OASIS COUNSELING CENTER
1531 Rockford Court • Kokomo, IN 46902
Ph: 765.453.4500 • Fax: 765.453.4525
www.TheOasisCounseling.com

2018 PATIENT INFORMATION

Patient Name:	**Birthdate:**	**Age:**	**Gender:** Male Female
Street Address:			
City:	**State:**	**Zip Code:**	
Home Phone:	**Cell Phone:**	**Work Phone:**	
Preferred Contact Number: Home Cell Work			
Email Address:			
☐ Check box if you DO NOT authorize us to communicate electronically with you using this email address			
Marital Status: N/A Single Married Separated Divorced Widowed			
Sexual Orientation: N/A Decline Heterosexual Homosexual Bi-Sexual			
Student Status: N/A Full-Time Part-Time			
Employment Status: N/A Full-Time Part-Time Self-Employed Retired Active Military			
Employer (If applicable):		**City/State:**	
Occupation:			
Primary Care Physician:		**City/State:**	
Ethnicity: Decline American Indian Asian African American Caucasion Hispanic or Latino Other			
Referral Source: Doctor Friend/Co-Worker Family Member Web Search Advertisement			

People Living in Your Household			
Name	**Relationship to Patient**	**Birthdate**	**Employer**

INSURANCE INFORMATION **Please provide your insurance card(s) to the receptionist. A copy of the card(s) will be placed in your file. If you don't have your insurance card with you, please complete the information below.**	
Name of Primary Insured Person:	
Primary Insured Birthdate:	**SSN:**
Primary Ins. Company:	
Secondary Ins. Company:	

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PATIENT CONSENT FORM

FINANCIAL RESPONSIBILITIES It is mutually understood that all charges for services are the responsibility of the patient. If the patient is a minor, the parent or guardian who signs this form will be held as the responsible party. Full payment on the account is expected at the time of service. We reserve the right to withhold further scheduling of appointments until payment is made.

INSURANCE For those patients who have insurance coverage, we will file a claim on your behalf. You will be responsible for any co-pay or other charges not covered by your insurance. You will be responsible for reporting any changes in your insurance coverage, such as new insurance, changes in your plan, etc.

DELINQUENT ACCOUNTS If your account should become delinquent, you will be responsible for any collection fees, court costs, and legal fees that shall be incurred in the collection process.

APPEALS AND GRIEVANCES I understand that I have a right to request reconsideration in the case that outpatient care is not authorized. I understand that the request for appeal can be made through my Provider Health Plan and that I risk nothing in exercising that right. I also understand that I have to submit a complaint/grievance and risk nothing to exercise that right. I understand that to submit a grievance, I may contact the Services Department of my Health Plan.

NO SHOW POLICY You will be charged a fee for failure to keep appointments, unless a cancellation is given prior to the scheduled appointment time. This fee must be paid in full before your next appointment. If you have three or more No-Shows on your account, you will be terminated from The Oasis Counseling Center LLC and will be responsible for seeking treatment elsewhere.

LATE CANCELLATION POLICY You will be charged a fee for multiple late cancellations (cancellations made the day of appointment) other than those that are deemed as unavoidable. The fee must be paid in full before your next appointment. We reserve the right to terminate your account at The Oasis Counseling Center LLC if you have multiple, consistent Late Cancellations.

MEDICATION MANAGEMENT If our office manages your medications, we require that you attend appointments and are actively involved in therapy with one of our Providers. If appointments are not scheduled and attended regularly, our office will not refill your medications until you are seen by a Provider in our office. Additionally, please refer to the No Show and Late Cancellation Policies above.

CONSENT FOR TREATMENT I authorize and request The Oasis Counseling Center LLC and its Providers to carry out Mental Health / Psychological treatments and/or diagnostic procedures during the course of my care as a patient as advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that while the course of therapy is designed to be helpful, it may, at times, be difficult and uncomfortable. I understand that I am consenting and agreeing only to those mental health services that my Provider is qualified to provide within: A. The scope of the Provider's license, certification, and training; or B. The scope of license,

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PATIENT CONSENT FORM (CONT.)

certification and training of those mental health Providers directly supervising the services received by the patient.

PERSONS ENTITLED TO EXERCISE PATIENT'S RIGHTS ON PATIENT'S BEHALF The following persons are entitled to exercise the patient's rights on the patient's behalf:

- If the patient is a minor (under the age of 18): The parent, guardian, or other court appointed representative of the patient.
- If the Provider determines that the patient is incapable of giving or withholding content: The patient's guardian, a court appointed representative of the patient, a person possessing a health care power of attorney for the patient, or the patient's health care representative.

ELECTRONIC COMMUNICATION The Oasis Counseling Center LLC occasionally uses email and text messaging to exchange information efficiently for the benefit of our patients. We recognize that email and text messaging are not a completely secure means of communication because these messages can be addressed to the wrong person or accessed improperly while in storage or during transmission. If you prefer not to authorize the use of email and/or text messaging s that contains your health information, it will not affect your health care in any way. We will continue to use U.S. Mail or telephone to communicate with you.

☐ Please check box if you DO NOT authorize the use of email and/or text messaging

RELEASE OF INFORMATION I authorize the release of information for claims, certification/case management/quality improvement and other purposes related to benefits of my Health Plan. I understand that release of information to other Providers, family, school systems, etc requires a separate release of information form.

I hereby agree to the terms of this policy regarding my financial responsibility and consent for treatment, which I have read and understood fully.

_____ _____

PATIENT SIGNATURE (OR PARENT/GUARDIAN IF PATIENT IS A MINOR) **DATE**

_____ _____

WITNESS SIGNATURE **DATE**

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PRIVACY POLICY

I understand that, under the Health Insurance Portability Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare Providers who may be involved in that treatment, directly or indirectly.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations, such as quality assessments and physician certifications.
- NOTICE TO MEDICAID PATIENTS ONLY: The Oasis Counseling Center LLC is under the supervision of Dr. Judey Budenz-Anders, PhD, HSPP, and Dr. Anthony A. Smith, M.D. They will need to see your treatment plan and notes in order to discuss your case for supervision purposes only.

All information between Provider and patient is held strictly confidential unless:

- The patient authorizes release of information with his/her signature.
- The patient presents a physical danger to self or others.
- Child/Elder abuse or neglect is suspected.

Additionally, if the patient is a minor (under the age of 18):

- A custodial parent and a noncustodial parent of a child have equal access to the child's health records, unless a court has issued an order that limits the noncustodial parent's access to the records, and The Oasis Counseling Center LLC has received a copy of the court order or has actual knowledge of the court order.

I have received, read, and understand this Privacy Policy. I understand that The Oasis Counseling Center LLC has the right to change its Privacy Policy from time to time, and that I may contact them at any time to obtain a current copy of this Privacy Policy. I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations. I also understand that a Provider is not required to agree to my requested restrictions, but if an agreement exists, the Provider is bound to abide by such restrictions.

_____	_____	_____
PATIENT NAME (PLEASE PRINT)	**PATIENT SIGNATURE (OR PARENT/GUARDIAN IF A MINOR)**	**DATE**
	_____	_____
	WITNESS SIGNATURE	**DATE**

OFFICE USE ONLY We attempted to obtain patient signature, but were unsuccessful.
Reason: _____ INITIALS ____ DATE _____

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PATIENT CONSENT TO EXCHANGE INFORMATION

I authorize The Oasis Counseling Center LLC and _____ **(Primary Care Physician)** to exchange information regarding my mental health/substance abuse treatment, and other medical information, for continuity of care purposes as may be necessary for the administration and provision of my healthcare coverage.

I understand this authorization shall remain in effect for one year, or throughout the course of this treatment, whichever is longer.

I understand that I may revoke this authorization at any time by written notice to The Oasis Counseling Center LLC. I also understand that it is my responsibility to notify The Oasis Counseling Center LLC if I choose to change my Primary Care Physician.

_____ _____
PATIENT NAME (PLEASE PRINT) **PATIENT DATE OF BIRTH**

_____ _____
PATIENT SIGNATURE (OR PARENT/GUARDIAN IF A MINOR) **DATE**

_____ _____
WITNESS SIGNATURE **DATE**

TO BE COMPLETED BY BEHAVIORAL HEALTH PROVIDER

PROVIDER NAME _____

DSM V _____ _____ _____

Treatment Plan: Type _____ **Frequency** _____ **Est Length of Tx** _____

Comments regarding treatment, medications and date of last session:

_____

_____

_____

_____

_____

_____

Treatment Completed? Yes __ No __

Provider Signature _____ **Date** _____

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PSYCHOSOCIAL INTAKE ASSESSMENT

YOUR NAME:		TODAY'S DATE:	

PRESENTING PROBLEM (PLEASE BRIEFLY EXPLAIN THE REASON FOR YOUR VISIT)

	Anxiousness		Physical Pain		Hyperactivity		Grief
	Depressed Mood		Decreased Energy		Worthlessness		Hallucinations
	Hopelessness		Delusions		Panic Attacks		Oppositionalism
	Guilt		Paranoia		Elevated Mood		Dissociative States
	Impulsiveness		Irritability		Sexual Victim		Obsessions/Compulsions
	Disruption of Thought Process or Content				Emotional/Physical Abuse Victim or Perpetrator		

SYMPTOMS HAVE BEEN PRESENT FOR (CHECK ONE)

	Less Than 1 Month		1-6 Months		7-11 Months		More Than 1 Year

MEDICAL PROBLEMS (MAJOR ACCIDENTS, INJURIES, ILLNESSES, HOSPITALIZATONS AND SURGERIES)

INCIDENT/MEDICAL PROBLEM	YEAR OCCURRED/STARTED

PAST MENTAL HEALTH TREATMENT AND DIAGNOSIS

DIAGNOSIS	TREATING DOCTOR'S NAME

CURRENT MEDICATIONS

MEDICATION	DOSE (MG)	REASON TAKEN

HIGHEST LEVEL OF EDUCATION COMPLETED (CHECK ONE)

	Elementary School		High School		Some College
	College Degree		Master's Degree		PhD or Higher

EMPLOYMENT

CURRENTLY EMPLOYED?		Yes		No		
EMPLOYER				JOB TITLE		

LIST CURRENT MARRIAGES AND DISSOLUTIONS

SPOUSE'S NAME						
	☐	STILL MARRIED	☐	DIVORCED	☐	SEPARATED
	☐	STILL MARRIED	☐	DIVORCED	☐	SEPARATED
	☐	STILL MARRIED	☐	DIVORCED	☐	SEPARATED

CAFFEINE / TOBACCO / ALCOHOL / ILLICIT DRUG USE

TYPE	DATE STARTED	DATE LAST USED	AMOUNT PER DAY

SPIRITUALITY (CHECK ALL THAT APPLY)

☐	Practicing	☐	Non-Practicing				
☐	Agnostic	☐	Atheist	☐	Catholic	☐	Christian/Protestant
☐	Jewish	☐	Muslim	☐	Other:		

ACTIVITIES YOU ENJOY

SOCIAL ORGANIZATIONS TO WHICH YOU BELONG (CHURCHES, CLUBS, CIVIC ORGANIZATIONS, ETC)

ABUSE / TRAUMA HISTORY

AGE WHEN ABUSE OCCURED	TYPE OF ABUSE							
	☐	Physical	☐	Mental	☐	Sexual	☐	Other:
	☐	Physical	☐	Mental	☐	Sexual	☐	Other:
	☐	Physical	☐	Mental	☐	Sexual	☐	Other:

DEVELOPMENTAL MILESTONES (LIST ANY DELAYS OR DIFFICULTIES)

INFANCY	
TODDLER/PRESCHOOL	
SCHOOL AGE	
MIDDLE/HIGH SCHOOL	

FAMILY PSYCHIATRIC HISTORY (ANXIETY, DEPRESSION, SCHIZOPHRENIA, BIPOLAR, ETC)

RELATIONSHIP TO YOU	DIAGNOSIS

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TO BE COMPLETED BY PROVIDER

CASE FORMULATION (INCLUDE THEORY FOR CAUSE OF IDENTIFIED PROBLEMS)

_____
_____
_____
_____
_____
_____

ATTRIBUTES THAT ENHANCE TREATMENT

_____
_____
_____
_____
_____
_____

DEFICITS THAT IMPEDE TREATMENT

_____
_____
_____
_____
_____
_____

DSM – V DIAGNOSIS

Axis I _____ **Axis II** _____ **Axis III** _____

Axis IV Family Social Educational Occupational Housing Economic

Health Care Legal Other: _____

Axis V Current _____ Highest in Past Year _____

PROVIDER SIGNATURE _____ **DATE** _____