Integrity Mental Health Intake Form

Patient Name:_____ Patient D.O.B:_____

Address:_____ City:_____

State:_____ Zip Code:_____ Social Security:_____

Preferred Phone #:_____ Additional Phone#:_____

Email:_____

Emergency Contact Name:_____

Relationship:_____ Phone Number:_____

INSURANCE INFORMATION

Insurance Company Name:_____

Member Name:_____

Member #:_____ Group#:_____

Psychiatric History

What are the problem(s) for which you are seeking help?

1._____

2._____

3._____

What are your treatment goals?

_____

_____

_____

Current Symptoms Checklist: (check once for any symptoms present, twice for major symptoms)

( )Depressed mood
( )Unable to enjoy activities
( )Sleep pattern disturbance
( )Loss of interest
( )Concentration/forgetfulness
( )Change in appetite
( )Excessive guilt
( )Fatigue
( )Decreased libido
( )Racing thoughts
( )Impulsivity
( )Increase risky behavior
( )Increased libido
( )Decreased need for sleep
( )Excessive energy
( )Increased irritability
( )Crying spells
( )Excessive worry
( )Anxiety attacks
( )Avoidance
( )Hallucinations
( )Suspiciousness
( )_____
( )_____

Suicide Risk Assessment

Have you ever had feelings or thoughts that you didn't want to live? Y/N
If YES, please answer the following. If NO, please skip to the next section.
Do you **currently** feel that you don't want to live? Y/N
How often do you have these thoughts?_____
When was the last time you had thoughts of dying?_____
*Has anything happened recently to make you feel this way?*_____
On a scale of 1 to 10, (ten being strongest) how strong is your desire to kill yourself currently?__
Would anything make it better?_____
Have you ever thought about how you would kill yourself?_____
Is the method you would use readily available?_____
Have you planned a time for this?_____
Is there anything that would stop you from killing yourself?_____
Do you feel hopeless/or worthless?_____
Have you ever tried to kill or harm yourself before?_____

Do you have access to guns? If yes, please explain_____

Medical History

For the following questions, *circle yes or no*, whichever applies. Your answers are for our records only and will be considered confidential. Please note that during your initial visit you will be asked some questions about your responses to this questionnaire and there may be additional questions concerning your health.

1. Are you in good health?.....Yes/No
2. Has there been any change in your general health within the past year?.....Yes/No
3. My last physical examination was on?_____
4. Are you now under the care of a physician? .....Yes/No
   If so, what is the condition being treated?_____
5. The name and address of my physician(s) is_____
6. Have you had any serious illness, operation, or been hospitalized within the past 5 years?.....Yes/No
7. Are you taking any medicine(s) including non-prescription medicine?.....Yes/No
   If so, what medicine(s) are you taking?_____
8. Do you have or have you had any of the following diseases or problems?
   a. Damaged heart valves or artificial heart valves, including heart murmur or *rheumatic heart disease*?.....Yes/No
   b. Cardiovascular disease (heart trouble, heart attack, angina, coronary insufficiency, coronary occlusion, high blood pressure, arteriosclerosis, stroke).....Yes/No
      1. Do you have chest pain upon exertion?.....Yes/No
      2. Are you ever short of breath after mild exercise or when lying down?.....Yes/No
      3. Do your ankles ever swell?.....Yes/No
      4. Do you have inborn heart defects?.....Yes/No
      5. *Do you have a cardiac pacemaker?*.....Yes/No
   c. Allergy.....Yes/No
   d. Sinus trouble.....Yes/No
   e. Asthma or hay fever.....Yes/No
   f. Fainting spells or seizures.....Yes/No
   g. Persistence diarrhea or recent weight loss.....Yes/No
   h. Diabetes.....Yes/No
   i. Hepatitis, jaundice, or liver disease.....Yes/No
   j. AIDS or HIV infection.....Yes/No
   k. Thyroid problems.....Yes/No
   l. Respiratory problems, emphysema, bronchitis, etc.....Yes/No
   m. Stomach ulcer or hyperacidity.....Yes/No
   n. Kidney trouble.....Yes/No
   o. *Tuberculosis*.....Yes/No

p. Persistent cough or cough that produces blood.....Yes/No
q. Persistent swollen glands in neck.....Yes/No
r. Low blood pressure.....Yes/No
s. Sexually transmitted disease.....Yes/No
t. Epilepsy or other neurological disease.....Yes/No
u. Cancer.....Yes/No
v. Problems with immune system.....Yes/No

Drug History

Drugs	Last Time Used	How Do You Use it	How Often	How Much	Type If Applicable
Alcohol					
Opiates					
Benzodiazepine					
Methamphetamine					
Cannabis					
Other					

Signature of Patient or Personal Representative Date

Print Name of Patient or Personal Representative Date

APPOINTMENT CANCELLATION/ NO SHOW POLICY

Thank you for trusting Integrity Mental Health. When you schedule an appointment with Integrity Mental Health we set aside enough time to provide you with the highest quality care. Should you need to cancel or reschedule an appointment please contact our office as soon as possible, and no later than 24 hours prior to your scheduled appointment. This gives us time to schedule other patients who may be waiting for an appointment. Please see our Appointment Cancellation/No Show Policy below:

- Effective July 16, 2018 any established patient who fails to show or cancels/reschedules an appointment and has not contacted our office with **at least 24 hour notice** will be considered a No Show and charged a **$75.00 fee. (showing up more than 5 minutes late to your appointment will result as a NO SHOW)**
- Any established patient who fails to show or cancels/reschedules an appointment with no 24 hour notice a **second** time will be charged a **$100.00 fee**.
- If a **third** No Show or cancellation/reschedule with no 24 hour notice should occur the patient may be **dismissed** from Integrity Mental Health.
- *Any new patient who fails to show for their initial visit will require a **$100 deposit** to reschedule.*

- As a courtesy, when the time allows, we make reminder calls for appointments. If you do not receive a reminder call or message, the above Policy will remain in effect.

We understand there may be times when an unforeseen emergency occurs, and you may not be able to keep your appointment. If you should experience extenuating circumstances please contact our Office Manager, who may be able to waive the No Show fee. You may contact Integrity Mental Health 24 hours a day, 7 days a week at the number below. Should it be after regular business hours Monday through Friday, or a weekend, you may leave a message.

Integrity Mental Health (480)834-3507

I have read and understand the Appointment Cancellation/No Show Policy and agree to its terms.

Signature (Parent/Legal Guardian) _____ Witness _____

Print Name _____ Date _____

FINANCIAL AGREEMENT

Patient Name:_____

If You Have Medical Insurance:
As a courtesy to you, Integrity Mental Health LLC will bill your medical insurance company for the services that are provided by our office. In order for the claim to process correctly, please ensure that the information that is provided to our office is accurate and current. If there is a change in insurance information, please let use know immediately. We will submit claims to secondary/tertiary insurance as long as we are given the correct information.

Deductibles, Co-Payments, and Coinsurance
Co-payments and deductibles are due at the time the service is rendered. Coinsurance and deductibles vary for each insurance policy and we can only approximate the percentage covered by each plan. You will begin receiving monthly statements with any balance after your insurance company has been billed. Delinquent accounts may be turned over to collection agency. You are responsible for any collection fees.

Referrals and Authorizations
A copy of your insurance card is required at every service. The card is descriptive and indicates whether or not an authorization is needed. If your insurance has designated a primary care physician (PCP), you must have required prior authorization from your PCP prior to your specialty office visit. If authorization is not provided, whether by yourself of through your insurance carrier, you will be required to pay for the visit at the time of services or reschedule the appointment until authorization is received.

Non-Participating Insurance Accounts
The financial obligations of patient who are insurance by non-participation carriers are considered a self-pay account. Self-pay accounts apply to patients who are covered by carriers with which that practice does not participate or patients without insurance or a card at time of service. It is ultimately your responsibility to verify coverage for your particular plan. If the insurance company denies the claim for a plan provision (for example pre-existing condition, maxed benefits, no outpatient services coverage), you will be responsible for the balance, and you agree to pay the full charge.

Medical insurance coverage is contact between you and your insurance company. Integrity Mental Health, LLC will not be involved in disputes between you and your insurance company regarding deductibles, co-payments, coverage charges, secondary insurance, 'usual and customary' charges, etc., other than to supply factual information as necessary. **You are ultimately responsible for the timely payment of your account.**

Payment Methods:
*We accept cash, checks, Visa, MasterCard, and Discover
*A $25 fee will be charged to all patients for any returned checks
We are committed to providing you with the best possible care and we are willing to discuss our professional fees at any time. Your clear understanding of our Financial Policy is important to our relationship. Please ask if you have any questions about our fees, Financial Policy, or your financial responsibility.

I acknowledge that I have read and agree to the above Financial Policy
Signature:_____Date:_____

Witness:_____Date:_____
*Parents or Guardian must sign if patient is under 18 years of age.

Crisis Information

- Crisis Response Network 24/7 Mental Health Assistance
  Phone: 602-222-9444
  TTY/TDD: 602-274-3360
  Toll free: 1-800-631-1314
  Toll free TTY/TDD: 1-800-327-9254

- National Suicide Prevention Lifeline
  Offers free 24 hour hot-line available to anyone in suicidal crisis or emotional distress.
  Phone: 1-800-273-8255

- Veteran's Crisis Line
  Phone: 1-800-273-8255, press 1

- Aurora Behavioral Health
  6350 S. Maple Ave.
  Tempe, Az 85283
  Phone: 480-345-5400

- Banner Behavioral Health
  7575 E. Earll Dr.
  Scottsdale, AZ 85251
  Phone: 480-448-7500

INTEGRITY Mental Health
Service Before Self

Authorization for Release of Protected Health Information

I hereby authorize _____
to disclose Protected Health Information (PHI) as deemed below.

Patient:
Name_____
Soc. Sec. #_____
DOB_____

Requestor (if other than patient):
Name_____
Relationship_____
Source of Legal Authority_____
_____

Name & Address of who to receive health records/information:

Integrity Mental Health
625 N. Gilbert Rd. Ste.
104 Gilbert, AZ 85234
Phone: # 480-834-3507
Fax: # 480-834-3982

☐ I wish to have the following records copied and I will pick them up at your facility
☐ **I request the facility copy the following records and fax/send them to the above address**

I request the release of **all** medical records created between Date: _____ and _____

Legal Authority Request:
☐ I am the Patient noted above
☐ I am the Patient's legal representative
☐ I am the Patient's Power of Attorney
☐ I am the Patient's legal Guardian
Requestor's Initials_____

I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse) for use in medical treatment or consultation, billing or claims payment, or other purposes as I may direct. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization.

If signing as a POA, please include a copy of documentation, as some providers will not release records without additional documentation.

Signature_____ Date_____
Relationship to Patient_____
Name of Person Completing this Form_____