mountain mind

New Patient Information

For your visit, please bring this with you insurance card and a government issued photo ID

Name (First, Last)	M.I.	Birth Date	Today's Date

Street Address	City	State/Zip

Driver's License/ID Number: State:

Home Phone:	Cell:	Email:

Circle which phone you prefer we call first If needed, may we leave a message on your answering machine? Yes □ No □

Primary Care Provider Name, Phone and Address

Therapist name, Phone and Address

Pharmacy Name, Phone and Street/City

In case of an emergency, is there someone we can contact (list below): Can we share with them information about your mental health condition? Please mark Yes or No next to their name

Yes	No	Name	Phone	Relationship
Yes	No	Name	Phone	Relationship

Intake Questionnaire

In order for us provide accurate and essential care for you, please fill out the following questionnaire

Name_____First Appointment Date_____

DOB_____Age_____Sex_____Weight_____Height _____

Allergies to medications? No **Yes** which ones?_____

Main purpose of the visit *(Please give a brief summary of the main problems)*

_____

Prior attempts to correct problem/prior psychiatric history (include therapy, treatments, etc.)

_____

Sleep behavior: sleepwalking, nightmares, recurrent dreams, problem initiating sleep/getting up/CPAP

_____

Are you willing and able to follow your treatment plan to reach your mental health and wellness goals?
Yes_____No _____

Have you ever attempted suicide? Yes_____No _____

If Yes how?_____

When?_____

Treatment received?_____

Are you having **thoughts of harming yourself or others** such as your spouse or children? Yes_____No____

Do you hear or see things that are not present? Yes_____No_____

Are you currently having any issues with concentration? Yes_____No_____

Are you currently having any problems completing a specific task? Yes_____No_____

Are you having any issues with your memory? Yes_____No_____

Do you have any implantable devices such as breast implants, pace makers, joint implants?

Yes_____ No_____ If yes, please describe _____

Have you ever suffered a concussion or head injury with loss of consciousness?
Yes_____ No_____
If yes, please describe nature of injury/year_____

Is there any weapon in your house? Yes_____No _____

If Yes, Is the weapon properly secured?_____

Do you have past history or current problems of (please circle):

delinquency, persistent lying, thefts, discipline problems in school, running away from home, vandalism, frequent initiation of fights, anger issues or other:

Before age 15? Yes_____No_____

After age 18? Yes_____No_____

SUBSTANCE HISTORY

Substance	Amount	Per	Date of last use/ Specify	Problems related to use?
Caffeine		□ Day □ Wk □ Mo□ Yr		□Yes□ No
Alcohol		□ Day □ Wk □ Mo □ Yr		□ Yes □ No
Tobacco		□ Day □ Wk □ Mo □ Yr		□ Yes □ No
Marijuana		□ Day □ Wk □ Mo □ Yr		□ Yes □ No
Cocaine		□ Day □ Wk □ Mo □ Yr		□ Yes □ No
Pain killers(specify)		□ Day □ Wk □ Mo □ Yr		□ Yes □ No
Heroin		□ Day □ Wk □ Mo □ Yr		□ Yes □ No
Other substance		□ Day □ Wk □ Mo □ Yr		□ Yes □ No

Ever experience withdrawal symptoms from alcohol or drugs?_____

Has anyone told you they thought you had a problem with drugs or alcohol?_____

Have you ever used drugs or alcohol first thing in the morning?_____

Have **YOU** been diagnosed with any of the following psychiatric illnesses?
Check any that apply.

❑	Condition	Date/or age diagnosed
□	Schizophrenia	
□	Bipolar disorder	
□	Depression	
	Anxiety disorder • OCD ❑ • Panic attacks ❑ • Post traumatic stress ❑ • Generalized anxiety ❑	
□	Alcoholism	
□	Drug addiction	
□	Eating disorder	
□	Psychiatric hospitalizations	
□	Nervous breakdowns	
□	Other (please specify)	

Please list all **prior psychiatric hospitalizations**, including substance abuse or rehab (if any) below.

Approximate Date	**Length of Stay**	**Reason for Admission**

Is there any history of mental illness or substance abuse among **your blood relatives**? Check any that apply and state their relationship to you father, maternal aunt, paternal grandfather, etc.)

❑	Condition	Date/or age diagnosed
□	Schizophrenia	
□	Bipolar disorder	
□	Depression	
	Anxiety disorder • OCD ❑ • Panic attacks ❑ • Post traumatic stress ❑ • Generalized anxiety ❑	
□	Alcoholism	
□	Drug addiction	
□	Eating disorder	
□	Psychiatric hospitalizations	
□	Nervous breakdowns	
□	Other (please specify)	

Past Medications

Please write psychiatric medications you remember (refer to the list on the next page to help recall)

		Check your response to it:				
Medication Name	Approximate age or dates used	Felt better on it	No difference / unsure	Felt worse on it	Worked at first, wore off	Note

Please list **all CURRENT medications** including supplements

Name of medication	Dose	Reason prescribed	Date begun

Do you have any of the following conditions?

Diabetes	YES	NO	Arthritis	YES	NO
High blood pressure			Chronic pain		
High cholesterol or lipids			Sexually transmitted diseases		
Heart disease			Renal/kidney disease		
Thyroid illness			Restless leg syndrome		
Seizure			Sleep apnea		
Migraines			Glaucoma		
Multiple Sclerosis			Liver disease / hepatitis		
Stroke			Heartburn /reflux		
Psoriasis			Asthma		
Family History of Diabetes			PCOS		
Other:					

For Women Only:

Are you currently pregnant, breast-feeding or considering pregnancy? **Yes**___No___

Is your menstrual cycle active? Yes_____No_____

First day of your last menstrual cycle?_____

Have you had a hysterectomy? Yes_____No_____

SOCIAL HISTORY

- Where you born in functional or dysfunctional family? Please explain.

_____

_____

- Were there any complications at your birth (premature birth, major medical problems?)

  □ Yes □ No If yes, please describe below:

_____

- Were there any problems in your early development (learning to walk, talk, etc.)?

  □ Yes □ No If yes, please describe below:

_____

_____

- Did you suffer from any major illnesses/injuries while you were growing up?

  □ Yes □ No If yes, please describe below:

_____

_____

- Are/were you a victim of any form of physical/sexual/emotional abuse? Physical Abuse:

  Physical Abuse: □ Yes □ No Age of occurrence:_____

  Sexual Abuse: □ Yes □ No Age of occurrence:_____

  Emotional Abuse: □ Yes □ No Age of occurrence:_____

- Level of education:

  ❑ High school Last grade attended _____

  ❑ College Number of years or degree _____

  ❑ Graduate level Number of years or degree _____

  ❑ Post graduate level

- What types of jobs have you had in the past?

_____

_____

- What is your employment status?

  □ Employed (Where and what do you do?)_____

  □ Retired from_____

  □ Unemployed_____

- **Are you receiving or applying for Medicaid FMLA or any form of short or long term disability?** You need to be seen at least 3 times before the provider will fill out any related documents. Please be aware that this is non-covered service by you insurance. **Separate fee** will apply.

  □ Yes (❑Receiving ❑Applying) □ No

- Do you feel like you have a strong support system from

  family, friends? □ Yes □ No

  children? □ Yes □ No

- Hobbies, sports, pastimes?

  _____

  _____

- History of legal issues? (DV, DUI, jail time, etc.) □ Yes □ No If yes, please describe:

  _____

  _____

  Are you currently: ( ) Married ( ) Partnered ( ) Divorced ( ) Single ( ) Windowed

  How long? _____

  If not married, are you currently in a relationship? (,) Yes ( ) No If yes, how long?_____

  Are you sexually active? ( ) Yes ( ) No

  How would you identify your sexual orientation?

  ( ) straight/heterosexual ( ) lesbian/gay/homosexual ( ) bisexual ( ) transsexual
  ( ) unsure/questioning ( ) asexual ( ) other ( ) prefer not to answer

What is your spouse or significant other's occupation? _____

Describe your relationship with your spouse or significant other:_____

_____

Have you had any prior marriages? ( ) Yes ( ) No If so, how many? _____

How Long?_____

Do you have children? ( ) Yes ( ) No If yes, list ages and gender:

Describe your relationship with your children:_____

List everyone who currently lives with you: _____

_____

Were you adopted? ( ) Yes ( ) No

What is your dominant hand? Left or right? Please circle

Spiritual life:

Do you belong to a particular religion or spiritual group? ( ) Yes ( ) No

If yes, what is the level of your involvement?_____

Do you find your involvement helpful during illness ( ) Yes ( ) No

Please describe:_____

_____

_____

(PHQ-9)

Patient Name:_____ Date: _____

1. **Over the last two weeks, how often have you been bothered by any of the following problems? Read each item carefully, and circle your response.**

	Not at all	Several days	More than half the	Nearly every day
	0	1	2	3
a. Little interest or pleasure in doing things				
b. Feeling down, depressed or hopeless				
c. Trouble falling/staying asleep or sleeping too much				
d. Feeling tired or having little energy				
e. Poor appetite or overeating				
f. Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
g. Trouble concentrating on things, such as reading the newspaper or watching television				
h. Moving or speaking so slowly that other people could have noticed. Or the opposite – being so fidgety or restless that you have been moving around a lot more than				
i. Thoughts that you would be better off dead or of hurting yourself in some way				
Totals				

2. **If you checked off any problem on this questionnaire so far, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?**

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
0	1	2	3

MDQ

Patient Name:_____Date: _____

Has there ever been a period of time when you were not your usual self (while not on drugs or alcohol) and...

	Yes	**No**
- you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?		
- you were so irritable that you shouted at people or started fights or arguments?		
- you felt much more self-confident than usual?		
- you got much less sleep than usual and found that you didn't really miss it?		
- you were more talkative or spoke much faster than usual?		
- thoughts raced through your head or you couldn't slow your mind down?		
- you were so easily distracted by things around you that you had trouble concentrating or staying on track?		
- you had more energy than usual?		
- you were much more active or did many more things than usual?		
- you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?		
- you were much more interested in sex than usual?		
- you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?		
- spending money got you or your family in trouble?		

If you checked YES to more than one of the above, have several of these ever happened during the same period of time?

Yes No

How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?

No problems Minor problem Moderate problem Serious problem

Insurance Certification

If you plan to use insurance, we want to make sure you avoid unpleasant surprises in your coverage. We require all patients to check the items below with their insurer before their first appointment. To gather this information, call your insurance and ask about your "Outpatient Mental Health Benefits":

❑ I wish to pay privately for services (you may skip the rest of this form) The payer for my mental health benefits is (circle one):

Medicaid, Medicare, United Health, Aetna, Cigna, Kaiser, BC/BS, Tricare, Magellan

❑ The payer is not listed above; it is:

❑ I understand that services at the Mountain Mind may not be covered by this insurer and agree pay the full cost for services while awaiting out-of-network reimbursements.

❑ My insurance I D# is_____My group # is_____

❑ I am the primary policy holder ❑I am not the primary holder and the primary holder is:

Deductible

My deductible for mental health visit is: $_____and renews on the_____month of each year.

Copays

My copay / coinsurance for mental health visits are: (enter a $ amount or a % if it is a coinsurance)

Authorization

❑ My insurer does not require prior authorization for outpatient mental health visits.

My insurer
Requires prior authorization and as provided me with this auth #:_____(if they do not supply a number, have them fax the required forms to use at **(719) 207-4464**

Agreement to Insurance Billing Policies

In signing below, I express understanding that my insurance coverage is a contract between myself and my insurer and accept responsibility for any charges they do not cover. I authorize the release of any medical or other information to my insurer that is necessary to process my claims. I authorize payment of medical benefits Mountain Mind for current and future services.

_____ _____

Signature of Patient (or Parent/Legal Guardian in under 18) Date

Treatment Consent and Acknowledgement

Mountain Mind offers quality psychiatric services. Effective care provision requires the following policies to enable:

1) **Financial Policy:** We ask that you plan ahead to pay at time of service your co-pay, co-insurance, any deductible not met or any portion you are responsible for. If you do not have insurance or your insurance does not cover these services, you are considered "Self-Pay" and payment is due in-full at time of service. We accept cash, check, Visa and MasterCard. Any returned checks are subject to a $30 service fee. Any returned check or payment due must be resolved before any future appointments can be arranged.

2) **Appointment /Cancellation Policy: All appointments should be kept as scheduled to ensure consistency in the treatment process. A full fee will be charged for cancellations without a 24 hour notice or non- appearance for a scheduled visit. Please note that missed appointments are not paid by your insurance company. As a general rule, for medication management patient must be seen at minimum every 3 months after medications are stabilized. If you need to schedule an urgent appointment during clinic hours, please call ahead for accommodations.** In case of inclement weather, please call our office first.

3) **Medication Policy:** Medication renewal will occur during the medication follow-up visit with the prescribing provider. No medication will be prescribed over the phone routinely. Any written script for a controlled substance which is lost will not be re-written. The patient must wait for the next eligibility date for the provider to prescribe. Any script for a controlled substance prescription which has expired requires a return appointment. **If medication treatment is indicated and patient is a Cannabis user there is a 30-day period to discontinue Cannabis. Mountain Mind reserves the right to drug test patients during any visit. The activation of THC on the brain mixed with psychotropic medications has been shown to exhibit many adverse drug events including and not limited to prolonged psychotic events/illnesses. You will NOT be prescribed medications if you test positive for any illicit drug including Cannabis.**

4) **Refill requests:** Please do not call our office for medication refills- call your pharmacy first, because most likely the pharmacy already has refills available on file. If refill is needed you must have your pharmacy fax us a request at least 7 days in advance

5) **Phone Policy:** Phone calls made for treatment purposes may be charged a fee. Phone calls for matters of short duration will not be charged. If you have any questions or having any side effects let us know and the message will be relayed to your provider. Phone call requests made after 3 p.m. may be returned next business day. In case of an emergency please call 911 or go the nearest emergency room. **Please turn cell phones off during appointments.**

6) General Office Policy In order to keep patients records accurate and complete we will bill your insurance company. A fee may be charged for the copying and release of these records to non-medical provider/private party. Letters and other documents generated by patient's request may also be charged a fee.

7) **Insurance:** Your insurance policy is a contract between you and your insurance company. While we do all we can to help our patients in communicating and negotiating with their insurance plan, we must inform patients that if any questions regarding coverage, benefits, or payment for services provided arise that it is their responsibility to resolve such issues. In the event of denials, errors, or non-covered services, the patient is responsible for all services rendered. If payment from your insurance carrier is not received within forty-five (45) days, we will seek full payment from you. Balance of services that are delayed or denied by your insurance company due to various reasons will become patient responsibility after thirty (30) days.

In signing below, you agree to begin treatment with the policies above and acknowledge receipt of the Privacy Notice.

_____

Patient Signature Date Insured/Parent/Guardian Date

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Printed Name:

_____

Patient's Rights as a Patient of Mountain Mind

1. The Patient has the right to considerate and respectful care and treatment, regardless of gender, race, sexual orientation, age, culture, disabilities, or religious beliefs
2. The Patient has the right to have their care and treatment information kept private, and have the opportunity to have their records released only with their written permission, except required by law.
3. Patients have a right to make informed choices regarding their medications, behavioral health services, and their providers.
4. The Patient has a right to expect reasonable continuity of care.
5. The Patient has the right to examine and receive an explanation of costs for treatment as applicable.
6. The Patient has the right to know what relationship Mountain Mind has with other health care providers and facilities in regard to their health care.
7. The Patient has the right to inquire as to their provider's degree, licensure, and training.
8. The Patient has the right to inquire as to the role of the providers on the treatment team in the treatment process.
9. The Patient has the right to an explanation of their condition and the treatment options.
10. The Patient has the right to expect that Mountain Mind will make reasonable effort in providing the identified services of the treatment plan.
11. The Patient has the right to be informed if Mountain Mind is engaging in research about behavioral health care and have the right to participate or refuse participation in that research.
12. The Patient has the right to register complaints to their behavioral health care professional and/or an administrator.

Patient's Responsibilities as a Patient of Mountain Mind

1. The Patient has the Responsibility to treat those providing care with dignity and respect.
2. The Patient has the Responsibility to ask questions regarding the diagnosis, treatment, medications, or any instructions.
3. The Patient has the Responsibility to follow instructions concerning medications, follow-up visits, and other essential components of their treatment and to notify their behavioral health care provider if the instructions cannot be followed or problems develop.
4. The Patient has the Responsibility to assist Mountain Mind in obtaining approvals for payments for treatment, referrals, and authorizations.
5. The Patient has the Responsibility to provide as much information as is possible to their provider to assist in the assessment and rendering of services.

_____	_____	_____	_____
Patient's Signature	Date	Parent/ Guardian Signature	Date

(Patients 12 to 18 must sign in addition to the parent)

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Mountain Mind's Notice of Privacy Policies, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

I hereby authorize Mountain Mind to release to my insurance company or its representative, any/all information requested to include my diagnosis and records of my mental health treatment by this practice. I also authorize and direct my insurance company to pay directly to Mountain Mind the amount due for treatment and/or services rendered. Patient/Insured agrees to pay for any/all services that are denied by the insurance company as not medically necessary, etc. Furthermore, I hereby give consent to Mountain Mind to render mental health services deemed necessary for myself and/or minor child as designated in the treatment plan.

Patient's Signature Date Parent/ Guardian Signature Date

_____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

_____ _____

Printed Name: Printed Name: