



NEW PATIENT INFORMATION: ADULT

Patient Last Name: _____ Patient First Name: _____ Patient Middle Name: _____

DOB: _____ Biological Sex: M F SSN: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

EMERGENCY CONTACT INFORMATION

First & Last Name: _____ Relationship: _____ Phone: _____

INSURANCE INFORMATION

Primary Insurance: _____ Policy #: _____
Group #: _____

Subscriber Name: _____ Subscriber DOB: _____
Relationship: _____

SSN: _____ Employer: _____

Secondary Insurance: _____ Policy #: _____ Group #: _____

Subscriber Name: _____

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:
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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.



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: \$200.00
	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 BENEFICIARY 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

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PATIENT RIGHTS & RESPONSIBILITIES PRACTICES:

I hereby acknowledge that the KaraLee & Associates, P.C. Notice of Patient Rights & Responsibilities 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, PC:

PATIENT/GUARDIAN SIGNATURE

DATE

COMPLIANCE WITH CLINIC REQUIREMENTS:

I hereby acknowledge an understanding of KaraLee and Associates, PC 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. and that 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 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**.

		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, PC 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 Testing Only Referred Out

Weekly Bi-weekly Monthly

Referral provided to: _____

Medical Concerns (if any): _____

Signature of Clinician: _____ Date: _____

PATIENT NAME: _____ DOB: _____

PERSONAL HISTORY

Presenting Symptoms

- | | |
|--|--|
| <input type="checkbox"/> Anger | <input type="checkbox"/> Hyperactivity |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Irritability |
| <input type="checkbox"/> Appetite change | <input type="checkbox"/> Mood swings |
| <input type="checkbox"/> Decreased concentration | <input type="checkbox"/> Paranoia |
| <input type="checkbox"/> Excessive worry | <input type="checkbox"/> Racing thoughts |
| <input type="checkbox"/> Feeling hopeless | <input type="checkbox"/> Sleep problems |
| <input type="checkbox"/> Homicidal Ideations | <input type="checkbox"/> Suicidal Feelings |

Presenting Concerns

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

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 (explain):

Have you experience behavior difficulties? No Yes (explain):

Occupation:

Employed? _____ If yes, name of employer: _____ Job Title: _____

Student? _____ If yes, name of school: _____ Major: _____

Circle one.... 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

If so, what branch? Army Air Force Coast Guard Navy Marines

Enlistment Date: _____

Discharge Date: _____

FAMILY INFORMATION

Marital status: Single Married Partnered Separated Divorced Widowed

Spouse/Partner name: _____ Age: _____ Living with you? Yes No

Number of Siblings: _____

I do not have children

Child Name	Age	Biological/Step/Adopted	Lives with you?
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> No
			<input type="checkbox"/> Yes <input type="checkbox"/> 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: _____

LEGAL HISTORY

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

Explain:

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/SMART group? No Yes: When? _____

Have you ever received a DWI, OWI, or DUI? 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 Benzodiazepines Barbiturates Crack Cocaine Heroin
 Opiates Medical Marijuana 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

(Cups per day)
Coffee: 1 2 3 4+
Tea: 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: _____

MEDICAL HISTORY

<p style="text-align: center;">Describe your current health</p> <p><input type="checkbox"/> Poor <input type="checkbox"/> Fair <input type="checkbox"/> Good <input type="checkbox"/> Very good</p>	<p>Are you experiencing any physical pain at this time?</p> <p><input type="checkbox"/> No <input type="checkbox"/> Yes</p> <p>Where? _____</p>
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Check all that apply to yourself or an immediate family member...

	Myself		
	Current	Past	
Abuse: Emotional/Physical/Sexual			<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling
Alcohol Abuse			<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling
ADD/ADHD			<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling
Anxiety			<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling
Asthma			<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling
Appendicitis			<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling
Bed wetting			<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling
Birth defects			<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling
Cancer			<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling
Chest pain			<input type="checkbox"/> Mother <input type="checkbox"/> Father <input type="checkbox"/> Sibling

Chicken pox			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Diabetes			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Diarrhea			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Exploitation			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Fainting			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Hearing			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
High blood pressure			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Migraines			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Nausea			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Psychiatric hospitalization			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling
Other:			<input type="checkbox"/> Mother	<input type="checkbox"/> Father	<input type="checkbox"/> Sibling

MEDICATION LOG

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

Medication	Dosage	Frequency	Prescriber

Allergies/Side Effects:

Pharmacy Name:

Phone Number:

MEDICAL HISTORY CONTINUED

List any major accidents or surgeries: Not Applicable

Surgeries...

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

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