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

Medical Intake Patient Information

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:

_____

_____

_____
_____

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: _____

Do you have any allergies? YES NO, if yes please list:
1. _____
2. _____
3. _____

Have you been in the hospital overnight in the last 5 years? Yes No, if yes please list:

Hospital	From	To	Reason
1. _____			
2. _____			

Are there any disease or illnesses which seem to run in your family such as diabetes, heart disease, or high blood pressure?
1. _____
2. _____
3. _____

Have you ever seen a psychiatrist, psychologist, or counselor before? Yes No, if yes please list:

Name	From	To	Problem
1. _____			
2. _____			

Have you ever had to take any nerve pills, tranquilizers, antidepressants, or sedatives before? Yes No, if yes please list:

Drug	Dose	Reason
1. _____		
2. _____		
3. _____		

Are you currently taking any of these medications list above? Yes No, if yes please list:

Drug	Dose	Reason
1. _____		
2. _____		
3. _____		

Have you been in the hospital for nerve problems, depression, or anxiety? Yes No, if yes please list:

Hospital	Date	Doctor	Problem
1. _____			
2. _____			

Drug Received at Hospital	Dose	Reason
1. _____		
2. _____		
3. _____		

Sleep, anxiety, or inability to concentrate may be treated with controlled substances such as Xanax or Ritalin, When these drugs are misused there are possible dangers of accidents, seizures, accidental overdoses, and toxic effects (such as when these medication are used in large doses, mixed with alcohol, marijuana and illegal drugs, and even medications prescribed for blood pressure, pain, and allergies). These medications, when misused, can interfere with the metabolism of other medications and cause potentially dangerous inter-reactions. To prevent problems, the following policies will be followed.

Controlled substances will not be prescribed or refilled on weekends. A 48 hour notice is required to obtain records, call the pharmacy, or for prescriptions to be written for any medication, and this cannot be done on the weekend. If a sedative drug is needed, a non-controlled medication such as Neurontin or an anticonvulsant will be prescribed. If a patient loses or has a prescription stolen for controlled substance or the actual medication, he or she may be discharged from the practice. If there is evidence of overuse, misuse, failure to keep appointments, or inability of a patient to control their use, no further prescriptions for controlled substances will be given. Instead an anticonvulsant such as Neurontin may be prescribed to prevent withdrawal. Losing two prescriptions or repeated request for early refills may result in a patient being discharged from the practice.

Controlled medications are clearly labeled as such on the prescription label, and you should ask your physician or your pharmacist if you have any questions. No prescriptions for opiate-like pain medications will be prescribed. A patient should contact their primary care physician or a pain center for such medications.

Signature _____

Date _____ Witness by _____

Patient Name _____ Date of Birth: _____

What Problem bothers you the most at the present time? _____

_____

_____

Please check the symptoms which currently bother you or have bothered you in the last six months. Circle more than one if they apply.

Sleep Disturbance	YES	NO
If yes, difficulty going to sleep	YES	NO
Awakening throughout the night	YES	NO
Early morning awakening	YES	NO
Are you blue, sad, despondent	YES	NO
Do you lack energy	YES	NO
Are you interested in your usual pastimes	YES	NO
Have you lost Weigh	YES	NO
If yes, how many pounds _____		
Have you lost interest in sex	YES	NO
Do you experience pleasure	YES	NO
Have you thought that you are more energetic than usual	YES	NO
Have you experienced a decrease in concentration	YES	NO
Do your thoughts run quickly from topic to topic	YES	NO
Are you experiencing racing thoughts	YES	NO
Do you have thoughts or fear others	YES	NO
Do you have trouble speaking in public to groups	YES	NO
Do you have a racing pulse	YES	NO
Do you have episodes of shortness of breath	YES	NO
Have you ever thought you would go crazy or lose control	YES	NO
Do you have difficulty crossing bridges over water	YES	NO
Do you have difficulty in elevators	YES	NO
Do you have difficulty flying	YES	NO
Do you have difficulty standing on a balcony or high rise	YES	NO
Are you ever compelled to do something that seems silly	YES	NO
Do you experience a thought that you cannot seem to get out your mind	YES	NO
Do you find yourself consuming huge amounts of sweets or starches at once	YES	NO
Do you collect things	YES	NO
Do you double check doors, appliances, or lock when leaving your home	YES	NO

Patient Name _____ Date of Birth: _____

CHECKLIST: REVIEW OF SYSTEMS

General: ☐Fatigue ☐Fever or chills ☐Weakness ☐Trouble sleeping
☐Change in appetite ☐Weight loss or gain amount_____

Psychiatric: ☐Nervousness ☐Depression ☐Stress ☐Memory loss ☐Hallucinations

Skin: ☐Rashes ☐Itching ☐Dryness ☐Color Changes
☐Hair and Nail changes

Head: ☐Headache ☐Head Injury

Ears: ☐Decreased hearing ☐Ringing in ears (tinnitus) ☐Earache ☐Drainage

Eyes: ☐Vision ☐Glasses or contacts ☐Pain ☐Redness ☐Blurry/double vision
☐Flashing light ☐Specks ☐Glaucoma ☐Cataracts
☐Date of last eye exam _____

Nose: ☐Stuffiness ☐Discharge ☐Itching ☐Hay fever ☐Nosebleeds
☐Sinus pain

Throat: ☐Teeth ☐Gums ☐Bleeding ☐Dentures ☐Soreness
☐Dry Mouth ☐Hoarseness ☐Date of last dental exam_____

Neck: ☐Lumps ☐Swollen glands ☐Pain ☐Stiffness

Respiratory: ☐Cough ☐Sputum ☐Wheezing ☐Painful breathing
☐Coughing up blood (hemoptysis) ☐Shortness of breath (dyspnea)

Cardiovascular: ☐Chest pain or discomfort ☐Tightness ☐Palpitations ☐Swelling(edema)
☐Shortness of breath w/activity (dyspnea) ☐Difficulty breathing lying down (orthopnea)
☐Sudden awakening from sleep w/shortness of breath (Paroxysmal Nocturnal Dyspnea)

Gastrointestinal: ☐Heartburn ☐Nausea ☐Vomiting ☐Constipation ☐Diarrhea

Urinary: ☐Frequency ☐Urgency ☐Burning or pain ☐Blood ☐Incontinence

Vascular: ☐Calf pain with walking (Claudication) ☐Leg Cramping

Musculoskeletal: ☐Muscle or joint pain ☐Stiffness ☐Back pain ☐Trauma ☐Swelling of joints

Neurologic: ☐Dizziness ☐Fainting ☐Seizures ☐Weakness ☐Numbness ☐Tingling ☐Tremor

Hematologic: ☐Ease of bruising ☐Ease of bleeding

Endocrine: ☐Heat or cold intolerance ☐Sweating ☐Frequent urination ☐Thirst

Patient Name _____ Date of Birth: _____