CONVENTIONS HEALTH

INTAKE FORM WITH HISTORY & BILLING INFORMATION

PATIENT INFORMATION

________________________	________________________	____	_____________	_____	_____	______________________
First Name	Last Name	M.I.	Date of Birth	Age	Sex	Social Security Number

____	____________________________	_____	_______________
Street Address	City	State	Zip Code

________________________________	________________________________	______________________________________
Primary Phone Number	Secondary Phone Number	E-mail

________________________________	___________________________________	___________________	___________________
Patient's Employer/School	Emergency Contact Name	Relationship	Phone Number

Preferred method of contact: ☐E-mail ☐ Primary Phone ☐ Secondary Phone
How did you hear about us? ☐Friend/Family ☐Therapist ☐Doctor ☐ Insurance ☐Internet ☐Other: _______________

Reason for Appointment: ____

Allergies: ____ *Height: ________ *Weight:________lbs. (required for dosing)

Current Medications (psychiatric & medical - including over the counter medications, vitamins, & herbal supplements)

____ ____

____ ____

____ ____

____ ____

Other Medical Conditions (Please check all that apply)

___ Diabetes Type 1/2
___ Hypertension/High blood pressure
___ High cholesterol/triglycerides
___ Sleep apnea
___ Thyroid problems
___ Heart problems
___ Stroke/TIA
___ Seizures
___ Head trauma
___ Tremors/Movement disorders (Parkinson's disease)
___ Skin conditions/rashes
___ GI problems
___ Other: __________________
___ Clotting disorders/blood clots
___ Anemia
___ Liver problems
___ Kidney problems
___ Respiratory problems (asthma, COPD)
___ Eye problems (glaucoma)
___ Pregnancy
___ Alzheimers/Dementia
___ Cancer
___ HIV/AID
___ Hepatitis
___ Pain

Tobacco (smoking/chewing/vaping): ☐ None ☐ ____ packs/day Alcohol: ☐ None ☐____________________
Drugs (including marijuana/THC/CBD): ☐ None ☐____________________

PRIMARY INSURANCE INFORMATION OF POLICYHOLDER

Insurance Company: _____________________________ Policy Number:__________________ Group Number:________________

________________________	________________________	____	_____________
First Name	Last Name	M.I.	Date of Birth

____	____________________________	_____	_______________
Street Address (if different from above)	City	State	Zip Code

________________________________	________________________________	___________________
Phone Number	Secondary Phone Number	Relationship to Patient

CONVENTIONS HEALTH

First Name ______ Last Name ______ M.I. ______ Date of Birth ______

SECONDARY INSURANCE INFORMATION OF POLICYHOLDER

Insurance Company: ______ Policy Number: ______ Group Number: ______

First Name ______ Last Name ______ M.I. ______ Date of Birth ______

Street Address (if different from above) ______ City ______ State ______ Zip Code ______

Phone Number ______ Secondary Phone Number ______ Relationship to Patient ______

In the the event we need to send medication, request an up to date medication list, or need to order labs, please list the following:

PHARMACY INFORMATION

*Pharmacy Name ______ *Pharmacy Phone Number ______ Pharmacy Fax Number ______

Pharmacy Street Address ______ City ______ State ______ Zip Code ______

PRIMARY CARE PHYSICIAN

Physician Name ______ Physician Phone Number ______ Physician Fax Number ______

LAB INFORMATION (Quest Diagnostics or other)

Lab Name ______ Lab Phone Number ______ Lab Fax Number ______

PRACTICE POLICIES & PATIENT RESPONSIBILITIES

Financial Policy

Please notify us of any changes to your address, phone number, and/or insurance coverage. Payment is due in full at the time of service including co-pay, co-insurance, charges not covered by insurance, deductible, or other account balances. Checks returned are subject to a fee of $40. For verification of insurance benefits, we require a copy of your insurance card and driver's license or state ID at registration. The parent accompanying a minor to their appointment is responsible for payments due.

Collections

Account balances older than 90 days, without communication from the responsible party may be turned over to our collection agency and a collection fee may be assessed. Please contact our billing department if you need assistance with your balance.

Cancellations & no-show appointments

Please notify the office at least 24 hours prior to your scheduled appointment time if you are unable to attend. If you arrive more than 10 minutes after your scheduled appointment time, it is up to the provider's discretion to keep your appointment. Canceling less than 24 hours in advance, arriving more than 20 minutes late, or no-show may result in a $75 fee for established patients/follow-up and $150 for initial psychiatric appointments. Appointment scheduling, re-scheduling, and urgent appointments requests, must be established by contacting the office directly, not via your provider's e-mail address or direct line. Multiple cancellations less than 24 hours in advance or no-shows is grounds for discharge from the practice. Due to unexpected and crisis situations, providers and staff request your patience while waiting.

Phone & Communication Policy

Communication outside of your appointment, including telephone calls with your provider or e-mails made for treatment purposes may incur a fee. Contact information is for internal use only including phone and electronic messaging to provide courtesy appointment reminders, account and insurance matters, and marketing. Telepsychiatry and teletherapy can only occur while you are in Illinois. It is

your responsibility to understand your coverage and obtain authorization for these services. Disrespectful conduct, use of profanity, or harassment of the office staff is grounds for discharge from the practice.

Medical Records & Other Documents

Paperwork (FMLA/disability, school forms, letters, etc.) will only be completed for established patients demonstrating commitment to improvement and will not be completed during initial assessments. Appointments must be made specifically for the completion of paperwork with documents sent at least 24 hours in advance for the clinician to review the required information/tests. Paperwork and patient requested medical records, greater than 25 pages, may be subject to a fee. Medical record requests must be submitted in writing and will be completed within 30 days of the request.

Urgent Matters/Emergencies

In the event of adverse medication side effects or urgent concerns, the office will try to accommodate these matters within normal business hours, whenever possible. However, you should go to urgent care or the emergency room if immediate assistance is needed. If you experience an emergency, call 911 or go to your nearest emergency room.

PRESCRIBER-PATIENT AGREEMENT

Refills

- Medication refills, early refills, or adjustments occur during appointments with your prescribing provider. If a refill is needed outside of your appointment, contact your pharmacy to send a refill request to the office.
- Request refills in a timely fashion. Refills may take up to 72 hours, if authorized by your prescriber.
- To avoid medication interactions, prescriptions can only be picked up from one preferred pharmacy.
- Do not request a refill when the clinic is closed, after hours, or on weekends in order for prescribers to prioritize truly emergent situations.
- Medication might not be replaced if lost, destroyed/damaged, or stolen without proper documentation. A police report is required for any stolen or missing controlled substances prior to fulfillment of the refill request, if authorized by your prescriber. Your prescriber reserves the right to deny replacing them at their discretion.
- Your prescriber may stop prescribing medications if you miss two consecutive appointments.

Medical

- Inform your prescriber of changes to your medical status, such as medication changes or diagnoses, to avoid interactions.
- Notify your prescriber immediately if you intend on becoming pregnant or become pregnant. Failure to do so could potentially harm the fetus and may result in discharge from the practice. The practice or prescriber will not be held responsible for any harm that may occur to you and/or your unborn child.

Medication Safety

- Use medication only as prescribed within the safety parameters discussed with your prescriber. Do not increase, decrease, or abruptly stop taking medication without your prescriber's knowledge or permission.
- Keep medications and prescriptions in a secure, safe place preventing others' access to these medications. Do not share or sell medications to anyone, including family members, as state and federal law prohibit this.
- Do not use alcohol or illegal substances while taking medications or while driving.
- Random pill counts and drug screens may be conducted for your safety and compliance monitoring.
- Tolerance can occur with the use of some medications. Tolerance is defined as a need for a higher dose to maintain the same effect. If your prescriber determines that continued escalation of the dose is not in your best interest, then these medications may need to be discontinued with a taper or may necessitate switching to another form of treatment.
- Your prescriber may choose to discontinue your medication, including controlled substances, if he/she believes that your:
    - condition is not improving
    - medication usage is escalating
    - functional ability is not increasing or if you begin to experience unacceptable side effects
- Benzodiazepines

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- These include, but are not limited to, Xanax (alprazolam), Klonopin (clonazepam), and Ativan (lorazepam) have certain associated risks. Some of these include but are not limited to:
  - drowsiness, dizziness, blurred vision, headache, poor concentration/confusion, impaired coordination, memory loss, grogginess, psychological addiction, depression, subtle personality changes, dreaming/nightmares, fatigue, stomach upset, muscle weakness, abuse/death
- If your benzodiazepine use is markedly decreased, stopped or reversed, you could experience withdrawal syndrome. Symptoms may occur within 24-48 hours of the last dose, which include, but are not limited to:
  - sweating, increased heart rate and high blood pressure, insomnia, abdominal cramps, tremors, diarrhea, muscle or bone aching, seizures. Usually they are self limited but could, in rare cases, be life threatening and may require hospitalization.

_____ I agree to waive any applicable privilege or right to privacy or confidentiality with respect to the prescribing of medications and authorize my prescriber, pharmacy and insurers to cooperate fully with any city, state or federal law enforcement agency in the investigation of any possible misuse, sale, or other diversion/inappropriate use of medication.

_____ I understand compliance with these responsibilities is required in continuing treatment with Conventions Psychiatry & Counseling. I understand my prescriber may stop prescribing medication, change my treatment plan, or discharge me from the practice if I fail to follow them. I have read this document and acknowledge understanding by signing it. Additionally, I certify that I have had all my questions answered satisfactorily.

_____ I acknowledge that I have been offered and/or received a written copy of Conventions Psychiatry & Counseling Notice of Privacy Practices. This notice provides in detail the uses and disclosures of my protected health information that may be used by this practice, my individual rights, how I may exercise my rights, and Conventions Psychiatry & Counseling's legal duties with respect to my protected health information.

_____ I hereby authorize Conventions Psychiatry & Counseling to release to my insurance company or its representative, any/full information requested, including but not limited to my diagnosis and records of my mental health treatment by this practice. I also authorize and direct my insurance company to pay directly to Conventions Psychiatry & Counseling 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. Furthermore, I hereby give consent to Conventions Psychiatry & Counseling to render mental health services deemed necessary to myself/my minor child.

_____ I acknowledge that I have read, understand, and agree to the policies and provisions of Conventions Psychiatry & Counseling as defined in this document.

Patient Signature: ____ **Date:** ____________________________
Parent/Guardian Signature: ____ **Date:** ____________________________
[Patient must sign if 12 years or older along with parent /guardian
Parent/Guardian Name: ____