**PATIENT INTAKE FORM**

If you are seeking to become a new client, please complete this form and fax it to:

203-404-3072 or email to office@holisticmc.com

**Section I - PATIENT INFORMATION:**

|  |  |  |  |
| --- | --- | --- | --- |
| First Name: |  | Last Name: |  |

|  |  |
| --- | --- |
| Street Address: |  |

|  |  |
| --- | --- |
| City, State, Zip: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Home Phone: |  | Cell Phone: |  |

|  |  |
| --- | --- |
| Email: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Social Security#: |  | Date of Birth: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Marital Status: | Single  Married | Gender: | Male  Female  Other |

|  |  |  |  |
| --- | --- | --- | --- |
| Are you currently employed? | Yes  No | Occupation: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Emergency Contact Name: |  | Relationship: |  |

|  |  |  |
| --- | --- | --- |
| Contact Phone: |  | if okay to release information, consent must be signed. |

Who May We Thank For Your Referral?

|  |  |
| --- | --- |
| Name: |  |

|  |  |
| --- | --- |
| Address |  |

|  |
| --- |
| Google search,  Health Grades,  Psychology Today,  Zocdoc Yelp Don’t recall  Other |

**Form Completed By:**

Self  Parent  Legal Representative  Spouse  Other

**Section 2 - INSURANCE INFORMATION:**

**Primary Insurance**

|  |  |  |  |
| --- | --- | --- | --- |
| Subscriber’s/ Policy Holder’s Name: |  | Date of Birth: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| ID# (on card): |  | Sponsor SS# |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of Client or Authorized Legal Representative: |  | Date: |  |

**Please give insurance Card and Picture ID to receptionist**

**Section 3- Pharmacy information**

|  |  |  |  |
| --- | --- | --- | --- |
| Name: |  | Phone Number: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Town/Zipcode: |  | Address: |  |

**Section 3 - CURRENT MEDICATIONS & DOSES**

Please list all Prescription and Over the Counter medications that the client is currently taking.

|  |  |  |
| --- | --- | --- |
| **Medication** | **Dose** | **# times per day** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**ALLERGIES:**

Please list all medication allergies and the reactions of the client.

|  |  |  |
| --- | --- | --- |
| **Allergy** | **Medication** | **Reaction** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

**Section 4 - DEPENDENCE & ILLICIT SUBSTANCE ABUSE HISTORY:**

|  |  |
| --- | --- |
| Do you smoke?  Yes  No If yes, how many packs a day & for how long? |  |

|  |  |
| --- | --- |
| If you are a former smoker, how long has it been since you quit? |  |

Do you drink Alcohol?  Yes  No Type  Beer  Liquor  Wine

|  |  |
| --- | --- |
| Frequency:  Socially  Minimally  Infrequently  Frequently How many: |  |

|  |  |
| --- | --- |
| Drug Use:  Yes  No If yes, what type: |  |

|  |  |
| --- | --- |
| Other Habits:  Yes  No If yes, please specify: |  |

**PATIENT CONSENT FORM**

## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Client Name:** |  | **DOB:** |  | **SSN** |  |

I understand that the information to be exchanged may contain protected substance abuse, psychiatric, and confidential HIV-related information (Protected Health Information).

**I authorize Holistic Medical Care, LLC to**

**Release** Protected Health Information to: and/or **Obtain** Protected Health Information from:

|  |  |  |  |
| --- | --- | --- | --- |
| Facility/Agency/Person: |  | Relationship: |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| Address: |  | City: |  | State: |  | Zip: |  |

|  |  |  |  |
| --- | --- | --- | --- |
| Phone Number: |  | Fax Number: |  |

**Protected Health Information that may be used or disclosed includes: [Check all that apply]**

**Complete Medical Record**  **Mental Health Information**  **Admission Assessment**

**Drug/Alcohol related information**  **Progress**  **Discharge Summary**

**Complete Medical Record**  **Medications**  **HIV/AIDS relation information**

**Notes Other (specify):**

**Date of treatment to be released / obtained:**

**All Dates of Service**  **Specified Dates**

|  |  |  |  |
| --- | --- | --- | --- |
| **Start Date:** |  | **End Date:** |  |

**The information released under this authorization will be used for the following purposes: [Check all that apply]**

|  |  |  |
| --- | --- | --- |
| **Assess for intake purposes** | **Provide Treatment** | **Review History** |
| **Coordinate Care** | **Review for Services** | **Other (specify):** |

**PATIENT CONSENT FORM**

## AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

I understand this information will be used to provide comprehensive and coordinated services. I agree that a copy of this authorization will be as valid as the original. I understand this authorization will expire 30 days from the date of discharge from the practice or one year from the date of my signature. I give this consent freely and voluntarily and understand that refusal to grant authorization will not prevent me from utilizing services upon acceptance to Holistic Medical Care, LLC.

I understand that I may revoke this consent at any time prior to the release of the above information by making the request in writing to Holistic Medical Care, LLC but that any such revocation will not apply to information already released while this authorization was in effect. I understand that information, once disclosed to others, may be re-disclosed to entities not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and therefore, may no longer be protected by HIPAA. The confidentiality of this record is required under chapter 899 of the Connecticut General Statutes as well as Title 42 of the United States Code. This material cannot be transmitted to anyone without your written authorization, as provided for in these statutes.

|  |  |
| --- | --- |
| Print Name: |  |

|  |  |
| --- | --- |
| Date: |  |

|  |  |
| --- | --- |
| Signature of Client or Authorized Legal Representative: |  |

# Holistic Medical Care, LLC

**TELEHEALTH INFORMED CONSENT**

|  |  |  |  |
| --- | --- | --- | --- |
| **Patient Name:** |  | **Date of Birth:** |  |

Telehealth is a form of telemedicine that allows clients to access psychiatric care using electronic communications to enable health care providers at different locations to share individual client medical information for the purpose of improving client care. The information may be used to diagnose & treat, psychotherapy, follow-up and/or client education.

**Purpose**

The purpose of this form is to obtain your consent to participate in our telepsychiatry services.

**Benefits of Telehealth**

* Improved access to psychiatric care by enabling a client to remain at his/her own home or office
* More efficient psychiatric evaluation and management

**Possible Risks**

As with any medical procedure, there are potential risks associated with the use of telepsychiatry. These risks include, but may not be limited to:

* In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the mental health professionals
* Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment

**Medical Information & Records**

All existing laws regarding your access to medical information and copies of your medical records apply to telepsychiatry services. Please note that telecommunications are not recorded or stored.

**Confidentiality**

Electronic systems used will incorporate network and software security protocols to protect the confidentiality of client identification and will include measures to safeguard the data to ensure its integrity against intentional or unintentional corruption.

By signing below, you are acknowledging that you agree to participate in telepsychiatry services.

|  |  |  |  |
| --- | --- | --- | --- |
| Signature of Client or Authorized Legal Representative: |  | Date |  |

|  |  |
| --- | --- |
| Printed name of Client or Authorized Legal Representative: |  |

# Holistic Medical Care, LLC

**GENERAL OFFICE POLICY**

**Appointments and Confirmation calls:**

It is the clients’ responsibility to keep their appointments or cancel within 48 hours. You will receive a courtesy text message to remind you 48-hours prior to your appointment. Please reply to confirm the appointment. If you are unable to keep the appointment, please contact us to reschedule. Holistic Medical Care LLC charges for all missed late, or canceled appointments that are not canceled within the 48-hour period.

It is our policy to discharge clients who miss or late-cancel three appointments in a six month period, even if these incidents are not consecutive.

Clients who are not seen in more than a six month period of time, without provider approval will be considered discharged from the practice. In order to reschedule any further appointments, the client will be directed back to intake to assess client appropriateness. It is not guaranteed that the client will be accepted back into the practice.

**Medication Refills:**

* We require 48-72 hours’ notice prior to your medications running out.
* Please contact the pharmacy to request a refill of your medications and speak with a pharmacist directly to confirm that no previous scripts are remaining on file before contacting the office.
* Controlled substances will only be written out or called into a pharmacy for a quantity that will be enough medication until the next scheduled appointment.
* No medication will be called in if a client has not been seen in the office for over three months.
* No medication will be called in if a client does not have a scheduled follow-up appointment.
* Lost or miss-utilized medications will not be replaced until the client is seen by the prescriber and a valid/verifiable reason is given. A police report may be required.

**Paperwork/Forms:**

If you require a letter, form or document be completed, we have ten business days to complete your requests.

**Medical Records Request:**

* If you request records of any kind, we have 30 days to complete your requests.

|  |  |
| --- | --- |
| Signature of Client or Authorized Legal Representative: |  |

|  |  |
| --- | --- |
| Date: |  |

|  |  |
| --- | --- |
| Printed name of Client or Authorized Legal Representative: |  |

**FINANCIAL POLICY**

We, the staff at Holistic Medical Care LLC, thank you for choosing us as your healthcare provider. We consider it a privilege to serve your needs and we look forward to doing so. We are committed to providing you with the highest level of care and to building a successful provider-patient relationship with you and your family. We believe your understanding of our clients’ financial responsibility is vital to that provider-client relationship and our goal is to not only inform you of the provisional aspects of that financial policy but also to keep the lines of communication open regarding them. If at any time you have any questions or concerns regarding our fees, policies or responsibilities please feel free to contact the office manager. We believe this level of communication and cooperation will allow us to continue to provide quality service to all of our valued patients.

**Fees and Payments**

Please understand that payment for services is an important part of the provider-client relationship. We make payment as convenient as possible **by accepting MasterCard, Visa and health savings credit cards**.

Payment for services will be due at the time of service including any co-insurance, co-pay or deductible amount

**A service fee of $15.00 will be charged for all copayments not paid at the time of service.** If there is a remaining balance due after your visit, we will charge the credit card on file. Please make sure that any remaining balance has been paid prior to your next visit. Additional fees may be incurred as a result of email communications and/or letter writing for occupational, educational, and other general purposes.

**Insurance**

**We are an in-network provider for major insurance.** If you utilize your out-of-network benefits, we will provide you with a receipt that you can submit to your insurance plan for partial reimbursement of our out-of-network fee. After payment of a deductible, out-of-network benefits may cover up to 80% of our fee. Check with your insurance to determine the extent of your outpatient mental/behavioral health coverage. I hereby authorize my insurance benefits to be paid directly to Holistic Medical Care LLC. I will accept financial responsibility for non-covered services. I also authorize the office to release information about services rendered by my provider to my insurance carrier(s) and allow a photocopy of my signature to be used to file insurance claims.

**Cancellation Policy and Missed Appointments**

**We have a 48-hour cancellation policy.** Since your scheduled time is reserved for you, if an appointment is not canceled within 48 hours, you will be responsible for **the full appointment fee**. This will not be covered by your insurance company. Repeated missed appointments without notification may cause you to be discharged from the practice so that we can provide care to other patients.

I have read and understand the above financial policy. I agree to assign insurance benefits whenever applicable. I also agree, in addition to the amount owed, I also will be responsible for the fee charged by the collection agency for costs of collections if such action becomes necessary.

|  |  |
| --- | --- |
| Signature of Client or Authorized Legal Representative: |  |
| Date: |  |

## PSYCHOTROPIC MEDICATION INFORMED CONSENT AND CONSENT FOR TREATMENT

|  |  |  |  |
| --- | --- | --- | --- |
| NAME |  | DOB |  |

I have reviewed the following medications and information with the Nurse Practitioner/Psychiatrist

|  |  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- | --- |
|  |  |  |  |  |  |  |  |  |
|  | Medication | Date | Initials |  |  | Medication | Date | Initials |
|  |  |  |  |  |  |  |  |  |
|  | Medication | Date | Initials |  |  | Medication | Date | Initials |
|  |  |  |  |  |  |  |  |  |
|  | Medication | Date | Initials |  |  | Medication | Date | Initials |
|  |  |  |  |  |  |  |  |  |
|  | Medication | Date | Initials |  |  | Medication | Date | Initials |
|  |  |  |  |  |  |  |  |  |
|  | Medication | Date | Initials |  |  | Medication | Date | Initials |
|  |  |  |  |  |  |  |  |  |
|  | Medication | Date | Initials |  |  | Medication | Date | Initials |
|  |  |  |  |  |  |  |  |  |
|  | Medication | Date | Initials |  |  | Medication | Date | Initials |

**The following topics have been discussed:**

* Name and description of the medication
* Potential for interactions
* Risks and benefits
* Expected outcomes
* Potential complications
* Risks and precautions related to driving
* Risks of addictions, withdrawals, and weight gain
* Risks of falls and other accidents
* Reasonable alternative medications and alternative of NO medication
* In females, risks association with pregnancy and lactation. Please inform us immediately if you become pregnant.
* Risk of concomitant drinking or using other drugs.
* Risk of tardive dyskinesia Which may be a permanent condition (certain medications)

I agree and consent to be treated by Vida Sarkodie or the covering doctor/nurse practitioner when not available.

I understand and give permission to the office to contact me for appointment reminders, billing/health concerns, and other matters.

I agree to allow the office to message, text, or email me.

I have been given the opportunity to ask questions about the information. I agree to take the above medications.

I have discussed treatment options in emergency situations with the doctor.

|  |  |  |
| --- | --- | --- |
|  |  |  |
| PATIENT/LEGAL GUARDIAN SIGNATURE |  | PHYSICIAN SIGNATURE |
|  |  |  |
| **Date** |  | **Date** |

**Notice of Privacy Practices**

# Patient Acknowledgement

|  |  |
| --- | --- |
| **Patient Name:** |  |
| **Date of Birth:** |  |

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how may I exercise these rights, and the practice’s legal duties with respect of my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice.

I understand I can obtain this practice's current notice of Privacy Practice on request.

|  |  |
| --- | --- |
| Signature: |  |
| Date: |  |
| Relationship to Patient: |  |

|  |  |
| --- | --- |
| (If signed by a personal representative of the patient) |  |