ADULT INTAKE FORM

General Information

First Name:________________Last Name:_______________Gender:____________

Date of Birth (mm/dd/yyyy):______________Social Security Number:_____________

Address:____

City:__________________State:______________________Zip Code:____________

Main Phone:________________________Other Phone:_______________________

Email Address:____

Emergency Contact

First Name:___________________________Last Name:______________________

Phone:____________________________Relationship:________________________

Do you authorize this person to discuss care or treatment with the clinic in case of an emergency? **YES** ☐ **NO** ☐

Insurance Information

Primary Insurance:________________________Policy Holder:_________________

Policy Holder's DOB (mm/dd/yyyy):_______________Relationship:______________

Policy Holder's Address:____

City:_________________________State:_______________Zip Code:____________

Policy Number:________________________Group Number:__________________

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Mental Health History

What are you seeking help for?

Have you ever received mental health diagnoses? If so, please list.

Have you ever engaged in self harm and/or experienced suicidal ideation? Please explain.

Please list any psychiatric medication you have taken or are currently taking:

Medication	Dates	Benefits/Side Effects

Medical History

Primary Care Physician:____

Please list any medical problems and/or serious procedures you have had:

Please list any medication you have taken or are currently taking for medical problems:

Medication	Dates	Benefits/Side Effects

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Please describe your use of alcohol, drugs and tobacco:

Please list any history of mental health issues, medical issues, and substance abuse among blood relatives:

Mother's Side **Father's Side**

Social History

Did you have any early developmental problems as a child? If so, please explain.

Were you/are you a victim of any form of emotional, physical and/or sexual abuse?

Have you ever been convicted of any crimes, served time and/or been on probation? Please explain.

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CONSENT TO TREATMENT

First Name:_____________________________Last Name:________________________

You are about to take an important step in your mental wellbeing. As your mental health provider, we will be entering into a protected relationship. Treatment might involve a multidimensional family approach. Due to this, consent is needed for all those participating in sessions.

We are treating you and we do our best to accurately diagnose you and design a comprehensive treatment plan that fits your goals and needs. This may include recommendations of certain types of therapy and/or medications. We will also work with your primary care physical to assure coordination of care. **_______(Initial)**

You are our client and you have confidentiality rights. Confidentiality does not apply under the following situations: reporting suspected child abuse and elder abuse, and anyone suspected in danger of harming themselves or someone else. Except in these situations, you have a right to confidentiality.

If we require or believe it is in your best interest to communicate with an outside source, we will request that you complete a release of information. To assure best therapeutic care, frequent appointments are recommended. Clients who have not been seen in 6 months will be considered inactive and will be required to complete a new evaluation. **_______(Initial)**

I,__________________________, do hereby seek and consent to take part in the treatment provided by Healing Minds, LLC. If I am attending group services, I also understand and consent that confidentiality still applies and that Healing Minds, LLC is not liable for group members breaking confidentiality. I understand that developing a treatment plan with my provider and regularly reviewing our work towards the treatment goals are in my best interest. I agree to play an active role in this process. I understand that no promises will be made to me regarding the results of my treatment or any other procedures provided by my mental health provider. **_______(Initial)**

At Healing Minds, LLC, we strive to provide consistency in your therapeutic care. However, there may be times when a change in therapist is necessary due to

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scheduling, availability, employment changes, or other clinic needs. Should a reassignment occur, we will notify you in advance and work closely with you to supporta smooth and thoughtful transition. ________**(Initial)**

INSURANCE AUTHORIZATION/RELEASE OF INFORMATION

First Name:________________________Last Name:_________________

I, the subscriber named below, authorize Healing Minds, LLC, to release any and all information pertaining to my treatment to any third party payer (such as my insurance company or a government agency) as needed to determine a claim for payment for such treatment and diagnosis.

Please note that insurance is considered a method of reimbursing the client for fees paid to the provider and is not a substitute for payment. Some companies pay fixed allowances for certain procedures, while others pay a percentage of the charge. I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance or third payer within a reasonable period of time, and not to exceed 90 days.

Client Name (please print):____

Client/Guardian Signature:________________________________Date:____________

Insurance Company:____

Healing MINDS
It's what we do

HIPAA NOTICE/PRIVACY PRACTICES

First Name:_____________________________Last Name:____________________

This notice describes how medical information about you may be used, disclosed and how you can get access to this information. **Please review this carefully.**

We understand the importance of privacy and are committed to maintaining the confidentiality of your information. We make a record of the medical care we provide and may receive such records from others. We use these records to provide or enable other health care providers to provide quality medical care, to obtain payment for services provided to you, and to enable us to meet our professional and legal obligations to operate this practice properly. We are required by law to maintain the privacy of protected health information, to provide individuals with notice of our legal duties and privacy practices with respect to protected health information, and to notify affected individuals following a breach of unsecured protected health information. This notice describes how we may use and disclose your medical information. It also describes your rights and our legal obligations with respect to your medical information. If you have any questions about this notice, please contact our office.

Client Name (please print):____

Client/Guardian Signature:____

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APPOINTMENT CANCELLATION AGREEMENT

First Name:______________________________Last Name:_____________________

We understand that things come up and you may need to miss your appointment. If you need to reschedule or cancel any appointments, Healing Minds requires **24 business hours notification (Monday through Friday, 8:00am to 5:00pm).** If you fail to cancel within the 24 hours prior to your appointment, a **$100 fee for the initial appointment will be charged to the card below or to the credit card on file, or a $75 fee for any follow-up appointments.** In addition, if you do not show for your appointment within 15 minutes of the start of the session, this fee will be charged. While our system reminds you of your appointment, it is your responsibility to call the office at 775-448-9760.

My signature acknowledges:

- In the case of a psychiatric emergency, I will call 911 or go to the nearest hospital
- I will adhere to the guidelines above
- I understand that Healing Minds will attempt to bill my insurance and that if my insurance does not pay for any reason, I am responsible for any remaining balance. This may include deductibles, copays, or out of pocket expenses.
- I authorize Healing Minds to charge all fees to the card kept on file if not paid within a timely manner
- If I have any questions regarding charges to my account, I will contact Leigh Miller for assistance at lmiller@healingminds.com
- I will not dispute any charges with my credit card company unless I have already attempted to rectify the situation directly with Healing Minds, LLC.

Signature:____________________________________Date:____________________

I authorize the following card and any card swiped into the system to be used for co-pays and fees for services provided to:

Client Name (please print):____

Card Number:____

Expiration Date:__________________________________ CVV:__________________

Signature:______________________________________Date:___________________

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