CLIENT INFORMATION FORM

For Office Use Only
Provider: ____________
DX: ____________

PLEASE FILL OUT THIS FORM COMPLETELY

TODAY'S DATE: ______________________

CLIENT NAME: ____
(LAST) (FIRST) (MIDDLE INITIAL)

STREET ADDRESS: ____

CITY: ______________ STATE: ______________ ZIP: ______________

PRIMARY PHONE: (____) ______________ HOME/CELL/WORK (PLEASE CIRCLE)

SECONDRY PHONE: (____) ______________ HOME/CELL/WORK (PLEASE CIRCLE)

CLIENT SOCIAL SECURITY#: ______-______-______ SEX: MALE / FEMALE

DATE OF BIRTH: __________ MARITAL STATUS: __________ RACE/ETHNICITY (OPTIONAL): __________

CURRENT PHARMACY PHONE: ____

IS CLIENT UNDER AGE 18: **YES / NO**
IF YES NAME OF PARENT/LEGAL GUARDIAN OF CHILD: ______________________________
DO YOU HAVE THE RIGHTS TO GIVE CONSENT OR MAKE DECISIONS FOR THE PATIENT? **YES/ NO**
IF YES, PLEASE PROVIDE PROPER DOCUMENTATION TO THIS EFFECT

REFERRED BY: FRIEND OR FAMILY / PCP/ OTHER MD / INSURANCE / PHONE BOOK / INTERNET / OTHER

PCP NAME: ______________ PCP PHONE: (____) ______________ FAX: (____) ______________

THERAPIST NAME: ______________________ PHONE: (____) ______________

CURRENT OCCUPATION: ____

EMPLOYER/SCHOOL (NAME AND ADDRESS): ______________________________

____

INSURANCE INFORMATION

INSURANCE COMPANY (NAME AND ADDRESS): ______________________________

____

MEMBER ID NUMBER/MEDICAID# ______________ GROUP/PLAN/POLICY#: ______________

PHONE # FOR MENTAL HEALTH BENEFITS/SERVICES: (____) ______________

POLICY HOLDER NAME: ______________________ DATE OF BIRTH: ______________

POLICYHOLDER'S ADDRESS: ____

CITY: ______________ STATE: ______________ ZIP: ______________ SEX: MALE / FEMALE

HOME PHONE: (____) ______________ WORK PHONE: (____) ______________

POLICYHOLDER'S SOCIAL SECURITY #: ______________ MARITAL STATUS: ______________

POLICYHOLDER'S EMPLOYER (NAME AND ADDRESS): ______________________________

____
(ADDRESS) (CITY) (STATE) (ZIP)

SECONDARY INSURANCE: N/A (Please skip ahead if this does not apply)

____

____

MEMBER ID NUMBER/MEDICAID# ____________________ GROUP/PLAN/POLICY#: __________

PHONE # FOR MENTAL HEALTH BENEFITS/SERVICES: (____)____________________

POLICY HOLDER NAME:____________________ DATE OF BIRTH: __________

POLICYHOLDER'S ADDRESS: ____________________

CITY: __________ STATE: __________ ZIP: __________ SEX: MALE / FEMALE

HOME PHONE: (____)__________ WORK PHONE: (____)__________

DID YOU OBTAIN <u>AUTHORIZATION</u> FOR SERVICES FROM YOUR INSURANCE COMPANY? YES / NO / NOT REQUIRED

AUTHORIZATION NUMBER: ____________________

<u>EMERGENCY CONTACT INFORMATION</u>

EMERGENCY CONTACT: ____________________ RELATIONSHIP: __________

STREET ADDRESS: ____________________

CITY: __________ STATE: __________ ZIP: __________ SEX: MALE / FEMALE

PRIMARY PHONE: (____)__________ HOME / CELL / WORK (PLEASE CIRCLE)

SECONDRY PHONE: (____)__________ HOME / CELL / WORK (PLEASE CIRCLE)

SPOUSE'S NAME (IF NOT EMERGENCY CONTACT): ____________________

PRIMARY PHONE: (____)__________ HOME / CELL / WORK (PLEASE CIRCLE)

SECONDRY PHONE: (____)__________ HOME / CELL / WORK (PLEASE CIRCLE)

<u>RELEASE OF INFORMATION NOTICE</u>

WE CANNOT RELEASE INFORMATION OF ANY KIND, INCLUDING INFORMATION ABOUT APPOINTMENTS, BILLING, AND/OR PRESCRIPTION REFILLS TO ANYONE OTHER THAN THE CLIENT OR PARENT/LEGAL GUARDIAN OF THE CLIENT.

<u>PLEASE SEE THE RECEPTIONIST</u> IF YOU WOULD LIKE A <u>RELEASE FORM</u> TO ALLOW US TO SPEAK TO SOMEONE OTHER THAN YOURSELF REGARDING YOUR CARE WITH US.

<u>CLINIC SATISFACTION</u>

MAY WE CONTACT YOU BY PHONE OR MAIL REGARDING SATISFACTION WITH SERVICES? YES OR NO

____________________ ____________________

SIGNATURE OF CLIENT OR LEGAL GUARDIAN DATE

AUTHORIZATIONS AND CONSENTS

CLIENT NAME: ______________________ GUARDIAN'S NAME (IF CLIENT IS UNDER 18): ______________________

1. *Authorization for Release of Information for Insurance Submission and Payment*

If you wish to have our office file your insurance, please present your insurance card. Some companies pay fixed allowances for treatment and others pay a percentage of the charge. **It is your responsibility to pay for any deductible amount, co-pay, any non-covered service, or service in which you are ineligible.** You are responsible for obtaining prior authorization for treatment from your insurance carrier. Failure to obtain authorization may result in increased financial expenses for your services. Authorization of service and payment by the insurance company is contingent on eligibility (at time of service) and benefits available. It is your responsibility to pay co-pay at each visit. I hereby authorize release of information necessary to file a claim with my insurance company and assign benefits directly to the therapist or group indicated on the claim. I hereby authorize release of information (including diagnosis) necessary for treatment and processing of claims for insurance reimbursement. **I understand I am financially responsible for any balance not covered by my insurance.**

____
Signature of Consumer/Legal Guardian/Legal Representative

2. *Authorization to Release Information to PCP*

Communication between behavioral health providers and your primary care physician is important to ensure that you receive comprehensive and quality health care. I hereby authorize release of my protected health information related to my evaluation and treatment to my primary care physician (PCP). I understand this information may include diagnosis, treatment plan, progress and medication information if necessary. I understand that I may revoke this consent in writing at any time except to the extent that it has been relied upon.

____
Signature of Consumer/Legal Guardian/Legal Representative

3. *Failed Appointments*

I agree to notify this office **at least twenty-four (24) hours** prior to my scheduled appointment if I decide to cancel/change. I understand I will be charged **a fee of $50.00** for an appointment not kept or cancelled at least 24 hours in advance. I also understand that this charge is **not** the co-pay amount and is **not** reimbursable by my insurance.

____
Signature of Consumer/Legal Guardian/Legal Representative

4. *Client Rights and Responsibilities*

A Person Receiving Services is Entitled to:

A. Mental Health/Chemical Dependency services in accordance with standards of professional practice, appropriate to his/her needs and designed to give him/her a reasonable opportunity to improve his/her condition.
B. Humane care, protection from harm, and to be treated with dignity and respect.
C. The right to participate in the development and review of his/her treatment plan, including the known effects of receiving and not receiving such treatment, or alternative treatment, if any.
D. The right to receive treatment in the least restrictive settings.
E. The right to review his/her own record in the presence of the primary therapist, unless the primary therapist's professional judgment deems this to be potentially detrimental to the person.
F. The right to confidential maintenance of all his/her identifying treatment information; no disclosure of such information without his/her written authorization, except in cases of medical emergency, by court order, or when otherwise dictated by law.
G. The right to register complaints and to have his/her complaints heard and action taken, if required, promptly.
H. The right to waive any of his/her rights, if the waiver is given voluntarily, knowingly, and in a competent state of mind. The waiver may be withdrawn at any time.

______________________________ ______________
Signature of Consumer/Legal Guardian/Legal Representative Date

5. ***Consumer Consent for Use/Disclosure of Health Care Information***
I understand that the consumer's health information is private and confidential. I understand that this office works very hard to protect the consumer's privacy and preserve the confidentiality of the consumer's personal health information.

I understand that my Provider may use and disclose the consumer's personal health information to help provide health care to the consumer, to handle billing and payment, and to take care of other health care operations. In general, there will be no other uses and disclosures of this information unless I permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual. Examples would be if a consumer threatened to hurt someone or if child abuse is reported.

My Provider has given me a detailed document called the "Notice of Privacy Practices" in my orientation handbook. It contains more information about the policies and practices protecting the consumer's privacy. I understand that I have the right to read the "Notice" before signing this agreement.

My Provider may update this "Notice of Privacy Practices." If I ask, the Privacy Officer or other appropriate administrative employee, they will provide me with the most current "Notice of Privacy Practices."

In effort to protect the individual consumer's PHI, we utilize an electronic scanning system to store medical records of consumers who have been discharged from treatment. This electronically scanned document is an exact photo-duplicate of the paper record and is by law accepted as the original document.

Under the terms of this consent, I can ask my Provider to limit how the consumer's personal health information is used or disclosed to carry out treatment, payment or health care operations. I understand that my Provider does not have to agree to my request. If my Provider does not agree to my request, I understand that my Provider would follow the agreed limits. Requests must be made in writing and my Provider will provide a form for this purpose by request.

I may cancel this consent in writing at any time by doing one of the following:

- Signing and dating a form called "Revocation of Consent for Use and Disclosure of Health Care Information" or
- Writing, signing, and dating a letter to my provider. If I write a letter, it must say that I want to revoke my consent to authorize the use and disclosure of the consumer's personal health information for treatment, payment and health care operations.

If I revoke this consent, my Provider does not have to provide any further health care services to the consumer or may require that the consumer pay directly for any service rendered.

My signature below indicates that I have been given the chance to review a current copy of "Notice of Privacy Practices." My signature means that I agree to allow my Provider to use and disclose the consumer's personal health information to carry out treatment, payment, and health care operations.

____ ________________________
Signature of Consumer/Legal Guardian/Legal Representative Date

6. ***Consent for Treatment Authorization***
I authorize and request my behavioral professional to carry out psychological evaluations, psychiatric evaluations, treatment and/or diagnostic procedures that now, or during the course of my treatment become, advisable. I understand the purpose of these procedures will be explained to me upon my request and that they are subject to my agreement. I also understand that while the course of my treatment is designed to be helpful, my behavioral healthcare professional can make no guarantees about the outcome of my treatment. Further, the psychotherapeutic process can bring up uncomfortable feelings and reactions such as anxiety, sadness, and anger. I understand that reactions will be worked on between my behavioral healthcare professional and me. With these understandings, I hereby authorize treatment for myself. I give permission for the Clinical Staff to develop a treatment plan and provide treatment.

____ ________________________
Signature of Consumer/Legal Guardian/Legal Representative Date

PATIENT TREATMENT AGREEMENT
Sunita Gupta MD PC

***It is understood that if a controlled substance is prescribed, Dr. Gupta will be the only provider prescribing the medication. Prescribing of these medications will be discontinued and/or the doctor patient relationship will terminate if you obtain these medications or similar medication from another physician without our knowledge.

****Please note refills will not be made during after-hours or on weekends*. You may leave a message on the office line 24 hours/day. Requests will be handled ONLY during office hours. Please plan for medication refills and make appointments at least one week ahead of time.

I will not share, sell, or trade my medication with anyone. I understand that if I breach this agreement my physician will be forced to stop prescribing controlled substances. Our office does not refill medications for lost or stolen prescriptions. If you have difficulty with withdrawal symptoms, you should go to the nearest emergency room.

I understand that my medications are my responsibility; I understand that lost or stolen medications will not be replaced under any circumstances.

I understand that refills of controlled substances will be made only at the time of an office appointment during normal business hours. Refills for controlled medications cannot be made over the phone. We do not mail prescriptions to patients or pharmacies.

I agree to take my medication exactly as prescribed. I understand that use of my medication at a greater rate will result in my being without medication for a period of time. **Our office does not provide early refills for medications**; any dosage changes must be approved by the doctor. Refills will normally be handled within 3-5 business days (not including Holidays or weekends)

I agree to adhere to the **payment policy** outlined by the office and insurance companies in conjunction. I agree to reimburse the fees of any collection agency, which may be based on a percentage at a maximum of 33% of the debt, and all costs, and expenses, including reasonable attorney's fees, we incur in such collection efforts.

I agree to conduct myself in a *courteous manner at all times*. Inappropriate language or behavior toward the administrative staff will not be tolerated.

I understand that violation of the above may be grounds for termination from this practice.

PATIENT SIGNATURE ____________________ DATE ____________________

CLIENT QUESTIONNAIRE: *ADULT**
NOT FOR CLIENTS UNDER AGE 15

Name ______________________________ Date ______________________________

CURRENT PHONE #______________________________
CURRENT ADDRESS______________________________

Has your address changed since last visit? ☐ Yes ☐ No ☐ N/A ***If Yes to either please tell receptionist***
Has your insurance changed since last visit? ☐ Yes ☐ No ☐ N/A

Over the last **2-4 weeks**, or since your last visit, how often have you been bothered by any of the following problems? Please **CIRCLE the problem which applies.**

0-Not at all 1-Several days 2-More than half the days 3-Nearly every day

1.	Little interest or pleasure in doing things	0	1	2	3
2.	Feeling down, depressed, hopeless, or crying spells	0	1	2	3
3.	Trouble falling or staying asleep OR sleeping too much	0	1	2	3
4.	Feeling tired or having little energy	0	1	2	3
5.	Poor appetite *OR* overeating, weight loss or gain, using laxatives or diet pills to loose weight, binging or vomiting food	0	1	2	3
6.	Feeling bad about yourself — that you are a failure or have let yourself or your family down	0	1	2	3
7.	Trouble concentrating or being organized, easily distracted, forgetting appointments, not finishing projects, losing things.	0	1	2	3
8.	Moving or speaking slowly, restless or fidgety	0	1	2	3
9.	Are you currently pregnant, planning on becoming pregnant, or breast feeding? **YES NO**				
10.	Thoughts that life is pointless OR that you don't care about living. Any thoughts or plans on hurting yourself **YES NO**	0	1	2	3
11.	Anxiety, panic attacks, heart racing, shaking hands, shortness of breath, feeling tense, difficulty relaxing or unwinding. Worried about things?	0	1	2	3
12.	Difficulty handling normal stress or keeping up with your normal routine.	0	1	2	3
13.	Less attraction to, or appreciation of, people who care about you	0	1	2	3
14.	Difficulties with husband/wife, partner/lover or boyfriend/girlfriend	0	1	2	3
15.	The stress of caring for children, parents or others. Stress at work or at school	0	1	2	3
16.	Being irritable, easily annoyed or angered, thoughts or plans on hurting others	0	1	2	3
17.	Hearing voices or seeing things when no one is there. Feeling paranoid or racing thoughts.	0	1	2	3

18. Are you abusing drugs and or alcohol? **NO YES, Explain:**
19. Are you currently taking SUBOXONE or CLOZARIL? **NO YES**

20. If you are receiving medication now is it working? **Not at all Somewhat Definitely helping**
Are you having any side effects? **NO YES, Explain:**
21. Have you seen any other medical professional and been prescribed any medication? **NO YES**
*** Including over-the-counter, prescription, vitamins and herbal supplements**
22. Have you recently been to or discharged from a hospital? **NO YES**
23. Are you applying for SSI, Disability, FMLA, Worker's Comp, or in need of a Legal or Drug & Alcohol Evaluation ? **NO YES: If yes please tell receptionist, this will require additional info and paperwork.**

CLIENT QUESTIONNAIRE: *ADULT**

NOT FOR CLIENTS UNDER AGE 15

NAME: ______________________ **DATE:** ______________________

DATE OF BIRTH: ______________________ **AGE:** ______________________

PLEASE FILL OUT THIS FORM COMPLETELY

For what problem(s) do you seek help today?

____

____

____

____

____

Circle **all that may apply:** Depression / Anxiety / Panic Attacks / Anger / Irritability / Attention / Concentration / Sleep Problems / Need to Change Doctors / Disability / FMLA / Immigration / Substance Abuse Treatment / Legal Issues

About **how long have these been problems?**	☐ *days*	☐ *weeks*	☐ *months*	☐ *years*
Is it	☐ *getting worse*	☐ *about the same*	☐ *getting better*	
Have you had similar problems before?	☐ *Yes*	☐ *No*		

PLEASE COMPLETE:

If you answer YES to any of the following questions please explain on space provided or attach explanation.
(Use back of form if more space is needed)

MEDICAL HISTORY

1. Please list your current medications.
***Including over-the-counter, prescription, vitamins, dietary & herbal supplements**

____

____

____

2. Medical Problems: ______________________

____

____

____

3. Are you allergic to any medication? **YES / NO**

____

____

4. Please list any operations that you have had. ______________________

____

PSYCHIATRIC HISTORY

5. Are you currently under the care of a therapist, counselor, psychologist, psychiatrist, etc? **YES / NO**
If so, who? ______________________

6. Have you ever been to see a therapist, counselor, etc. in the past? **YES / NO**

____

7. Are you taking or have you been treated in the past with psychiatric medication? **YES / NO**
Please list, include strength, dosage, length of trials, and positive or negative effects of medications.

8. Have you ever been hospitalized because of an **emotional, nervous, psychiatric**, or **substance abuse problem?** **YES/NO**

9. What activities do your symptoms prevent you from performing? (Example: work, school, sleep)

10. Have you ever been treated with ECT (shock treatment) / TMS / VNS / CLOZARIL / SUBOXONE ? **YES / NO** ______

SUBSTANCE USE HISTORY

11. Do you smoke or use tobacco products? **YES / NO** If so how often? ______

12. Do you drink alcoholic beverages? **YES / NO** If so how often? ______

13. Do you currently or have you previously abused any illegal or legal drugs? **YES / NO**

PERSONAL AND SOCIAL HISTORY

14. Did you suffer from any traumatic experiences as a child? **YES / NO**

15. Did you have any juvenile behavioral problem(s)? **YES / NO**

Please check any problem(s) that you have experienced.

Running Away	Fighting	Skipping School	Drug or Alcohol Problems	Lying
Shoplifting	Cruelty to Animals	Fire Setting	Juvenile Court	

16. **Please check your Marital Status:** Single Married Widowed Separated Divorced

17. How many times have you been married? ______ N/A

18. If currently in a relationship, is it going well? **YES / NO**

19. Are there any problems? **YES / NO**

20. Do you have children? **YES / NO** If so, how many and what age(s) ______

21. Are you having any problems with your child(ren)? **YES / NO**

22. What type of relationship do you have with your parent(s)? ______

23. How many siblings do you have? Brother __________ Sister__________

24. How is your relationship with your siblings?

____

____

24. With whom do you presently live with?______________________________________

25. What are your religious beliefs?____

26. Please list your personal hobbies and social interests?

____

____

____

EDUCATIONAL AND OCCUPATIONAL HISTORY

27. What is your highest level of education completed? ___________________________

29. Have you ever been in the armed forces? **YES / NO**
Years of Enlistment. __________________ Rank ________________
Any physical combats? **YES/NO** Honorable discharge? **YES/NO**

30. Are you currently employed? **YES / NO**
If so, please provide company name, job title, and years of employment.

____

____

FAMILY HISTORY

31. Has anyone in your family (blood relative) suffered from emotional problems, nervous problems, depression or any other stress conditions? **YES/NO**

____

____

32. Has anyone in your family (blood relative) had problems with drugs or alcohol? **YES/NO**

____

____

33. Do any medical problems run in your family? **YES/NO**

____

____

34. Has anyone in your family ever attempted or committed suicide? **YES/NO**

____

____

Medication Consent Form

Patient Name: ___________________________ **DOB:**________________

My provider, Dr. Sunita Gupta, has educated me regarding the medication that has prescribed to ☐ me, ☐ my child, ☐ or the person for whom I am legal guardian and I consent to the administration of this medication. I have been informed of the reason or purpose for which this medication was prescribed. I have been educated regarding possible side effects of this medication including side effects other that those already explained to me, and that I should promptly inform the doctor or the doctor's staff if there are unexpected changes in my condition, possible drug and or food interactions that may occur while taking the medication, and possible effects of this medication if this person taking the medication becomes pregnant. It is recommended that women who are or may become pregnant, or are breast-feeding discuss this with their doctor before taking any medication. I have been informed that the medication that I am being prescribed, ______________________________, Has not received FDA approval for this use, I further understand that the side effects of use in treatment of my condition have not been determined/ publicized at this time. Having been advised of this, I consent to the use of this medication without FDA approval for this use. I have been informed that I should report that I am taking this medication to any other health care provider who's treating me for any condition. I have informed my provider of any food and/ or drug allergies that I have. I have informed my provider of all medical conditions for which I am receiving treatment. My provider has informed me about controlled substances, risk of dependence, potential for tolerance, abuse, misuse, DEA policy, Office Policy regarding prescriptions for controlled substances. I have been advised to abstain from Alcohol/ Drugs/Herbal medicines. I have been advised that most psychiatric medications can cause drowsiness, so I agree to abstain/ exercise caution while driving and/or operating heavy equipment.

______________________________ ________________

Patient or Parent/Guardian Signature Date

______________________________ ________________

Dr. Sunita Gupta or Physician Staff Date