



INTAKE FORM – ADULT

Name: _____

Date of Birth: _____ Sex: _____ Marital status: _____

Address: _____

City, State, ZIP Code: _____

Home phone: _____ Cell phone: _____

Work phone: _____ Email: _____

(Mark * next to the best number where we can reach you)

Employed By: _____ Occupation: _____

Business Address: _____

City, State, ZIP Code : _____

Emergency Contact Person (Name/Phone Number):

Insurance Company: _____ ID#: _____

Primary Care Doctor (Name/Practice): _____

Phone Number: _____ Fax Number: _____

Would you like a letter to be sent to your primary care physician regarding today's visit: Yes / No

Referred by: _____ May I thank them: Yes / No

Signature: _____ **Date:** _____

PAST MEDICAL HISTORY

PAST MEDICATIONS	CURRENT MEDICATIONS

HOSPITALIZATIONS/SURGERIES	
DATE	REASON

MAJOR MEDICAL CONDITIONS	
(i.e. diabetes, hypertension, head traumas, cardiac problems, asthma, or other breathing problems, cancer, etc.)	
CONDITION	LENGTH OF TIME

PAST PSYCHIATRIC HISTORY	
(i.e. mental health and chemical dependency)	

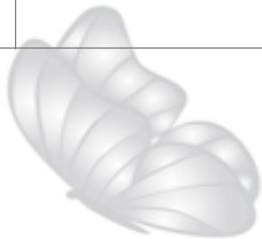
FAMILY MENTAL HEALTH & CHEMICAL DEPENDENCY HISTORY

ALLERGIES: _____

SUBSTANCE ABUSE HISTORY

(COMPLETE FOR ALL PATIENTS 12 AND OVER)

SUBSTANCE	AMOUNT	DURATION	FIRST USE	LAST USE
CAFFEINE				
TOBACCO				
ALCOHOL				
MARIJUANA				
OPIOIDS/ NARCOTICS				
AMPHETAMINES				
COCAINE				
HALLUCINOGENS				
OTHERS				



AUTHORIZATION FOR RELEASE OF INFORMATION

Print Name of Client

Date of Birth

If client is a minor:

Print Name of Parent/Guardian

Date of Birth

I hereby authorize **Achieve Medical Center**, to exchange information with:

Name of Agency/Person/Organization: _____

Address: _____

City, State, ZIP Code: _____

Phone No: _____

Fax No: _____

With the knowledge that such contact discloses the fact that mental health services have been/are being provided.

This disclosure of information is required for the following purpose(s):

- Evaluation
- Treatment Planning/Course
- Other _____

And will consist of the following types of information:

- Entire Record
- Dates / Results of Medical Assessments & Diagnoses
- Medication History
- Results of Psychological Testing
- Discharge Summary
- Educational Information
- Legal Information
- Other _____

The information and records released pursuant to this consent will not be used for any other purpose.

This consent becomes effective immediately. This consent may be revoked by the undersigned at any time. If not revoked, it shall terminate at the end of treatment with **Achieve Medical Center** I understand that I may receive a copy of this authorization. There is a risk that the person receiving information or documents pursuant to this authorization may re-disclose the information and documents in a manner that will no longer provide protection for the information and documents.

Signature of Client

Date: _____

Signature of Parent, Guardian or Conservator

Date: _____

- All requests for release of information must be in writing. If there are any parties to which you do not want to release this information. Please complete a Request for Special Privacy Protection (HF 04a).

CONSENT FOR TREATMENT

I hereby authorize and request **Achieve Medical Center, Professional Corporation**, to carry out psychiatric and psychological examination, evaluation, treatment and/or diagnostic procedures which 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 these are subject to my agreement. I fully understand that while the course of my treatment is designed to be helpful, **Achieve Medical Center, Professional Corporation**, can make no guarantees whatsoever about the outcome of my treatment. I also understand that the psychopharmacotherapeutic process can initiate and bring up uncomfortable feelings and reactions including, but not limited to anxiety, sadness, anger and physical side effects. I understand that this is a normal response to working through unresolved life experiences and that these reactions will be jointly worked on between my therapist and me.

Patient/Guardian Signature:

Date

GENERAL CONSENT TO TREATMENT IN CASE OF DEPENDENT/CHILD/MINOR

I am the legal guardian and/or representative of the patient and on the patient's behalf legally authorize **Achieve Medical Center, Professional Corporation**, to deliver mental health care services to the patient. I also understand that all policies described in this statement apply to the patient I represent.

Signature of Guardian/Legal Representative:

Date

Relationship to Patient: _____

HIPPA NOTICE OF PRIVACY PRACTICES

A federal law, known as the "HIPAA Privacy Rule" requires that we tell you how we may use and give out personal health information about you to others. This summary will tell you what our Privacy Notice contains.

HOW WE MAY USE AND SHARE YOUR PROTECTED HEALTH INFORMATION

We may use and share personal health information that is protected (PHI) to you or your personal representative. We may use and share this information:

- For healthcare treatment that doctors, nurses and other clinicians give you
- For certain business activities called "health care operations" and
- For payment.

Some examples of how we may use and share PHI about you without your written permission including sharing information:

- To report abuse, neglect, or domestic violence
- To prevent a serious threat to your other's health or safety
- To prevent public health problems
- To agencies that audit, investigate and inspect health programs for the public's health
- For lawsuits and other legal proceedings
- For research
- To the Government for specialized purposes, such as military or national security; and
- For worker's compensation.

YOUR RIGHTS

You have the following rights as described in our Notice:

- The right to ask us if we will put more limits on the way we use and share PHI about you
- The right to share confidential communications from us
- The right to see and get a copy of PHI about you
- The right to ask us for a report that describes how and with whom we share PHI about you.

If you have any questions regarding your rights or privacy, please inquire with our office or reference <http://www.hhs.gov/ocr/privacy>.

I hereby acknowledge that I have read a copy of this HIPAA Notice of Privacy Practices. I further acknowledge that I may obtain a copy if requested.

PATIENT (PRINT): _____

SIGNATURE: _____ DATE: _____

FOR PATIENTS UNDER THE AGE OF 18:

RESPONSIBLE PARTY (PRINT): _____

RELATIONSHIP TO PATIENT: _____

SIGNATURE: _____ DATE: _____

OFFICE POLICIES

Confidentiality:

Confidentiality is essential for effective psychiatric treatment. No information will be released without your consent, except for the following situations: By law, I am required to report suspected child or elder abuse, domestic violence, and take action when a patient is considered to be danger to themselves or other.

Payment Policy:

Scheduled appointment times are reserved specifically for you. Failure to provide 48 hours cancellation notice or missed appointments will be billed and your credit card will automatically be charged.

A credit card will be held on file to guarantee payment but will not be charged without notification.

Medication Policy:

You are responsible to make an appointment to see me in person at least once every 2 months to receive refills of your medications.

Requests for refills may take up to 48 hours to be available at your pharmacy and are not done on weekends or holidays.

Notify Achieve Medical Center of any side effects of your medication.

Notify Achieve Medical Center if you suspect or know that you are pregnant or if you plan to become pregnant in the near future.

Notify Achieve Medical Center any time another physician starts you on a new medication, or if there are significant changes in your psychiatric or medical condition.

Additional Services:

Services required outside of treatment session will be charged a fee. These will include consultations with other professionals, court appearances, and document preparation such as completing legal forms, conservatorship petitions, letters, etc.

I have read, understand and agree to the above policies.

Patient Name

Signature of Patient or Responsible Party (if patient is a minor)

Date

PATIENT ARBITRATION AGREEMENT

The contract below is an arbitration agreement. By signing this agreement, we are agreeing that any dispute arising out of the medical services you receive is to be resolved in binding arbitration rather than a suit in court. I believe the method of resolving disputes by arbitration is one of the fairest systems for both patients and physicians. Arbitration agreements between health care providers and their patients have long been recognized and approved by the California courts. By signing this agreement you are changing the place where your claim will be presented. You may still call witnesses and present evidence. Each party selects an arbitrator (party arbitrators), who then select a third, neutral arbitrator. These three arbitrators hear the case. This agreement generally helps to limit the legal costs for both patients and physicians. Further, both parties are spared some of the rigors of trial and the publicity that may accompany judicial proceedings. Of course, my goal is to provide medical care in such a way as to avoid any such disputes. I know that most problems begin with communication. Therefore, if you have any questions about your care, please ask me.

By signing this agreement, the patient agrees with the provider that any dispute between you and Achieve Medical Center and any dispute relating to medical services rendered for any condition, including any services rendered prior to the date this agreement was signed, and any dispute arising out of the diagnosis, treatment, or care of the patient, including the scope of this arbitration clause and the arbitrability of any claim or dispute, against whomever made (including, to the full extent permitted by applicable law, third parties who are not signatories to this agreement) shall be resolved by binding arbitration. Any award of the arbitrator(s) may be entered as a judgment in any court having jurisdiction. In the event a court having jurisdiction finds any portion of this agreement unenforceable, that portion shall not be effective and the remainder of the agreement shall remain effective. This agreement shall be governed by and interpreted under the Federal Arbitration Act, 9 U.S.C. Sections 1-16.

This agreement binds all parties whose claims may arise out of or relate to treatment or service provided by the physician, including any spouse or heirs of the patient and any children, whether born or unborn, at the time of the occurrence giving rise to any claim. In the case of any pregnant mother, the term "patient" herein shall mean both the mother and the mother's expected child or children. This provision for arbitration may be revoked by written notice delivered to the physician within 30 days of signature.

If the patient intends this agreement to cover services rendered before the date it is signed (including, but not limited to, emergency treatment) patient should initial below:

Effective as of the date of first medical services.

Patient/Responsible Party Initials: _____

The patient understands that the result of this arbitration agreement is that claims, including malpractice claims he/she may have against the physician, cannot be brought as a lawsuit in court before a judge or jury, and agrees that all such claims will be resolved as described in this section.

Patient Name _____

Signature of Patient or Responsible Party (if Patient is a Minor) _____ **Date** _____