardian Signature Date

Staff Signature: _____ Date: _____

GRIEVANCE PROCEDURE

I, _____, have read the grievance procedure. I understand that I have the right to file a grievance and I understand how to file a grievance.

_____ _____

Client Signature Date Parent/Legal Guardian Signature Date

Staff Signature: _____ Date: _____

YOUR PROVIDER'S RESPONSIBILITIES

By signing below, you are certifying that you have read and understand the Provider's Responsibilities as a patient at Blues & Soul Psychiatry.

_____ _____

Client Signature Date Parent/Legal Guardian Signature Date

Staff Signature: _____ Date: _____

TREATMENT AWARENESS

By signing below, I certify that I have read the information regarding Blues & Soul Psychiatry treatment awareness policies and that I consent to be evaluated for treatment.

_____ _____

Client Signature Date Parent/Legal Guardian Signature Date

Staff Signature: _____ Date: _____

PRACTICE POLICIES

By signing below, I certify that I have read the information regarding Blues & Soul Psychiatry Practice Policies including, pre-licensed professionals, appointments/cancellations, attendance policy, appointment length, insurance/billing, co-pays/session fees, additional fees that could apply, telephone calls and emergencies, and electronic communication; and that I consent to be evaluated for treatment.

_____ _____

Client Signature Date Parent/Legal Guardian Signature Date

Staff Signature: _____ Date: _____