Prime Behavioral Health, LLC

ADULT INTAKE PACKET

Client Name ____

Street Address ______________________________ PO Box ______________

City/State/Zip ____

Home Phone # ____________________ **May we call this #? Yes No, May we leave a msg? Yes No**

Daytime Phone # __________________ **Can we contact you here? Yes No Leave msg? Yes No**

Cell Phone # ______________________ **May we call this #? Yes No, May we leave a msg? Yes No**

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

Primary Care Physician & Phone #:______________________________________

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.***

______________________________@______________________________

Emergency Contact Name (required):__________________________ **Phone #:**____________

Address (required):____

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 01/2019

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	❑	❑	❑	**Hallucinogens**	❑	❑	❑
Marijuana	❑	❑	❑	**Inhalants**	❑	❑	❑
Hashish	❑	❑	❑	**Cocaine**	❑	❑	❑
Stimulants	❑	❑	❑	**Heroin**	❑	❑	❑
Sedatives	❑	❑	❑	**Other**: ______________	❑	❑	❑

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

Drug/Alcohol Type	Age of 1st use	Date of last use	Frequency	Amount Used	Method ❑Oral ❑Smoked ❑Nasal ❑Injection
Drug/Alcohol Type	Age of 1st use	Date of last use	Frequency	Amount Used	Method ❑Oral ❑Smoked ❑Nasal ❑Injection
Drug/Alcohol Type	Age of 1st use	Date of last use	Frequency	Amount Used	Method ❑Oral ❑Smoked ❑Nasal ❑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.***

❑ Bedwetting
❑ Blood in Stool
❑ Breathing Difficulty
❑ Confusion
❑Consciousness Loss
❑Constipation
❑ Other: ________________________________
❑Coughing
❑Diarrhea
❑Dizziness
❑Falling
❑Gait Unsteadiness
❑Hearing Loss
❑Lightheadedness
❑Memory Problems
❑Muscle Weakness
❑Nervousness
❑Panic Attacks
❑Pulse Irregularity
❑Sleep Problems
❑Seizures
❑Tingling in Arms/Leg
❑Tremors
❑ Vision Changes
❑ Vomiting

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.

		Client		Family	Comment
Problem	**Now**	**Past**	**Never**	**History**	**(Indicate family member relationship to client)**
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**

Revised December, 2014

Prime Behavioral Health, LLC

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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)

______________________________ ____________
Client Signature **Date**

* *

Revised 10/15

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We like to keep your information current. 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
______________________________	______________________________
______________________________	______________________________
______________________________	______________________________

Signature ___________________________________ Date_______________

****

APPOINTMENT REMINDERS BY PHONE, TEXT AND/OR EMAIL

We can now send you appointment reminders by email or SMS text. **PLEASE READ THE FOLLOWING:** The appointment reminder will include only the date and time of your appointment and your service provider's name. We will not encrypt the messages. Health care information sent by regular e-mail or SMS text 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 or SMS text, please confirm that you accept responsibility for these risks, and will not hold us responsible for any event that occurs after we send the message.

Failure to receive appointment reminder by call, SMS text, or email does not release the responsible party of any responsibility for a charge that may be incurred for a missed appointment or late cancellation (less than 24 hours). You are responsible for keeping the card that is available for you at the window when you schedule your appointments or for appointments made by phone.

By checking a box below that enables E-mail reminders or SMS text reminders, and entering an email address or phone number, you acknowledge that you have received the information shown above and acknowledge your consent.

☐ Enable email reminders
☐ Enable SMS text reminders
☐ Phone call only

Recipient email: [ ]

Recipient Mobile Number: [ ]