

Prime Behavioral Health, LLC
ADULT INTAKE PACKET

Client Name _____

Street Address _____ PO Box _____

City/State/Zip _____

Home Phone # _____ **May we call or leave a message at this number?** Yes No

Daytime Phone # _____ **May we contact you here and leave a message?** Yes No

Cell Phone # _____ **May we call or leave a message on this phone?** Yes No

Client Date of Birth _____ Age: _____ Social Security # _____

Primary Care Physician & Phone #: _____

Emergency Contact Name (required): _____ **Phone #:** _____

Address (required): _____

If we may email you, please provide your address below. *Bear in mind that email IS NOT SECURE. NO PRIVATE INFORMATION OTHER THAN YOUR NAME, EMAIL ADDRESS AND/OR APPOINTMENTS WILL BE INCLUDED.*

_____ @ _____

Insurance Information (Copy of Insurance Card and ID is Required)

• This section is required to be filled out in full •

1) **Primary** Insurance Company _____ Ins Co Phone # _____

Employer of Subscriber _____

Name of Subscriber _____ Date of Birth _____

Address of Subscriber (if different from Client) _____

Subscribers Social Security # _____ Relationship to Client _____

2) **Secondary** Insurance Company _____ Ins. Co Phone # _____

Employer Name _____

Name of Subscriber _____ Date of Birth _____

Address of Subscriber (if different from Client) _____

Subscribers Social Security # _____ Relationship to Client _____

IF THERE IS A THIRD INS. PLEASE NOTIFY RECEPTIONIST TO GIVE YOU ATTACHMENT

CLIENT AGREEMENT

The above information is current and correct to the best of my knowledge.

I understand my insurance coverage as noted above and that I am responsible for paying the co-pay, if required, and/or the amount not covered by my insurance policy. This agreement also grants authorization to PBH to release such information as may be necessary for completion of my insurance claim with payment of benefits to PBH for services rendered.

Client Name (please print)

Client Signature

Date

Witness

Date

Revised 01/16

Prime Behavioral Health, LLC

647 Hill Rd. North, Unit B
Pickerington, OH 43147
614-833-6900

711 North Columbus St., Ste. 100
Lancaster, OH 43130
740-653-6500

Client Intake Form

Instructions: To assist us in helping you, please fill out this form as fully and openly as possible. All private information is held in strictest confidence within legal limits. If certain questions do not apply to you, leave them blank.

Identifying Information

Name: _____ Date of Birth: _____ Age: _____
Gender: Male Female Race: _____ Height: _____ Weight: _____
Hair Color: _____ Eye Color: _____

Behavioral Health

Why are you seeking counseling?

What issues or circumstances do you believe contribute to your problem(s)?

How long has this problem(s) persisted? _____

Under what conditions do the problems usually get worse?

Under what conditions do the problems usually improve?

Have you previously been involved in counseling? No Yes If yes, describe the reasons for counseling, who provided the counseling, and the outcome.

Counselor _____

Reason:

Outcome:

List your greatest strengths:

List your greatest weaknesses:

Psychiatric Hospitalizations: None Past Recent

| Dates of Service: | # of Days | Where & Reason (suicidal, depressed etc.) |
|-------------------|-----------|---|
|-------------------|-----------|---|

| | | |
|-------------------|-----------|---|
| Dates of Service: | # of Days | Where & Reason (suicidal, depressed etc.) |
|-------------------|-----------|---|

Behavioral Health Symptom Checklist

Please indicate the degree to which you have experienced any of the following symptoms in the last 4 weeks.

0 = Never 1 = Occasionally 2 = Regularly 3 = Frequently

- _____ 1. Trembling, or feeling shaky
- _____ 2. Shortness of breath or smothering sensation
- _____ 3. Racing heart, heart palpitations or chest pain (circle which)
- _____ 4. Moist palms or excessive sweating
- _____ 5. Dizziness, lightheadedness, unsteady or faint (circle which)
- _____ 6. Nausea, diarrhea, or other abdominal distress (circle which)
- _____ 7. Frequent headaches or other muscle aches
- _____ 8. Startle easily
- _____ 9. Irritability (loses temper easily)
- _____ 10. Worrying a lot
- _____ 11. Trouble swallowing, "lump in throat", or choking sensation
- _____ 12. Fearful of or embarrassed by being watched or being the focus of attention
- _____ 13. Avoid talking to strangers
- _____ 14. Fear of embarrassment
- _____ 15. Persistent fear of an object (snakes) or situation (high places) considered excessive or unreasonable
- _____ 16. High levels of anxiety in the presence of an object or situation
- _____ 17. Regular and disturbing thoughts about a past traumatic experience
- _____ 18. Regular and disturbing dreams about a past traumatic experience
- _____ 19. Avoidance of thoughts feelings, or conversations associated with a traumatic experience
- _____ 20. Excessive hand washing or fear of germs
- _____ 21. Excessive checking (i.e., doors, locks, stove)
- _____ 22. Excessive need for order or neatness or counting ritual(s)
- _____ 23. Unusual and persistent sad feelings
- _____ 24. Diminished interest or participation in enjoyable or important activities
- _____ 25. Difficulty concentrating or poor memory (circle which)
- _____ 26. Tire easily or low energy level
- _____ 27. Thoughts of suicide
- _____ 28. Increased or decreased sleep (circle which): avg. hrs per night _____
- _____ 29. Feelings of hopelessness
- _____ 30. Persistent and abnormally elevated mood
- _____ 31. Over inflated feelings of self-worth
- _____ 32. Decreased need for sleep
- _____ 33. Rapid or racing thoughts
- _____ 34. Excessive involvement in pleasurable activities
- _____ 35. Excessive and/or reckless spending
- _____ 36. See or hear things that others around you are unable to perceive
- _____ 37. Hold ideas or beliefs that are not shared by others
- _____ 38. Self induced vomiting
- _____ 39. Excessive exercise
- _____ 40. Use of laxatives or diuretics to lose weight
- _____ 41. Dieting (very strict, women consuming less than 1400 daily calories or men less than 2000 calories)
- _____ 42. Careless mistakes in school work, work, or other activities
- _____ 43. Can only pay attention for short periods at school/work/home
- _____ 44. Failure to complete schoolwork, chores, duties
- _____ 45. Hyperactive: fidgets, squirms, talks excessively
- _____ 46. Acts without thinking of consequences

Drug and Alcohol History

Indicate the level of use for each substance by checking the appropriate box.

| | No Use | Past use | Current Use | | No Use | Past use | Current Use |
|------------|--------------------------|--------------------------|--------------------------|---------------|--------------------------|--------------------------|--------------------------|
| Alcohol | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Hallucinogens | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Marijuana | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Inhalants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Hashish | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Cocaine | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Stimulants | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Heroin | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| Sedatives | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | Other: | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If current or past use is indicated to any of the above items compete the following questions?

| | | | | | |
|-------------------|----------------------------|------------------|-----------|-------------|---|
| Drug/Alcohol Type | Age of 1 st use | Date of last use | Frequency | Amount Used | Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection |
| Drug/Alcohol Type | Age of 1 st use | Date of last use | Frequency | Amount Used | Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection |
| Drug/Alcohol Type | Age of 1 st use | Date of last use | Frequency | Amount Used | Method <input type="checkbox"/> Oral <input type="checkbox"/> Smoked <input type="checkbox"/> Nasal <input type="checkbox"/> Injection |

Are you currently pregnant? No Yes Are you an IV drug user? No Yes

Have you ever received inpatient drug and/or alcohol treatment? No Yes

If yes, When? _____ Where? _____

Have you ever received outpatient drug and/or alcohol treatment? No Yes

If yes, When? _____ Where? _____

Are you involved in any community self-help groups such as AA No Yes

Family History

Marital status: Single Married Divorced Separated Widowed
 Living with a Significant Other but Never Married

If married: how long have you been married? _____ Spouse's age: _____

Are you presently experiencing any serious marital conflicts?

No Yes If yes, explain: _____

If you have ever been divorced: How many times were you previously married? _____

Date of divorce(s) _____

Prior to the divorce(s), how long were you married? _____

Reasons for divorce(s) _____

Living Situation: Own Home Parent's Home Relative's Home Homeless Group Home
 Residential Other _____

| Household Member's Names (if client lives in more than one household list household 1 – 2) | Relation to the Client | Age | Race | Occupation or School | Level of Education |
|--|------------------------|-----|------|----------------------|--------------------|
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| | | | | | |
| Significant Family Members/Others not listed above: | Relation to the Client | Age | Race | Occupation or School | Level of Education |
| | | | | | |
| | | | | | |

Briefly describe any problem areas that occur between yourself and people you live with.

Medical History

Physician Name: No Yes _____ Phone: _____

Address: _____
Street & Number City State Zip

Date of most recent physical exam: _____ By Whom: _____

Results: _____

Immunizations - Check the immunizations for the following diseases: Chicken Pox Diphtheria German Measles
 Measles Mumps Polio Small Pox Tetanus

Drug Allergies: _____ *

List any major illness and/or operations

Have you had any medical hospitalizations in the last three years No Yes, if yes, complete below:

| Hospital | City | Date | Reason |
|----------|------|------|--------|
| | | | |
| | | | |

List any *current* physical concerns (e.g. high blood pressure, headaches, dizziness, etc.):

List any *past* physical concerns:

Have you ever had head trauma that resulted in loss of consciousness and/or required medical treatment? No Yes

What medications are you now taking? List all medications including over the counter and herbal therapy, dose (if known), how long taken, and the doctor who prescribed the medication.

Prescription/Over the Counter Medication: No Yes

Out of Medication: No Yes

Current Medication: _____
 Total Daily Dosage: _____
 Reason: _____
 Compliance No Yes Partial Unknown

Current Medication: _____
 Total Daily Dosage: _____
 Reason: _____
 Compliance No Yes Partial Unknown

Current Medication: _____
 Total Daily Dosage: _____
 Reason: _____
 Compliance No Yes Partial Unknown

Current Medication: _____
 Total Daily Dosage: _____
 Reason: _____
 Compliance No Yes Partial Unknown

Current Medication: _____
 Total Daily Dosage: _____
 Reason: _____
 Compliance No Yes Partial Unknown

Current Medication: _____
 Total Daily Dosage: _____
 Reason: _____
 Compliance No Yes Partial Unknown

Do you think these medications help you get better? N/A No Yes Unknown

Do you use caffeine? No Yes from (coffee, tea, soda) _____ Daily Use _____

Do you use tobacco? No Yes from (cigarettes, snuff, snus) _____ Daily Use _____

Describe your appetite? Poor Appetite Average Appetite Large Appetite

Has your weight changed in the last year? No Yes If yes, by how much? _____ weight gain loss

How much sleep do you get each night? _____ When you go to bed, how long does it take you to fall asleep? _____

Do you awaken in the night and have difficulty returning to sleep? No Yes Do you awaken before you plan to get up? No Yes

Has client had any of the following **symptoms in the past 60 days?** Please check.

- | | | | |
|---|--|---|---|
| <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Coughing | <input type="checkbox"/> Lightheadedness | <input type="checkbox"/> Sleep Problems |
| <input type="checkbox"/> Blood in Stool | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Memory Problems | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Breathing Difficulty | <input type="checkbox"/> Dizziness | <input type="checkbox"/> Muscle Weakness | <input type="checkbox"/> Tingling in Arms/Leg |
| <input type="checkbox"/> Confusion | <input type="checkbox"/> Falling | <input type="checkbox"/> Nervousness | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Consciousness Loss | <input type="checkbox"/> Gait Unsteadiness | <input type="checkbox"/> Panic Attacks | <input type="checkbox"/> Vision Changes |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Hearing Loss | <input type="checkbox"/> Pulse Irregularity | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Other: _____ | | | |

Health History Questionnaire

Health History Questionnaire: Have you or any of your relatives (related by blood) had any of the following health problems? If a blood relative has had the condition, please write down the relationship to the you (parent, brother or sister, aunts/uncles, cousins, children, etc.) in the comment section.

| Problem | Now | Client | | Family History | Comment (Indicate family member relationship to client) |
|------------------------------|-----|--------|-------|----------------|--|
| | | Past | Never | | |
| AIDS | | | | | |
| Alcoholism | | | | | |
| Anemia | | | | | |
| Anxiety | | | | | |
| Arthritis | | | | | |
| Asthma | | | | | |
| Bipolar Disorder | | | | | |
| Bleeding Disorder | | | | | |
| Brain Tumor | | | | | |
| Cancer | | | | | |
| Cirrhosis | | | | | |
| Depression | | | | | |
| Diabetes | | | | | |
| Drug Abuse | | | | | |
| Epilepsy/Seizures | | | | | |
| Eye Disease | | | | | |
| GI Problems | | | | | |
| Glaucoma | | | | | |
| Headaches | | | | | |
| Head Injury | | | | | |
| Hearing Problems | | | | | |
| Heart Disease | | | | | |
| Hepatitis | | | | | |
| High Blood Pressure | | | | | |
| Hyperactivity | | | | | |
| Jaundice | | | | | |
| Kidney Disease | | | | | |
| Learning Problems | | | | | |
| Lung Disease | | | | | |
| Low Blood Pressure | | | | | |
| Menstrual Pain | | | | | |
| Oral Health/Dental | | | | | |
| Schizophrenia | | | | | |
| Sexually Transmitted Disease | | | | | |
| Speech Problems | | | | | |
| Stroke | | | | | |
| Suicide | | | | | |
| Thyroid | | | | | |
| Tuberculosis | | | | | |

If the client has had any of the above, please write the problem, what treatment was received, and when:

| | |
|---------------------------------|-------|
| Problem and Treatment Received: | When: |
| Problem and Treatment Received: | When: |

Educational History

Highest Degree attained: High School Associate Degree/2yr tech Bachelor's Degree Master's Degree Ph.D.

Highest Academic Year completed: _____ Highest Vocational Year Completed: (if applicable) _____

Type of school placement: Regular Special Education Home-Schooled Unknown

Type of Special Education Placement: None Cognitive Disability Emotional Disability
 Learning Disability Multiple Disabilities
 Other: _____

Did you have difficulties in school? No Yes. If yes, please explain

Do you have special communication needs? TTD Device Interpreter Services

Employment History**Employment Status**

Employed Full Time (30 or more hours) Employed Part Time If part time, number of hours worked weekly _____

Job/Occupation: _____

Unemployed Unemployed due to disability. Date Last Worked _____

If unemployed, do you want to work? No Yes. If yes, what kind of work would you like to do? _____

Current Employment

Name of employer: _____

Job Position: _____ How long have you been in this position _____

Date Last Worked _____

Have you been disciplined by your supervisor? Yes No

Have you had frequent tardiness? Yes No

Have you had frequent absences? Yes No

Are you satisfied with your job Yes No

Family Financial History:

Amount of Monthly Income _____ Source(s) of income: _____

Loss of Income due to: _____

Financial Problems No Yes If yes, explain: _____

Military History

Are you currently in the military? No Yes If yes, what branch? _____ How long? _____

Rank: _____ What work did you do for the military? _____

Have you recently been deployed to a combat zone? No Yes If yes, have you experienced any psychological or physical difficulties because of this deployment? No Yes explain? _____

Have you ever been in the military? No Yes If yes, what branch? _____ How long? _____

Rank: _____ What work did you do for the military? _____

When were you discharged? _____ Type of discharge: _____

Have you ever been deployed to a combat zone? No Yes If yes, when? _____ Have you experienced any psychological or physical difficulties because of this deployment? No Yes explain? _____

Interests and Community Involvement

What meaningful activities, including leisure and recreational activities to you engage in?

What community activities, including volunteer work are you involved in?

What religious or spiritual activities do you participate in?

List any cultural or family traditions you have?

Legal History

Do you have a Legal Guardian/Custodian? No Yes If yes, Name: _____ Phone: _____

Civil Proceedings: _____ Current Past When? _____

Domestic Relations Court (Custody, Protective Services, Restraining Orders): _____ Current Past When? _____

Child Support Enforcement Orders: _____

Job and Family Service Involvement with Family: _____

Caseworker assigned to Family: _____ **Phone:** _____

Juvenile Court Involvement (for Child Abuse, Neglect or Dependency): Current Past When? _____

Current Legal Status: None Awaiting Charges On Probation/Parole Conditional Release
 Outpatient Commitment Incarcerated
 Other: _____

Legal Charges: Juvenile No Yes If yes,
 Felony Misdemeanor Charge: _____ Current Past When? _____
 Felony Misdemeanor Charge: _____ Current Past When? _____

Legal Charges: Adult No Yes If yes,
 Felony Misdemeanor Charge: _____ Current Past When? _____
 Felony Misdemeanor Charge: _____ Current Past When? _____

Incarcerations:
From _____ **To** _____ **Where** _____ **Conviction:** _____
From _____ **To** _____ **Where** _____ **Conviction:** _____

Probation/Parole Officer: _____ **Phone:** _____

Print Name (Person completing questionnaire): _____ **Signature:** _____ **Date:** _____

Reviewer Name/Degree (if applicable) _____ **Signature:** _____ **Date:** _____

Comments:

To the best of my knowledge, all the information I have given is accurate. I understand the information contained in my chart kept at Prime Behavioral Health, LLC, may not be released to anyone without my written consent, with these exceptions:

- If the law mandates disclosure
- If you have placed yourself or someone else in clear and imminent danger
- For the purposes of therapist supervision & consultation, within the ethical guidelines of the American Counseling Association.

CLIENT'S SIGNATURE _____ DATE _____

PLEASE PRINT LAST NAME _____ FIRST NAME _____

CANCELLATIONS & MISSED APPOINTMENTS

All appointment cancellations require a **24-hour notice** or in the case of illness, a message prior to 8:00 am on the appointment day. Our voicemail is available 24 hours/day to take messages after hours or on the weekends if you need to cancel an appointment. Adequate notification respects the doctor/therapist's time as well as allows availability to others requesting services. Failure to not show at all or to give a less than 24-hour notice on cancellations will result in a \$35.00 charge which must be paid prior to scheduling another appointment. In addition, arriving late to appointments could also result in charges that would be equal to the time you kept your therapist waiting. **Insurance will not be billed for this.**

I HAVE READ THE OFFICE POLICY AND RECEIVED A COPY OR HAD ACCESS TO IT ON THE WEBSITE. I UNDERSTAND AND AGREE TO THE TERMS CONTAINED IN IT.

Client/Legal Guardian Signature Date

Witness Date

Prime Behavioral Health, LLC

CONSENT FOR TREATMENT AND INFORMATION SHEET

The decision to begin mental health treatment is one that may have important results for your life. Research has shown that individuals entering therapy achieve more favorable results when they have a good understanding of what to expect. We have developed this sheet to provide you with an overview, but no information sheet can answer all questions, so please feel free to ask us about any questions you have.

Individual sessions usually last 45-60 minutes providing us with time to think about what you have said, make notes, and plan your services. Your first session will usually be devoted to assessing the type and extent of the problems and concerns you have and to plan your services.

Your therapist has a responsibility to ask questions about your history, your life situation, and your current distress. Your therapist also has a responsibility to be open with you and to provide direct information about your treatment.

As a client in our office, you will also have certain responsibilities for payment and for keeping your appointments. Your most important responsibility, however, is to yourself – to work towards the goals we mutually set, and to work toward your goals both during sessions and during days between sessions. This is your time for you.

If you fail to inform our office of any change of insurance (i.e., termination of policy, addition of new policy, or change in a policy) prior to or by the effective date of the change, which results in failure of our office to be able to bill and receive payment for any charges incurred, you will be billed directly for those charges to the extent of the allowed amount for those charges by the most recent insurance policy provided to us.

There are charges which are not covered by insurance for missed appointments and late cancellations. Please refer to the Canceled and Missed Appointment Policy form for details on these charges.

Once any charge has remained on your account for 90 days, the entire outstanding balance will be forwarded to a collection agency. Any fees and/or interest added by the collection agency will be charged to you in addition to the outstanding balance which you owed to Prime Behavioral Health.

We place a high value on the confidentiality of your records. Records will be held confidential except as required by law, or as released by your written authorization. In a small number of situations, therapists are legally required to reveal information; for example, if you reveal information that indicated a clear danger of injury to yourself or others. Records may, on occasion, be reviewed for quality and appropriateness of care by the clinic or by your insurance company.

Every effort is made to answer calls during our regular office hours. If we are unable to answer or the office is closed at the time of your call, please leave a message, and we will return your call as soon as we can.

Entering psychotherapy requires a commitment of time, energy and resources, and often also requires some courage to make the first appointment. Your commitment will be honored here and you will be treated with respect. Thank you for choosing our office.

**I HAVE READ THE ABOVE AND UNDERSTAND AND AGREE TO MY RESPONSIBILITIES, AND
CONSENT FOR TREATMENT.**

Signature

Printed Name of Client

Date

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COURT FEE SCHEDULE

- All fees charged for court activity are based on portal-to-portal travel.
- A retainer for the estimated full amount of the fee will be required one week before a court appearance.
- If actual fees exceed estimated fees, clients will be responsible for the remainder of the fee within one week of rendered services.
- Fees will be assessed in four-hour blocks.

Fee Rates

- Fees for court related activities requested more than two weeks in advance = \$120 *per hour* (Minimum = \$480)
- Fees for court related activities requested less than two weeks in advance = \$240 *per hour* (Minimum - \$960)

Cancellation Policy

- If request for court related activities is cancelled at least 2 weeks prior to scheduled appearance, the client will be entitled to a full refund minus any time the counselor used for preparation.
- If request for court related activities is cancelled at least 1 week prior to scheduled appearance, the client will be entitled to a 50% refund minus any time the counselor used for preparation.
- No refund will be given for cancellations that occur within the week of the scheduled activity.
- If a counselor is subpoenaed for court related activity and the subpoena is cancelled, regardless of retainer not being submitted, the client will be responsible for the initial requested fee.

Consideration for modification of this fee schedule will be made on a case-by-case basis.

Client Signature

Date

Your signature states that you are aware of this policy. ***Please sign even if you feel that this will not apply to your situation.***

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**FEE SCHEDULE
All Counselors**

| | |
|----------------------------------|--------------|
| Initial Session | \$160 |
| Office Visit ~60 Min | \$150 |
| Office Visit ~45 Min | \$120 |
| Office Visit ~30 Min | \$ 80 |
| Family Counseling ~45 Min | \$130 |

I have read and understand the Financial Policy and office procedures at Prime Behavioral Health, LLC. I agree to the cancellation/reschedule policy. I further understand I will need to make my co-pay at each visit. I acknowledge that I have either received a copy of this policy or have it available to me from the website at www.carebyprime.com

Client Name (please print)

Date

Client Signature

Revised 10/15

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Receipt of Notice of Privacy Practices Acknowledgement Form

I hereby acknowledge that on _____ I received the Notice of Privacy Practices of Prime Behavioral Health, LLC, or was notified of its availability on the website during my initial call, which sets forth the ways in which my personal health information may be used or disclosed by Prime Behavioral Health, LLC, and outlines my rights with respect to such information.

Please list anyone to whom we may speak or leave a message in regard to appointments or payments/billing along with their relationship to you.

| NAME | RELATIONSHIP |
|-------|--------------|
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

Would you like for us to leave information regarding scheduling and appointments on your voicemail?

Voicemail _____ YES _____ NO

Signature _____

Date _____

October, 2015

APPOINTMENT REMINDERS THROUGH EMAIL

We can send you an appointment reminder by email as opposed to a phone call. The appointment reminder will include ONLY THE DATE AND TIME OF YOUR APPOINTMENT AND YOUR SERVICE PROVIDER NAME. We will not encrypt the messages. Health care information sent by regular email could be lost, delayed, intercepted, delivered to the wrong address, or arrive incomplete or corrupted. If you understand these risks and would like to receive an appointment reminder by email, we need you to confirm that you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message.

Do you agree to receive your appointment reminders via email?

YES NO (check here if you prefer phone calls for reminders)

(If yes, please provide your email address. Also, if yes, please inform us of any changes or updates to your email address as they occur.)

Email address (if not already provided)

I have read and understand the risks involved with accepting my appointment reminders via email.

SIGNATURE

DATE

CLIENT PRINTED NAME

August 2016