Resilience
BEHAVIORAL HEALTH GROUP

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Contact Information & Demographics Form

Patient Information

First Name* _____ MI* _____ Last Name* _____

Address* _____

City* _____ State* _____ Zip Code* _____

Date of Birth (DOB) * _____ Age* _____ Social Security Number* _____

Biological Sex* _____ Race/Ethnicity* _____

Primary Phone* _____

Can voicemails be left for you at the primary phone number listed?*
☐ Yes ☐ No
Can text messages be sent to you at the primary phone number listed?*
☐ Yes ☐ No
Do you wish to receive appointment reminders at the primary phone number listed?*
☐ Yes ☐ No

Secondary Phone _____

Can voicemails be left for you at the secondary phone number listed?
☐ Yes ☐ No
Can text messages be sent to you at the secondary phone number listed?
☐ Yes ☐ No
Do you wish to receive appointment reminders at the secondary phone number listed?
☐ Yes ☐ No

Email* _____

Can emails be sent to you at the address listed?*
☐ Yes ☐ No

Referral Source _____

Guarantor Information

Who is the guarantor (i.e., the party financially responsible) for the services rendered?*
☐ Patient
☐ Legal Representative – Patient Under 18 Years of Age
☐ Legal Representative – Patient Considered Incapacitated Adult

Please provide information on the guarantor if someone other than the patient. This section must be completed by the legal representative of any patient under 18 years of age or considered an incapacitated adult.

First Name _____ MI _____ Last Name _____

Address
_____

City _____ State _____ Zip Code _____

Date of Birth (DOB) _____ Age _____ Social Security Number _____

Primary Phone
_____

Can voicemails be left for you at the primary phone number listed?
☐ Yes ☐ No
Can text messages be sent to you at the primary phone number listed?
☐ Yes ☐ No
Do you wish to receive appointment reminders at the primary phone number listed?
☐ Yes ☐ No

Secondary Phone
_____

Can voicemails be left for you at the secondary phone number listed?
☐ Yes ☐ No
Can text messages be sent to you at the secondary phone number listed?
☐ Yes ☐ No
Do you wish to receive appointment reminders at the secondary phone number listed?
☐ Yes ☐ No

Email
_____

Can emails be sent to you at the address listed?
☐ Yes
☐ No

Insurance Information

First Name of Policy Holder _____

Last Name of Policy Holder _____

Date of Birth (DOB) of Policy Holder _____

Social Security Number of Policy Holder _____

Employer of Policy Holder _____

Relationship of Policy Holder to Client _____

Name of Insurance _____

Name of Insurance Health Plan _____

Insurance Contract Number _____

Insurance Group Number _____

Occupational Information

Occupation _____

Employer _____

Length of Employment _____

Please specify if the figure provided is the approximate number of weeks, months, or years.

Educational Information

Highest Level of Education _____

Are you currently a student?

☐ Yes

☐ No

If you are currently a student, what type of schooling best describes your enrollment status? _____

Physical Health Information

Please list any medical conditions that you are currently experiencing. _____

Please list any prescription drugs that you are currently taking.

_____

Primary Care Provider

_____

Primary Care Physician _____ Primary Care Phone Number _____

Psychiatric Information

Please list any previous mental disorder diagnoses that you have received.

_____

Do you have a history of mental health problems?
☐ Yes ☐ No

Do you have a history of substance use problems?
☐ Yes ☐ No

Have you ever received mental health services?
☐ Yes ☐ No

If you have previously received mental health services, what type(s) of care did you participate in during treatment?

☐ Individual Psychotherapy
☐ Couples Psychotherapy
☐ Family Psychotherapy
☐ Group Psychotherapy
☐ Psychiatric Care
☐ Assertive Community Treatment
☐ Residential Care
☐ Substance Use Rehabilitation
☐ Inpatient Psychiatric Hospitalization (Voluntary)
☐ Inpatient Psychiatric Hospitalization (Involuntary)

If you previously received outpatient mental health services, approximately how long did you participate in treatment?

_____

Please specify if the figure provided is the approximate number of weeks, months, or years.

If you previously received outpatient mental health services, what was the reason for seeking treatment?

_____

Emergency Contact Information

First Name* _____

Last Name* _____

Phone Number* _____

Relationship Description* _____

General Intake Information

Please briefly describe the reason for the intake appointment. *

_____

_____

Presenting Concerns

Please select all that apply.

☐ Anxiety/Panic
☐ Depressed Mood
☐ Trauma/Posttraumatic Stress
☐ Stress/Life Adjustment
☐ Relationship Issues
☐ Anger/Irritability
☐ Obsessions/Compulsions
☐ Grief/Loss
☐ Sleep Disturbances
☐ Inattention/Hyperactivity
☐ Hallucinations/Delusions
☐ Personality Disorganization
☐ Workplace Issues
☐ Legal Matters
☐ Substance Use
☐ Other, specify: _____

Release of Information to Third Party Payors/Agents and Authorization & Assignment of Benefits Agreement for Payment of Services

I authorize my provider, Resilience Behavioral Health Group, to disclose portions of the clinical record on the client named above to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of psychiatric/psychological and/or substance abuse diagnosis, history and physical examinations, intake assessment, treatment plan, progress notes, testing results, discharge summary and any other information or records necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release my provider, Resilience Behavioral Health Group, and its' officers, agents, employees, and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payment be made to my provider of service, Resilience Behavioral Health Group, on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be patient responsibility by the third party payor.
5. I understand that any expense that is incurred by my provider, Resilience Behavioral Health Group, associated with collecting the balance on my account (such as collection fees and/or attorney's fees) will be my responsibility to pay.

Signature of the Client or Guarantor* _____ Date* _____

Please sign your full name.

Medicare Authorization & Assignment of Benefits Agreement

To be completed by <u>MEDICARE PATIENTS ONLY</u>.

I request that payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished by or in the office of my provider of service, Resilience Behavioral Health Group. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefit of related services.

Signature of the Client or Guarantor* _____ Date* _____

Please sign your full name.