Mental Health Alliance
815 Flack Avenue, Alliance NE 69301
Phone 308-762-2723 Fax 308-217-4277
www.Mental HealthAlliance.biz

NEW PATIENT PAPERWORK

Date: _____ Referred by: _____
Patient Name: _____Previous Name (if any):_____
Parent or Legal Guardian name (if applicable):_____
Who is responsible for this account? _____Relationship to patient:_____
Patient Date of Birth: _____ Patient Age: _____Patient Social Security#: _____
Pt. Gender: ☐Male ☐ Female Are you a Veteran? ☐Yes ☐No
Pt. Marital Status: ☐ Single ☐Married ☐Widowed ☐Divorced ☐Separated ☐ Significant Other
Spouse name (if applicable): _____ Spouse Date of Birth:_____
Home Address: _____ City, State, Zip:_____
Billing Address (if different): _____City, State, Zip:_____
Home Phone: _____ Cell Phone: _____Other:_____
Can we leave a message at any of these numbers? ☐ Yes ☐ No Message#:_____
E-mail address: _____ Would you like to be contacted by e-mail? ☐ Yes ☐ No
Do you have a primary care provider? ☐ Yes ☐ No Provider name:_____
Pharmacy: _____Location: _____
Do you have a living will or durable power of attorney? ☐ Yes ☐ No ☐ I don't know ☐ I would like more information
What is your primary language? ☐English ☐ Spanish ☐Other:_____
Do you speak any other languages? ☐Yes ☐No If yes, please specify:_____
Race: ☐African American ☐Caucasian ☐Hispanic ☐Native American ☐Other:_____
Religious preference: ☐ Atheist ☐ Catholic ☐Christian ☐No preference ☐Other:_____
Are you employed? ☐Yes ☐No If yes, who is your employer?_____
Are you a student? ☐Yes ☐No If yes, where do you attend school?_____
Are you a ward of the state? ☐Yes ☐No If yes, who is your caseworker?_____

Do you have Medicare? ☐ Yes ☐ No If yes, what is your Medicare ID number?_____
Do you have Medicaid? ☐Yes ☐No If yes, what is your Medicaid ID number?_____
Do you have insurance coverage? ☐ Yes Please provide the information requested below.
☐ No If no, please speak with our office manager or billing manager.

NOTICE: IF YOU DO HAVE INSURANCE AND DO NOT PROVIDE US WITH CORRECT INFORMATION, YOU WILL BE RESPONSIBLE FOR ALL CHARGES

PRIMARY INSURANCE

Subscriber (cardholder) Name: _____DOB: _____
Relationship to patient: _____ Subscriber Social Security #:_____
Insurance Company: _____Effective Date: _____
ID Number: _____ Group Number: _____
Subscriber Mailing Address: _____ City, State, Zip: _____
Subscriber Phone Number: _____ Alternate Phone:_____

SECONDARY INSURANCE

Subscriber (cardholder) Name: _____DOB: _____
Relationship to patient: _____Subscriber Social Security#: _____
Insurance Company: _____Effective Date: _____
ID Number: _____ Group Number: _____
Subscriber Mailing Address: _____ City, State, Zip: _____
Subscriber Phone Number: _____ Alternate Phone:_____

Mental Health Alliance
815 Flack Avenue, Alliance NE 69301
Phone 308-762-2723 Fax 308-217-4277
www.Mental HealthAlliance.biz

Patient name:_____

INFORMED CONSENT

By signing this form, I acknowledge that I have been offered a copy of Mental Health Alliance's Consent to Treat and that if I have any questions or concerns regarding the informed consent, I can contact Mental Health Alliance. I understand that by signing this form I am giving my permission for myself or my child/dependent to receive services and medication management by Mental Health Alliance.

_____

Client (or parent/guardian's) Signature ***Date*** ***Staff Initials***

ASSIGNMENT OF INSURANCE BENEFITS AND AUTHORIZATION TO RELEASE MEDICAL INFORMATION

By signing this form, I authorize Mental Health Alliance's office to release any information necessary to expedite insurance, EAP, or self-pay claims. I understand that I am responsible for any, and or all charges (i.e., copayments, deductibles, payment plans, and self-pay plans) based on insurance coverage or other arrangements. I also understand that if I do not have or provide insurance information, my account will be considered Self Pay and I am responsible for ***ALL*** charges at the time of service.

client (or parent/guardian's) Signature_____ ***Date:***_____***Staff Initials***_____

NOTICE OF PRIVACY PRACTICES

By initialing below, I acknowledge that I have been offered a copy of the Notice of Privacy Practices for Mental Health Alliance and if I have any questions or concerns regarding the Notice or my privacy rights or would like a copy of this form, I can contact Christine's office or visit **https://mentalhealthalliance.biz**

Client (or parent/guardian's) Initials_____ ***Date***_____***Staff Initials***_____

CLIENT RIGHTS AND RESPONSIBILITIES STATEMENT

By initialing below, I acknowledge that I have been offered a copy of the Client's Rights and Responsibilities Statement for Mental Health Alliance and if I have any questions or concerns regarding the Statement or my responsibilities or would like a copy of this form, I can contact Christine's office or visit **https://mentalhealthalliance.biz**

Client (or parent/guardian's) Initials_____ ***Date***_____

DESCRIPTION OF SERVICES

Medication Management is the use of prescription medication to control symptoms of behavioral health problems. A prescription for medication can be written by a physician (MD), Physician Assistant (PA) or Nurse Practitioner (APRN).

There are many different medications available, and the med provider decides, after gathering a full history, which one(s) to use. After a patient starts medication, the provider generally will want to see him/her back in the office in two weeks to see how he/she is doing. Often it takes time to find the most effective medication for a patient. Dosages might need to be changed, different medications tried, others added to help with side effects, etc. Part of medication management now may include DNA testing. Once the patient is stable, appointments can be spaced out to be several months apart. If a provider decides medication is appropriate for a patient, they will discuss the risks and benefits of their options. Initial appointments generally last 60 minutes and follow-up visits are 15 minutes.

Sometimes a person experiences an acute problem situation and medication helps during this time. When the situation resolves itself, the patient can discontinue using medication. Other patients have chronic conditions and use medication on an ongoing basis.

By initialing below, I acknowledge that I have been offered a copy of the description of med management services for Mental Health Alliance and if I have any questions or concerns regarding services or would like a copy of this form, I can contact Mental Health Alliance or visit www.mental healthalliance.biz.

Client (or parent/guardian's) Initials_____ ***Date***_____ ***Staff Initials***_____

_____

Staff Signature ***Date***

Mental Health Alliance
815 Flack Avenue, Alliance NE 69301
Phone 308-762-2723 Fax 308-217-4277
www.Mental HealthAlliance.biz

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name _____ Date of Birth _____

Address _____ Telephone _____

Information to be disclosed:

☐ **Pick Up Prescriptions**

Person(s) to whom this information may be given *(verification of identification may be requested).*

_____ _____

_____ _____

☐ **Pick Up Medications**

Person(s) to whom this information may be given *(verification of identification may be requested).*

_____ _____

_____ _____

☐ **Appointment Information**

Person(s) to whom this information may be given *(verification of identification may be requested).*

_____ _____

_____ _____

☐ **Coordination of Care between Health Care Providers**

I, _____, hereby authorize Mental Health Alliance to converse with and to disclose information regarding my behavioral health treatment including, but not limited to, any treatment for alcohol and drug abuse, mental disorder or developmental disability to _____ *(Primary Care Provider)* for the specific purposes of providing coordination and continuity of care. My primary care physician shall not be entitled to any information beyond such treatment information without my written consent. I understand that this primary care consent form shall remain in effect throughout the course of treatment.

☐ **I DO NOT** give consent to release information to my Primary Care Physician

I certify that this request has been made voluntarily and that the information given above is accurate to the best of my knowledge. I have been informed what information will be given, its purpose, and who will receive the information. Information is protected by Federal confidentiality rules (42 FR Part 2). I understand that I may revoke this consent at any time. This consent automatically expires after one year or on completion of treatment, unless renewed annually by initialing and dating the bottom of this form. Revocation of someone will be indicated by striking through the name and initialing and dating.

Signed_____ _____
(Patient or Personal Representative) (Date)

Signed _____ _____
(Witness) ` (Date)

Mental Health Alliance
815 Flack Avenue, Alliance NE 69301
Phone 308-762-2723 Fax 308-217-4277
www.Mental HealthAlliance.biz

Mental Health Alliance

Scheduling and Payment information

Payment for providers in this office are due at the time of service. This includes self-payments for those without insurance as well as patients who will be paying co-payment amounts and deductible amounts.

Under the Health Insurance Portability Act of 1996 (HIPAA), it is now a federal crime to defraud private insurance companies. Failure to collect co-pays is also a violation of the False Claims Act. Violations can result in fines and criminal prosecution for providers.

According to the law, we cannot routinely waive co-insurance or co-payment fees. If you feel that you are unable to pay the full amount, you must speak with the billing manager to see if there are arrangements that can be made for payment following a payment schedule. You must do this **BEFORE** your first appointment.

As providers, we are responsible for collecting all payments due from the patient, after which we file with your insurance company to receive the amount to be paid by insurance. If we do not collect co-insurance payments at the time of service, and a patient subsequently refuses to pay, we can be held accountable for that, and could potentially face criminal charges, and be deactivated from that insurance company as a provider for anyone using that insurance.

We are obligated to report to your insurance company any refusal of payments or delinquent payments. For the patient, not paying your co-payments could result in losing your insurance.

If you believe you will not be able to pay in full for an appointment, you must make payment arrangements with the billing manager in advance of the appointment.

If you do not make payment arrangements in advance and cannot pay for your appointment, we may reschedule your appointment.

I acknowledge that I have received a copy of the payment information for Mental Health Alliance and affiliate providers.

Patient name (printed_____

Signed_____ _____
(Patient or Personal Representative) (Date)

Signed _____ _____
(Witness) ` (Date)

Mental Health Alliance
815 Flack Avenue, Alliance NE 69301
Phone 308-762-2723 Fax 308-217-4277
www.Mental HealthAlliance.biz

Patient name:_____

Health History for New Patients

Your answers on this form will help your provider get an accurate history of your medical concerns and conditions. Please complete this entire packet. If you cannot remember specific details, please provide your best guess.

Main reason for today's visit: _____

Other concerns: _____

If you have seen any other providers for psychiatric medications, please list their name and when you saw them:

_____

Please list the names of any current or previous therapist/counselor and when you saw them:

_____

Please list any previous psychiatric hospitalizations, include the name or city of hospital and dates:

_____

In the past **2 weeks**, have you been bothered by: little interest or pleasure in doing things? □ **No** □ **Yes**
Feeling down, depressed, or hopeless? □ **No** □ **Yes**

MEDICATIONS: Please list (or show us your own printed record) all prescriptions and non-prescription medications, vitamins, home remedies, birth control pills, herbs, inhalers, etc. Use the back of this form if you need more room and let us know you wrote there.

□ **I DO NOT TAKE ANY MEDICATIONS**

Medication	Dose (e.g., mg/pill)	How many times per day?

_____ □ more on back

Allergies or intolerance to medications (include type of reaction): □ **NONE**_____

_____

_____

Symptoms:

Please check any behaviors or symptoms that you have frequently:

___aggression	___emotional	___recurring thoughts	___Alcohol dependence
___Fatigue	___restless (can't sit still)	___anger	___forgetful
___sexual difficulties	___antisocial behavior	___hallucinations	___sick often
___anxiety	___heart palpitations	___sleeping problems	___avoiding people
___hopelessness	___social difficulties	___chest pain	___impulsivity
___suicidal thoughts	___crying	___Inattention	___depression
___thoughts disorganized	___Irritability	___trauma/abuse history	___judgment errors
___difficulties in school/work	___trembling/shaking	___disorientation	___loneliness
___withdrawing	___distractibility	___memory impairment	___worrying
___dizziness	___mood shifts	___phobias and fears	___drug use
___nightmares	___changes in eating habits	___panic attacks	___elevated mood
___paranoid	___other(s) (specify)_____		

Mental Health Alliance
815 Flack Avenue, Alliance NE 69301
Phone 308-762-2723 Fax 308-217-4277
www.Mental HealthAlliance.biz

Women's Health History

Total number of pregnancies: _____ Total number of births: _____
Date (month/day if known) of the last menstrual period (if you are still menstruating): _____
Age you started your menstruation cycle: _____
Age at end of menstruation cycle_____

OTHER HEALTH ISSUES:

Tobacco Use:

1. Do you smoke cigarettes? Yes No Never have (If you have never smoked, skip to the Alcohol Use section now)
2. Do you want to quit smoking? Yes No Maybe Have you tried quitting in the past? Yes No
3. Quit date: _____ How many months/years did you smoke? _____
4. Approximately how many packs a day do/did you smoke? _____

Other tobacco use: Pipe Cigar Snuff Chew e-cigarettes vaping Other: _____

Alcohol& Drug Use:

1. # of caffeinated drinks per day_____ Type: Soda Coffee Energy Drinks
2. # of alcoholic drinks per week _____ Type: Beer Wine Liquor
3. Have you ever felt like you should cut down on your drinking? Yes No
4. Do people often criticize you about your drinking? Yes No
5. Have you ever felt bad or guilty about your drinking? Yes No
6. Have you ever had a drink first thing in the morning? Yes No
7. Do you use marijuana or recreational drugs? Yes No
8. Have you ever used needles to inject drugs? Yes No

SOCIAL HISTORY

1. What is your highest level of education (circle one):
   K 1 2 3 4 5 6 7 8 / 9 10 11 12 / GED 1 2 3 / 1 2 3 4 +
   Grade School High School Vocational School College
2. Marital Status: ___Single ___Married ___Divorced ___Separated ___Widowed ___Partner ___Other:_____
3. Spouse/Partner's name: _____ Number of children: _____
4. Number of grandchildren: _____ Number of great grandchildren: _____
5. Do you have any siblings? ___Yes ___No Number of sisters: _____ Number of brothers:_____
6. Who lives at home with you? _____
7. Are you employed? ___Yes ___No
   - If yes, who is your employer? _____ How long? _____
   - If you are not employed, choose the reason for your unemployment:___Retired ___In between jobs ___Leave of Absence ___Disabled ___Homemaker
     Other:_____
8. Do you have any beliefs or practices from your religion, culture, or otherwise that we should know about? Please indicate below
   - ☐ **No, I have no beliefs or practices that need to be included in my care.**
   - ☐ Beliefs or practices: _____

Sexual Activity

1. Are you currently sexually active? __Yes ___No
2. Your sexual partners have been: ___Male ____Female ____ Both
3. Birth control method, please circle: condom pill diaphragm vasectomy IUD Depo shot Implant none other_____

Mental Health Alliance
815 Flack Avenue, Alliance NE 69301
Phone 308-762-2723 Fax 308-217-4277
www.Mental HealthAlliance.biz

PERSONAL/FAMILY MEDICAL HISTORY: *Circle any of the following conditions for* ***you personally***. If you have a family member with any of the following conditions, please write their relationship to you, i.e. mother, brother, etc. ☐ I was adopted and/or don't know my family medical history ☐ No personal history to report

ADHD _____
Alcohol/Drug abuse _____
Allergies _____
Anemia _____
Anxiety _____
Arthritis _____
Asthma _____
Atrial fibrillation _____
Autism Spectrum Disorder _____
Back Injury _____
Bipolar _____
Bladder problems _____
Blood clots _____
Cancer, Type: _____ _____
Cataracts _____
Chronic Fatigue Syndrome _____
Chronic Pain _____
Cirrhosis _____
Concussion _____
Congestive Heart Failure (CHF) _____
Dementia _____
Diabetes _____
Ear infections _____
Eating disorder _____
Eczema _____
Endometriosis _____
Fibromyalgia _____
GERD/Heartburn _____
Glaucoma _____
Gout _____
Headaches _____
Hearing Loss _____
Heart attack _____
Heart Disease _____
Hepatitis, Type: A B C _____
High blood pressure _____
High Cholesterol _____
Irritable Bowel Syndrome (IBS) _____
Learning disabilities _____
Liver Disease _____
Kidney problems _____
Migraine Headaches _____
Motor Vehicle accident _____
Multiple Sclerosis (MS) _____
Neuropathy _____
Osteoporosis _____
Prenatal exposure to alcohol/drugs _____
PTSD _____
Schizophrenia _____
Seizure/Epilepsy _____
Sexually transmitted Disease _____
Skin Conditions: _____
Sleep apnea (Use CPAP) _____
Stomach Ulcer _____
Stoke / TIA _____
Suicide attempt _____
Thyroid_____
Traumatic Brain Injury (TBI) _____
Tuberculosis (TB) _____
Other _____
_____

Surgical History Procedure(s)
Please include date, if known

☐ Appendectomy_____
☐ Back/neck surgery_____
☐ Biopsy, Location: _____
☐ EGD (Stomach scope)_____
☐ Cataract_____
☐ C-section_____
☐ Colonoscopy_____
☐ Ear tubes_____
☐ ECT_____
☐ Oral surgery_____
☐ Gallbladder removal:_____
Circle one laparoscopic or abdominal
☐ Heart surgery_____
☐ Heart catheterization_____
☐ Hernia repair_____
☐ Hysterectomy:_____
Circle one Laparoscopic Vaginal Abdominal
☐ Joint surgery: _____
Which joint? _____
☐ Mastectomy_____
☐ Ovary removal: Right Left Both_____
☐ Sinus surgery_____
☐ Tonsillectomy_____
☐ Tubal Ligation _____
☐ Vasectomy_____
☐ Wisdom teeth-under anesthesia _____
☐ Other:_____