Patient Demographics

General Information:

Today's Date:		Date of Birth:
Name:		Gender: ❑Male ❑ Female
Address:		SSN:
City:	State:	Zip:
Home Phone:	Work Phone:	Cell Phone:
Email:		Preferred Contact Method: ❑Home ❑Work ❑Cell
Race:		Language: ❑ English ❑Spanish ❑Other
Employer:		

Financially Responsible Party Information:

Responsible Party: ❑Self ❑Spouse ❑Dependent	Date of Birth:
Responsible Party Name:	
Responsible Party Address:	
Phone:	❑Home ❑Work ❑Cell

Insurance Information:

Policy holder: ❑Self ❑Spouse ❑Dependent	Subscriber Date of Birth:
Subscriber Name:	Subscriber Employer:
Insurance Company Name:	
ID#:	Group#:

Emergency Contact:

Name:	
Relationship:	Phone: ❑Home ❑Work ❑Cell

Pharmacy Information

Preferred Pharmacy:		
Address:		Phone:
City:	State:	Zip:

By signing I verify the information on this page is correct to the best of my knowledge. I understand quoted benefits are not a guarantee of payment and I am responsible for any portion not covered by insurance. I authorize the release of any medical or other information needed to process insurance claims. I also authorize payment of medical benefits to this practice for services rendered.

Print Name _____ Signature _____

If not signed by patient, please indicate relationship to patient (i.e., parent, Power of Attorney, etc.)

Relationship _____ Date _____

Witnessed by _____ Date _____

FINANCIAL STATEMENT OF UNDERSTANDING

- Initial _____ Payment is expected on the day of your appointment. Your insurance contract requires that we collect your copay for services. A $15.00 fee will be charged if payment is not made on the date of service
- Initial_____ All balances should be paid within 20 days of the date of service
- Initial_____ Missed Appointment Fee: We require at least 24 hours' notice to cancel an appointment. We provide a 24 hour live answering service, courtesy confirmation calls, and can take your call during business hours. If we are not notified of your missed appointment:
    - You will be responsible for the missed appointment fee
        - $45.00 for a therapy appointment
        - $50.00 for a medical appointment
    - You will not be rescheduled until the fee for the missed appointment is paid.
    - We cannot bill your insurance for the missed appointment fee.
- Initial_____ You are required to keep three consecutive visits with your provider before we are able to complete any FMLA, or Disability forms. Please review our Disability Form Fee Notice if you have a request. Fees for these forms can range from $25.00 - $75.00 and must be paid prior to the forms being reviewed and completed.
- Initial_____ There is a $45.00 fee for returned checks. If not paid in full within 10 days your account will be turned over to the Worthless Check Unit in Rock Hill, which will result in additional fees.
- Initial_____ Requests for medical records are charged a base fee of $15.00. If records are provided to include greater than 30 pages, an additional $ .65 per page is charged. If records are provided to exceed 50 pages, an additional $.50 per page is charged.
- Initial_____ Upon request prescriptions can be mailed, a $15.00 fee will be required prior to mailing.
- Initial_____ It is your responsibility to meet all requirements for EAP Authorizations as set forth in your EAP contract.
- Initial_____ It's your responsibility to provide correct insurance information at the time of service. If incorrect information results in insurance denial, balances will be your responsibility.

I understand the above statement of fees and policies.

_____ _____

Patient/Authorized Person Signature Date

_____

Authorized Person Relationship to Patient *(if applicable)*

_____ _____

Witness Date

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

Concerning the use of my personal medical information, I ALLOW the following family members and/or friends as written below on my behalf:

1) _____

Print Full Name of Person

- ☐ to schedule/reschedule/cancel appointments
- ☐ to pick up written prescriptions or samples
- ☐ to discuss billing information
- ☐ to discuss insurance information

2) _____

Print Full Name of Person

- ☐ to schedule/reschedule/cancel appointments
- ☐ to pick up written prescriptions or samples
- ☐ to discuss billing information
- ☐ to discuss insurance information

3) _____

Print Full Name of Person

- ☐ to schedule/reschedule/cancel appointments
- ☐ to pick up written prescriptions or samples
- ☐ to discuss billing information
- ☐ to discuss insurance information

- Initial_____ I have been presented with a copy of The Saluda Counseling Center's Notice of Privacy Practices, I understand this notice and that my information may be used only as permitted under federal and state law.

_____ _____

Patient/Authorized Person Signature Date

_____ _____

Printed Name Authorized Person Relationship to Patient (*if applicable)*

_____ _____

Witness Signature Date

Confidential Patient Information for Adult Clients

Thank you for completing this form. The information you provide will help create a treatment plan tailored to meet your needs. The purpose of this questionnaire is to get a complete picture of your marital and/or family background. By obtaining this information, we can save valuable interview time. Therefore, answering these routine questions as fully and as accurately as you can is appreciated. All case records are strictly confidential. NO One is permitted to see your case record without your written permission (except in situations deemed potentially life-threatening or if court ordered). If you have questions about questionnaire, please feel free to ask at any time. If you do not wish to answer a question, you may write, "I do not wish to answer."

Patient Name _____ Today's Date: _____

Address _____ City _____ State _____

Zip _____ Home Phone: _____ Cell Phone: _____

Gender: ☐Male ☐Female Age: _____ Date of Birth: _____

Employer: _____ Occupation: _____

Marital Status: ☐Single ☐Married ☐Divorced ☐Widowed ☐Separated ☐Engaged ☐Living Together

Spouse's Name: _____ Date of Birth:_____ Age: ___

Employer: _____ Occupation: _____

Emergency Contact: _____Telephone: _____

Name of Children	Date of Birth	Grade	Lives with you?
_____	_____	_____	☐Yes ☐NO
_____	_____	_____	☐Yes ☐NO
_____	_____	_____	☐Yes ☐NO
_____	_____	_____	☐Yes ☐NO
_____	_____	_____	☐Yes ☐NO

Briefly describe what problems or difficulties you are presently experiencing:

_____
_____
_____
_____

What type of counseling or treatment have you had before? _____

_____

_____

Current Medication: _____

_____

_____

Name and telephone number of all physicians currently providing care:

Physician: Telephone:

_____ _____

_____ _____

_____ _____

Have you, or any on in your family ever attempted or committed suicide: ❑YES ❑ No

If yes, please indicate whom and when: _____

_____

_____

Family History:

<u>Father:</u>

Living? ❑YES ❑ No Father's age _____ Deceased? ❑YES ❑ No Age at time of death? ____

Cause of Death: _____ Your age at time of his death _____

Father's Occupation: _____

<u>Mother</u>:

Living? ❑YES ❑ No Mother's age _____ Deceased? ❑YES ❑ No Age at time of death? ____

Cause of Death: _____ Your age at time of her death _____

Mother's Occupation: _____

Please check any of the following which apply and indicate the family member involved such as spouse, child, father, mother, brother, sister, you, etc:

Event:	Family Member Involved
☐Death in family	_____
☐Divorce	_____
☐Trouble with law	_____
☐Financial trouble	_____
☐Serious illness	_____
☐Mental illness	_____
☐Job or school difficulty	_____
☐Drugs	_____
☐Alcohol	_____
☐Interpersonal problems	_____
☐Sexual abuse/assault	_____
☐Physical abuse/assault	_____
☐Depression	_____
☐Suicide/homicide	_____
☐Serious accident	_____
☐Other	_____

Have you ever used: (check all that apply)

☐ alcohol ☐ sedatives ☐ barbiturates ☐ tobacco ☐ heroin
☐ LSD ☐ caffeine ☐ methadone ☐ PCP ☐cocaine/crack
☐ stimulants ☐ tranquilizers ☐ pain medications ☐ marijuana
☐ inhalants, glue, Freon, butane, gasoline

Has anyone in your family ever been concerned about your abuse of drugs or alcohol? ☐Yes ☐No

Patient Name _____ Date of Birth: _____

Current Sign/symptoms:

0=None
1= Mild (impacts quality of life but no significant impairments of day to day functioning)
2=Moderate (significant impact on quality of life and/or day to day functioning)
3=Severe (profound impact on quality of life and day to day functioning)

Depressed mood (sadness)	0	1	2	3
Eating patterns (increase/decrease)	0	1	2	3
Sleep Patterns (increase/decrease)	0	1	2	3
Elimination disturbance	0	1	2	3
Low energy	0	1	2	3
Problems with coordination	0	1	2	3
Poor concentration	0	1	2	3
Agitation (can't be still)	0	1	2	3
Mood swings	0	1	2	3
Irritability	0	1	2	3
General anxiety	0	1	2	3
Panic attacks	0	1	2	3
Phobias (excessive fears of certain things)	0	1	2	3
Repeating unwanted thoughts or behaviors	0	1	2	3
Bingeing	0	1	2	3
Purging	0	1	2	3
Anorexia	0	1	2	3
Suspiciousness of others	0	1	2	3
Hearing things without apparent cause	0	1	2	3
Seeing things without apparent cause	0	1	2	3
Aggressive behaviors	0	1	2	3
Not complying with rules or laws	0	1	2	3
Sexual problems	0	1	2	3

Any other physical/medical problems specify

_____	0	1	2	3
_____	0	1	2	3
_____	0	1	2	3
_____	0	1	2	3

Patient Name _____ Date of Birth: _____