Integrated Mental Health Services LLC
Jeannie V. Pasacreta, PhD, APRN CEO & Clinical Director
4 Abbey Lane, Newtown, CT. 06470
203-270-0080 (phone) 203-304-1191 (fax)
info.imhs@gmail.com
www.IntegratedMentalHealthServices.com

INTAKE FORM

Please provide the following information and answer the questions below. Please note: information you provide here is protected as confidential information.

Please fill out this form and bring it to your first session.

Name: _____
(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____
(Last) (First) (Middle Initial)

Birth Date: _____ /_____ /_____ Age: _____ Gender: □ Male □ Female

Marital Status:
□ Never Married □ Domestic Partnership □ Married
□ Separated □ Divorced □ Widowed

Please list any children/age: _____

Address: _____
(Street and Number)

_____
(City) (State) (Zip)

Home Phone: ( ) May we leave a message? □ Yes □ No

Cell/Other Phone: ( ) May we leave a message? □ Yes □ No

E-mail: _____ May we email you? □ Yes □ No
*Please note: Email correspondence is not considered to be a confidential medium of communication.

Referred by (if any): _____

Have you previously received any type of mental health services (psychotherapy, psychiatric services, etc.)?
□ No
□ Yes, previous therapist/practitioner: _____

Emergency Contact, Name/Phone #: _____

Are you currently taking any prescription medication?
□ Yes
□ No
Please list: _____

_____

Have you ever been prescribed psychiatric medication?
□ Yes
□ No
Please list and provide dates: _____

_____

GENERAL HEALTH AND MENTAL HEALTH INFORMATION

1. How would you rate your current physical health? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific health problems you are currently experiencing:

_____

2. How would you rate your current sleeping habits? (please circle)

Poor Unsatisfactory Satisfactory Good Very good

Please list any specific sleep problems you are currently experiencing:

_____

3. How many times per week do you generally exercise? _____

What types of exercise to you participate in? _____

4. Please list any difficulties you experience with your appetite or eating patterns:

_____

5. Are you currently experiencing overwhelming sadness, grief, or depression?
□ No
□ Yes

If yes, for approximately how long? _____

6. Are you currently experiencing anxiety, panic attacks, or have any phobias?
□ No
□ Yes

If yes, when did you begin experiencing this? _____

Do you have any drug/food allergies? If yes, please list drug/food, reaction, severity and when it started.

_____

_____

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7. Are you currently experiencing any chronic pain?
□ No
□ Yes

If yes, please describe: _____

8. Do you drink alcohol more than once a week? □ No □ Yes

9. How often do you engage recreational drug use?
□ Daily □ Weekly □ Monthly □ Infrequently □ Never

10. Are you currently in a romantic relationship? □ No □ Yes

If yes, for how long? _____

On a scale of 1-10, how would you rate your relationship? _____

11. What significant life changes or stressful events have you experienced recently:

_____

_____

_____

FAMILY MENTAL HEALTH HISTORY:

In the section below, identify if there is a family history of any of the following. If yes, please indicate the family member's relationship to you in the space provided (father, grandmother, uncle, etc.).

	Please Circle	List Family Member
Alcohol/Substance Abuse	yes/no	
Anxiety	yes/no	
Depression	yes/no	
Domestic Violence	yes/no	
Eating Disorders	yes/no	
Obesity	yes/no	
Obsessive Compulsive Behavior	yes/no	
Schizophrenia	yes/no	
Suicide Attempts	yes/no	

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ADDITIONAL INFORMATION:

1. Are you currently employed? □ No □ Yes

If yes, what is your current employment situation?

_____

Do you enjoy your work? Is there anything stressful about your current work?

_____

_____

2. Do you consider yourself to be spiritual or religious? □ No □ Yes

If yes, describe your faith or belief:

_____

3. What do you consider to be some of your strengths?

_____

_____

_____

_____

4. What do you consider to be some of your weaknesses?

_____

_____

_____

_____

5. What would you like to accomplish out of your time in therapy?

_____

_____

_____

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LIMITS OF CONFIDENTIALITY

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect
When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults
If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances
Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance Providers (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to clients.

Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

Client Signature (Client's Parent/Guardian if under 18)

Today's Date

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CANCELLATION POLICY

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than a 24-hour notice unless it is due to illness or an emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

Client Signature (Client's Parent/Guardian if under 18)

Today's Date

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Insurance Information

Insurance: _____ Plan Type: _____

ID#: _____ Group#: _____

Guarantor Name: _____ Guarantor DOB: _____

Address: _____

Phone #: _____

Relationship to Patient: _____

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CLIENT CONSENT AND AGREEMENT TO RECEIVE PSYCHOLOGICAL SERVICES

Please read the following information carefully. After you have read this agreement, please sign your name below to accept the terms of this agreement.

A. CONSENT TO TREAT

As a legally consenting individual, I agree to receive psychotherapy/psychopharmacological services provided by Integrated Mental Health Services and it's staff**.**

As legal guardian/representative, I agree on behalf of my child/ward to allow IMHS to provide psychotherapeutic/psychopharmacological services.

By receiving medication management at IMHS, I agree to receive therapy at this facility. I understand that this will lead to better care as my therapist works directly with the doctor.

B. FINANCIAL RESPONSIBILITY AND ASSIGNMENT OF BENNEFITS

I understand that I am expected to pay for each session at the time it is held. I understand that I am expected to pay any copayment/deductible that is due at the time of my scheduled session. I understand that I will receive a bill for services rendered in the event that payment has not been collected at the time of my scheduled session. I authorize direct payments to be made by my insurance company (primary, secondary, third party), up to the total amount of my psychotherapeutic/psychopharmacological care charges. I certify that the information I have provided in connection with any application for payment is correct.

I understand that if my account remains unpaid for 60 days and arrangements for payment have not been agreed upon, IMHS has the option of using legal means to secure payment. This may include but will not be limited to, the hiring of a collection agency, going through small claims court; which will require our disclosure of otherwise confidential information.

C. APPOINTMENTS

I understand that if I fail to cancel a scheduled appointment 24 hours in advance I will be billed for a full session fee. Without 24 hour notice we can not use this time for another client. A bill will be mailed to all clients who do not show for scheduled sessions or who fail to cancel scheduled sessions 24 hours in advance. Thank you for your consideration regarding this important matter.

D. EMERGENCIES

IMHS operates by appointment only. If you have an emergency you should call 911 or go to your local emergency room.

E. RIGHT TO DISCONTINUE TREATMENT

IMHS has the right to discontinue treatment for any appropriate reasons, including but not limited to, repeated lateness and excessive cancellations, non-compliance with medication or treatment plans/goals.

F. LIMITS OF CONFIDENTIALITY

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Duty to warn and protect

When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the mental health professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of children and vulnerable adults
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Prenatal exposure to controlled substances
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Minors/Guardianship
Parents or legal guardians of non-emancipated minor clients have the right to access the clients' records.

Insurance providers (when applicable)
Insurance companies and other third party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to, types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries.

I agree to the above limits of confidentiality and understand their meanings and ramifications.

G. RELEASE OF PROFESSIONAL RECORDS

IMHS maintains a clinical record for each client. It could include information about your reasons for seeking therapy, a description of the ways in which your problem impacts your life, your diagnosis, the goals that we set for treatment, any past clinical records that we receive from other providers, and reports of any professional consultations. You may receive a copy of your clinical records once we receive a signed records release form.

IMHS also keeps a set of notes called psychotherapy notes. Pursuant to HIPAA, these records are specifically defined and carry special protection. They have a very specific meaning under the HIPPA law. These records are not released without specific written permission from the client or court of law.

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Psychotherapy notes are treated differently from other mental health information both because they contain particularly sensitive information and because they are the personal notes of the therapist/doctor that typically are not required or useful for treatment, payment, or health care operations purposes, other than by the mental health professional who created the notes. Therefore, with few exceptions, the Privacy Rule requires a covered entity to obtain a patient's authorization prior to a disclosure of psychotherapy notes for any reason, including a disclosure for treatment purposes to a health care provider other than the originator of the notes.

H. PATIENT RIGHTS

A separate list of Patient Rights as well as a copy of your HIPPA rights are provided as separate documents for your records. Please review these documents carefully.

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS CONSENT AND AGREEMENT TO RECEIVE PSYCHOLOGICAL SERVICES IN ITS ENTIRETY AND AGREE TO IT'S TERMS.

_____ _____

Signature of Client or Personal Representative Date

_____ _____

Print Name of Patient or Personal Representative Patient DOB

_____ _____

Description of Personal Representatives Authority If Signed By Rep. Please Include Patients' name

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PATIENT BILL OF RIGHTS/RESPONSIBILITIES

• Clients have the right to be treated with dignity and respect.
• Clients have the right to fair treatment, regardless of race, ethnicity, creed, religious belief, sexual orientation, gender, age, health status, or source of payment for care.
• Clients have the right to have their treatment and other patient information kept private. Under certain laws records may be released without patient permission.
• Clients have the right to access care easily and in a timely fashion.
• Clients have the right to a candid discussion about all their treatment choices, regardless of cost or coverage by their benefit plan.
• Clients have the right to share in developing their plan of care.
• Clients have the right to the delivery of services in a culturally competent manner.
• Clients have the right to information about the organization, its providers, services, and role in the treatment process.
• Clients have the right to information about provider work history and training.
• Clients have the right to information about clinical guidelines used in providing and managing their care.
• Clients have a right to know about advocacy and community groups and prevention services.
• Clients have a right to freely file a complaint, grievance, or appeal, and to learn how to do so.
• Clients have the right to know about laws that relate to their rights and responsibilities.
• Clients have the right to know of their rights and responsibilities in the treatment process, and to make recommendations regarding the organization's rights and responsibilities policy.
• Clients have the responsibility to treat those giving them care with dignity and respect.
• Clients have the responsibility to give providers the information they need, in order to provide the best possible care.
• Clients have the responsibility to ask their providers questions about their care.
• Clients have the responsibility to help develop and follow the agreed-upon treatment plans for their care, including the agreed-upon medication plan.
• Clients have the responsibility to let their provider know when the treatment plan no longer works for them.
• Clients have the responsibility to tell their provider about medication changes, including medications given to them by others.
• Clients have the responsibility to keep their appointments. Patients should call their providers as soon as possible if they need to cancel visits.
• Clients have the responsibility to let their provider know about their insurance coverage, and any changes to it.
• Clients have the responsibility to let their provider know about problems with paying fees.
• Clients have the responsibility not to take actions that could harm others.
• Clients have the responsibility to report fraud and abuse.
• Clients have the responsibility to openly report concerns about quality of care.
• Clients have the responsibility to let their provider know about any changes to their contact information (name, address, phone, etc.).
• Clients have the right and the responsibility to understand and help develop plans and goals to improve their health.

I have read and understood my rights and responsibilities.

_____
Client Signature

_____
Date

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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. Client's name: _____
   First Name Middle Name Last Name

2. Date of Birth: ___/___/___

3. Date authorization initiated: ___/___/___

4. Authorization initiated by:

_____
Name (client, provider, or other) Information to be released:

5. Information to be released:
   Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

   Other (describe information in detail):

   _____

6. Purpose of Disclosure: The reason I am authorizing release is:
   My request

   Other (describe information in detail):
   _____

7. Person(s) Authorized to Make the Disclosure:
_____

8. Person(s) Authorized to Receive the Disclosure:
_____

9. This Authorization will expire on ___/___/___ or upon the happening of the following event:

Authorization and Signature: I authorize the release of my confidential protected health information, as described in my directions above. I understand that this authorization is voluntary, that the information to be disclosed is protected by law, and the use/disclosure is to be made to conform to my directions. The information that is used and/or disclosed pursuant to this authorization may be re-disclosed by the recipient unless the recipient is covered by state laws that limit the use and/or disclosure of my confidential protected health information.

Signature of the Patient:
_____

Signature of Personal Representative:
_____

Relationship to Patient if Personal Representative:
_____

Date of signature: _____

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The following specifies your rights about this authorization under the Health Insurance Portability and Accountability Act of 1996, as amended from time to time ("HIPAA").

1. Tell your mental health professional if you don't understand this authorization, and they will explain it to you.

2. You have the right to revoke or cancel this authorization at any time, except: (a) to the extent information has already been shared based on this authorization; or (b) this authorization was obtained as a condition of obtaining insurance coverage. To revoke or cancel this authorization, you must submit your request in writing to your mental health professional and your insurance company, if applicable.

3. You may refuse to sign this authorization. Your refusal to sign will not affect your ability to obtain treatment, make payment, or affect your eligibility for benefits. If you refuse to sign this authorization, and you are in a research-related treatment program, or have authorized your provider to disclose information about you to a third party, your provider has the right to decide not to treat you or accept you as a client in their practice.

4. Once the information about you leaves this office according to the terms of this authorization, this office has no control over how it will be used by the recipient. You need to be aware that at that point your information may no longer be protected by HIPAA.

5. If this office initiated this authorization, you must receive a copy of the signed authorization.

6. ***Special Instructions for completing this authorization for the use and disclosure of Psychotherapy Notes***. HIPAA provides special protections to certain medical records known as "Psychotherapy Notes." All Psychotherapy Notes recorded on any medium (i.e., paper, electronic) by a mental health professional (such as a psychologist or psychiatrist) must be kept by the author and filed separate from the rest of the client's medical records to maintain a higher standard of protection. "Psychotherapy Notes" are defined under HIPAA as notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a private counseling session or a group, joint, or family counseling session and that are separate from the rest of the individual's medical records. Excluded from the "Psychotherapy Notes" definition are the following: (a) medication prescription and monitoring, (b) counseling session start and stop times, (c) the modalities and frequencies of treatment furnished, (d) the results of clinical tests, and (e) any summary of: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date.

   In order for a medical provider to release "Psychotherapy Notes" to a third party, the client who is the subject of the Psychotherapy Notes must sign this authorization to specifically allow for the release of Psychotherapy Notes. Such authorization must be separate from an authorization to release other medical records.