NEW PATIENT INFORMATION:
ADULT

Patient Last Name:	Patient First Name:	Patient Middle Name:
DOB:	Sex: ☐ M ☐ F	SSN:

Address:	City:	Zip:

Home Phone:	Cell Phone:	Email:

EMERGENCY CONTACT INFORMATION			
Last Name:	First Name:	Relationship:	Phone:

INSURANCE INFORMATION		
Primary Insurance:	Policy #:	Group #:
Subscriber Name:	Subscriber DOB:	Relationship:
SSN:	Employer:	

Secondary Insurance:	**Policy #:**
Subscriber Name:	**Group #:**
Subscriber DOB:	**Relationship:**
SSN:	**Employer:**

I AGREE THAT ALL INFORMATION LISTED ABOVE IS CORRECT & I CONSENT TO TREATMENT.	
Patient Signature:	Date:

OFFICE USE ONLY:		
Appointment Date:	Appointment Time:	Clinician:
DX:		

FINANCIAL POLICIES

Thank you for choosing KaraLee & Associates, P.C. as your mental health care provider. Please understand that payment of services rendered is considered part of your treatment and is expected at each session.

KaraLee & Associates, P.C. providers accept most insurance carriers but each patient may be responsible for an annual deductible or copayment, depending on their insurance provider. It is the patient's responsibility to keep financial accounts current including copays, deductibles, and service fees.

Please initial below stating you understand our financial policies:

_____ I understand that KaraLee & Associates, P.C. has the right to charge me $60 for missed appointments and cancellations with less than 24 hours notification. Missed appointments or cancellations fees *cannot* be billed to my insurance company.

_____ I agree that if for any reason a check is returned on my account I will be responsible for a $35 returned check fee in addition to original fee(s) for service(s).

_____ I agree to notify KaraLee & Associates, P.C. of any changes in my address, phone number, insurance, or responsible party, if applicable, prior to my next appointment.

_____ I understand that if my balance remains unpaid for more than 90 days and/or exceeds $200, KaraLee & Associates, P.C. may refer my account to a collection agency and future services may be withheld.

_____ I understand that I am financially responsible for services provided, whether or not paid for by insurance. Any service charges which are not covered by my insurance provider are my responsibility. Detailed fees for service are listed on the following page.

_____I hereby acknowledge that the KaraLee & Associates, P.C. Notice of Privacy Practices is available to me upon request

(OVER)

FINANCIAL POLICIES CONTINUED

Potential Fees Incurred by Patient	Fee Associated
Records Request (legal, insurance or personal use)	Base Fee: $23.23 plus:
	Pages 1-20: $1.16 per page
	Pages 21-50: $0.58 per page
	Pages 51+: $0.23 per page
Records Request (continuation of care, records faxed to another medical office only)	Free of Charge
Paperwork/Forms to be completed by clinician or psychiatrist (Short/Long-Term Disability, FMLA, Worker's Compensation)	$250.00 Charge (psychiatrists to be booked for an hour long appointment)
Letters to be written by clinician or psychiatrist (Disability, Probation, for School, for Lawyer)	Fee determined by time needed to complete:
	15 minutes: $62.50
	30 minutes: $125.00
	45 minutes: $187.50
	60 minutes: $250.00
Cancellation of Appointment with clinician or psychiatrist (less than 24 hours notice given)	$60.00
Private Pay Clients (no insurance or insurance not used)	Clinicians - Initial Appointment: $150.00
	Clinicians - Subsequent Appointments: $90.00
	Psychiatrist - Initial Appointment: $150.00
	Psychiatrist - Medication Reviews: $60.00

______________________________ ____________________

PATIENT/GUARDIAN SIGNATURE **DATE**

ADVANCED BENEFICIARY NOTICE OF NON-COVERAGE

Patient Name: _________________________ DOB: ________________

Insurance: ____________________ ID#__________________________

I, ___________________________ agree to arrange a payment plan with my provider to continue services in the event that my insurance coverage lapses or does not cover services rendered. I understand that an Advanced Beneficiary Notice Form (below) must be filled out prior to continuing services.

REASON FOR ADVANCED BENIFICIARY NOTICE
(Patient/Guardian is responsible for any or all of the following reasons

1. Maximum visits allowed per insurance contract have been reached.
2. Patient is insured by straight Medicaid.
3. Deductible, copay, co-insurance not eligible for secondary insurance payment.
4. MD No-Show/ Late Cancel.
5. Therapist No-Show / Late Cancel.
6. Other: __________________________________

Amount of Payment Responsibility

MD Evaluation: $160.00

MD Medication Review: $60.00

No-Show/ Late Cancel: $60.00

I agree that I am the responsible party and KaraLee and Associates, P.C. may ask for payment at the time services are rendered. By signing below, I understand that in the event that my insurance does not pay for my mental health services, I agree to pay the amount due for services.

Patient/ Guardian Signature: ___________________________ Date: _______________

Clinician Signature: _________________________________ Date: ________________

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that the KaraLee & Associates, P.C. Notice of Privacy Practices is available to me upon request:

PATIENT/GUARDIAN SIGNATURE: ________________ DATE: _______

CONSENT FOR TREATMENT

I hereby consent to receive treatment for therapeutic/psychological services through KaraLee & Associates, P.C.:

PATIENT/GUARDIAN SIGNATURE: ________________ DATE: _______

COMPLIANCE WITH CLINIC REQUIREMENTS

I hereby acknowledge an understanding of KaraLee and Associates, P.C. requirements. It is required to engage in ongoing therapy in order to maintain appointments with the psychiatrist.

PATIENT/GUARDIAN SIGNATURE: ________________ DATE: _______

UNDERSTANDING OF LEGAL PARTICIPATION

I hereby acknowledge the legal participation limits of KaraLee and Associates, P.C.

Therapists and Psychiatrists do not participate in custody proceedings, custody assessments, or court hearings.

PATIENT/GUARDIAN SIGNATURE: ________________ DATE: _______

OFFICE USE ONLY:

We attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- ☐ Individual refused to sign
- ☐ Communication barriers prohibited obtaining the acknowledgement
- ☐ An emergency prevented us from obtaining acknowledgement
- ☐ Other (specify): ____

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: ___________________________ **Age:** ____ **Sex:** ❑ **Male** ❑ **Female** **Date:**________

If this questionnaire is completed by an informant, **what is your relationship with the individual?** ___________________
In a typical week, approximately how much time do you spend with the individual? ____________________ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, circle the number that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	0	1	2	3	4	
	2. Feeling down, depressed, or hopeless?	0	1	2	3	4	
II.	3. Feeling more irritated, grouchy, or angry than usual?	0	1	2	3	4	
III.	4. Sleeping less than usual, but still have a lot of energy?	0	1	2	3	4	
	5. Starting lots more projects than usual or doing more risky things than usual?	0	1	2	3	4	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	0	1	2	3	4	
	7. Feeling panic or being frightened?	0	1	2	3	4	
	8. Avoiding situations that make you anxious?	0	1	2	3	4	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	0	1	2	3	4	
	10. Feeling that your illnesses are not being taken seriously enough?	0	1	2	3	4	
VI.	11. Thoughts of actually hurting yourself?	0	1	2	3	4	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	0	1	2	3	4	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	0	1	2	3	4	
VIII.	14. Problems with sleep that affected your sleep quality over all?	0	1	2	3	4	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	0	1	2	3	4	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	0	1	2	3	4	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	0	1	2	3	4	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	0	1	2	3	4	
XII.	19. Not knowing who you really are or what you want out of life?	0	1	2	3	4	
	20. Not feeling close to other people or enjoying your relationships with them?	0	1	2	3	4	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	0	1	2	3	4	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	0	1	2	3	4	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	0	1	2	3	4	

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COORDINATION OF CARE WITH PRIMARY CARE PHYSICIAN

NOT A REQUEST FOR RECORDS

Patient Name:	DOB:

☐ Authorize ☐ Do Not Authorize
The release of any information to my physician by KaraLee & Associates, P.C. and

Physician Name:		Phone #:	Fax #:	
Address:		City:	State:	Zip:

To exchange information regarding mental/health/substance abuse treatment. The information exchanged may include diagnosis, medications prescribed and/or any medical concerns related to care. The purpose of this disclosure is for the coordination of care between KaraLee & Associates, P.C. and my physician. This release expires upon termination of my treatment with KaraLee & Associates, P.C. or upon my written request.

Patient/Guardian Signature:	Date:

OFFICE USE ONLY

Date Admitted/Assessed:	Diagnosis:
TYPE OF TREATMENT & FREQUENCY	
☐ Individual ☐ Family ☐ Group	☐ Weekly ☐ Bi-weekly ☐ Monthly
Medical Concerns (if any):	
Signature of Clinician:	Date:

PATIENT NAME: ______________________________ **DOB:** _____________________

PERSONAL HISTORY

Presenting Symptoms:

- ☐Anger
- ☐Anxiety
- ☐Appetite Change
- ☐Crying Spells
- ☐Decreased Concentration
- ☐Excessive Worry
- ☐Feeling Hopeless
- ☐Hyperactivity
- ☐Irritability
- ☐Mood Swings
- ☐Paranoia
- ☐Racing Thoughts
- ☐Sleep Problems
- ☐Suicidal Feelings
- ☐ Homicidal Ideations

Presenting Concerns:

- ☐Academic Issues
- ☐Behavior Issues
- ☐Health Issues
- ☐Legal Issues
- ☐ Relationship Issues
- ☐ Sexual Issues
- ☐ Work Issues

SOCIAL INFORMATION

Do you usually spend leisure time: ☐ Alone ☐ With family ☐ With friends

Describe your strengths: _____________ ______________ _______________ ________________

Describe your hobbies: _____________ ______________ _______________ ________________

SUICIDAL ISSUES

Have you ever thought about suicide? ☐No ☐ Yes
If yes, explain: ____

Do you have a history of suicide attempts? ☐No ☐ Yes
If yes, when: _____________________________ How: ____________________________

Do you currently feel suicidal? ☐No ☐ Yes
If yes, explain: ____

EDUCATION & EMPLOYMENT

EDUCATION LEVEL:

☐ Did not complete high school ☐ High School Diploma ☐ GED ☐ Vocational Training
☐ Associate's Degree ☐ Bachelor's Degree ☐ Master's Degree ☐ Doctorate

Have you experienced academic difficulties? ☐No ☐ Yes: ________________________

Have you experience behavior difficulties? ☐No ☐ Yes: ________________________

OCCUPATION:

☐Employed Employer Name: _______________________ Job Title: ________________________
☐ Student School Name: __________________________ Major: ___________________________
☐Homemaker ☐ Retired ☐ Unemployed

What are your primary means of financial support:

☐ Self-Employed ☐ Full/Part Time Job ☐ Parents ☐Spouse ☐Retirement ☐ Disability

Have you ever served in the military? ☐No
☐ Yes: ☐ Army ☐ Air Force ☐ Coast Guard ☐Navy ☐Marines

Enlistment Date: Discharge Date:

FAMILY INFORMATION

Marital status: ☐Single ☐ Married ☐ Partnered ☐ Separated ☐ Divorced ☐ Widow

Spouse/Partner Name: _____________ **Age:** ___________ **Living with you?** ☐ YES ☐ NO
Number of Siblings: _______________

Children: ☐ I do not have children

Child Name	Age	Biological/Step/Adopted	Lives with you?
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO
			☐ YES ☐ NO

Describe your relationship with your family:
At Childhood: ☐ Poor ☐ Strained ☐Good ☐ Excellent
At Adulthood: ☐ Poor ☐ Strained ☐Good ☐ Excellent
At Present: ☐ Poor ☐ Strained ☐Good ☐ Excellent

(OPTIONAL)

Were you raised in a home that practiced religion? ☐ No ☐Yes

Are you currently practicing religion? ☐ No ☐Yes

☐ Catholic ☐ Christian ☐ Hindu ☐ Jewish ☐ Protestant ☐ Muslim ☐ Other: _______________

Which ethnic group do you identify with:
☐ African-American/Black ☐ Asian ☐ Caucasian ☐ Hispanic ☐ Native American ☐ Other: ___________

MEDICAL HISTORY

Describe your current health:	**Are you experiencing any physical pain at this time?**
☐ Poor ☐ Fair ☐ Good ☐ Very good	☐ No ☐ Yes: Where: ________________________

Check all that apply to yourself or an immediate family member:

	Myself		Family Member (indicate)
	Current	Past	
Abuse: Emotional/Physical/Sexual			☐ Mother ☐ Father ☐ Sibling
Alcohol Abuse			☐ Mother ☐ Father ☐ Sibling
ADD/ADHD			☐ Mother ☐ Father ☐ Sibling
Anxiety			☐ Mother ☐ Father ☐ Sibling
Asthma			☐ Mother ☐ Father ☐ Sibling
Appendicitis			☐ Mother ☐ Father ☐ Sibling
Bed wetting			☐ Mother ☐ Father ☐ Sibling
Birth defects			☐ Mother ☐ Father ☐ Sibling
Cancer			☐ Mother ☐ Father ☐ Sibling
Chest pain			☐ Mother ☐ Father ☐ Sibling
Chicken pox			☐ Mother ☐ Father ☐ Sibling
Diabetes			☐ Mother ☐ Father ☐ Sibling
Diarrhea			☐ Mother ☐ Father ☐ Sibling
Fainting			☐ Mother ☐ Father ☐ Sibling
Hearing			☐ Mother ☐ Father ☐ Sibling
High blood pressure			☐ Mother ☐ Father ☐ Sibling

Migraines			☐ Mother ☐ Father ☐ Sibling
Nausea			☐ Mother ☐ Father ☐ Sibling
Psychiatric hospitalization			☐ Mother ☐ Father ☐ Sibling
Other:			☐ Mother ☐ Father ☐ Sibling

MEDICATION LOG

List prescribed or over-the-counter medication(s) or herbal supplements you **currently** take below

Medication	Dosage	Frequency	Prescriber

Allergies/Side Effects: ____

Pharmacy Name: ________________________ **Pharmacy Phone Number:**____________________________

MEDICAL HISTORY CONTINUED

List any major accidents or surgeries: ☐ Not Applicable

Surgerie(s): Type: _________________ Reason: ______________ Date: ____________
Type: _________________ Reason: ______________ Date: ____________
Accidents/Injuries: Type: _________________ Date: ____________
Type: _________________ Date: ____________

Do you have any diet or nutritional concerns: ☐ No ☐ Yes: ______________________________

Have you gained weight in the last 60 days: ☐ NO ☐ YES

Have you lost weight in the last 60 days: ☐ NO ☐ YES

Do you ever:
☐ Over-eat ☐ Induce vomiting ☐ Use laxatives ☐ Exercise to get rid of calories ☐ Skip meals

LEGAL HISTORY

Are you currently involved in: ☐ Custody ☐ Probation ☐ DUI/OWI ☐ Divorce

SUBSTANCE USE

ALCOHOL USE:

Do you currently drink? ☐NO ☐ YES: What is your weekly consumption: _________

Have you ever been told you should cut down on drinking? ☐No ☐ Yes

Have you ever felt bad about your drinking habits? ☐No ☐ Yes

Have you ever attended an aa group? ☐No ☐ Yes: When: ____________________

Have you ever received a MPI, DWI or OWI? □No □ Yes: When: ________________

Have you ever been treated for alcohol use: □No □ Yes: When: ___________

DRUG USE:

Do you use illegal drugs or drugs not prescribed to you: □No □ Yes

Drugs Used: □ Amphetamines □ Crack/Cocaine □ Heroine/Opiates □ Marijuana □ Over-the-counter
□ Other: __________

Have you ever attended a NA group? □No □ Yes: When: __________________

Have you ever been treated for drug use: □No □ Yes: When: ___________

CAFFEINE USE: □ Not Applicable

Coffee: Cups per day □ 1 □ 2 □ 3 □ 4+
Tea: Cups per day □ 1 □ 2 □ 3 □ 4+
Pop: □ 1 □ 2 □ 3 □ 4+
Energy Drinks: □ 1 □ 2 □ 3 □ 4+

SMOKING: Please check below the response that best summarizes your CIGARETTE smoking status
□ *Never* smoked
□ Former smoker: Month/Year Quit: ___________
□ Current smoker: Average number of cigarettes smoked per day: ____________

THERAPY GOALS Please list what you hope to accomplish during therapy.
1.
2.
3.
4.

PATIENT/GUARDIAN SIGNATURE **DATE**

CLINICIAN SIGNATURE **DATE**

MEDICAL DIRECTOR SIGNATURE **DATE**