Baker Street
Behavioral Health

Psychiatry Intake Form

PATIENT INFORMATION

Last Name:	Middle Initial:	First name:
Birth Date:	Age:	Gender: ☐ M ☐ F ☐ Other

Pronouns (this helps Baker Street Behavioral Health understand the best way to address you):
☐ She/Her ☐ He/Him ☐ They/Them ☐ I prefer not to say ☐ Prefer to self-describe ____

Mailing Address:

Home Phone:	May we leave you a message? ☐ Yes ☐ No
Cell Phone:	May we leave you a written message? ☐ Yes ☐ No
Email Address:	May we email you? ☐ Yes ☐ No

Please list any children and their ages:

Marital Status:
☐ Never Married ☐ Married ☐ Domestic Partnership ☐ Separated ☐ Divorced ☐ Widowed

Ethnic Group:	Race:	Language:
Emergency Contact:	Phone:	Relationship:

WHO MAY WE THANK FOR YOUR REFERRAL?

(REQUIRED) WHY ARE YOU HERE TODAY?

HEALTH AND SOCIAL INFORMATION

Do you currently have a primary care physician? ☐ Yes ☐ No	When was your last physical?
If yes, Name:	Phone:
Address:	
Are you currently seeing more than one medical Health Specialist? ☐ Yes ☐ No	
If yes, why?	
Please list any allergies / reactions:	
Please list any persistent physical symptoms, or health concerns (e.g. chronic pain, headaches, hypertension, diabetes):	
Are you currently on medications to manage a physical health concern? ☐ Yes ☐ No	
If yes, list:	
Are you having any problems with your sleep habits? ☐ Yes ☐ No	
If yes, ☐ Sleeping too little ☐ Sleeping too much ☐ Poor quality sleep ☐ Disturbing dreams ☐ Other:	
How many times per week do you exercise?	What activities?
Are you having difficulty with appetite or eating habits? ☐ Yes ☐ No	
If yes, ☐ Eating less ☐ Eating more ☐ Binging ☐ Restricting ☐ Purging ☐ Other:	
Have you experienced significant weight change in the last 6 months? ☐ Yes ☐ No	

Do you drink alcohol?	If yes, how many drinks:	Do you engage in recreational drug use?
☐ Yes ☐ No	per day? a week?	☐ Daily ☐ Weekly ☐ Monthly ☐ Occasionally ☐ Never

If yes, list: 1. 2. 3. For how long?
Do you smoke cigarettes or use other tobacco products? ☐ Yes ☐ No If yes, Type/Frequency:
Have you had suicidal thoughts recently? ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
Have you ever attempted suicide? ☐ Yes ☐ No If yes, When?
Do you self-harm? (e.g. cutting) ☐ Frequently ☐ Sometimes ☐ Rarely ☐ Never
In the past year have you experienced any significant life changes or stressors? If yes, explain:
Are you currently in a romantic relationship? ☐ Yes ☐ No If yes, how long?
What is the quality of your relationship?

	Yes	No	If yes, when?
Extreme depressed mood	☐	☐	
Dramatic mood swings	☐	☐	
Rapid speech	☐	☐	
Extreme anxiety	☐	☐	
Panic attacks	☐	☐	
Phobias	☐	☐	
Sleep disturbances	☐	☐	
Hallucinations	☐	☐	
Unexplained losses of time	☐	☐	
Unexplained memory lapses	☐	☐	
Alcohol/substance abuse	☐	☐	
Frequent body complaints	☐	☐	
Eating disorder	☐	☐	
Body image problems	☐	☐	
Repetitive thoughts (i.e obsession)	☐	☐	
Repetitive behaviors (i.e frequent hand washing)	☐	☐	
Homicidal thoughts	☐	☐	
Suicidal attempts	☐	☐	

TREATMENT HISTORY

Are you currently receiving psychiatric services, counseling, or psychotherapy? ☐ Yes ☐ No	
If yes, current practitioner's name:	If no, but past practitioner's name:
Are you currently or previously taking prescribed psychiatric medications (antidepressants or other)? ☐ Yes ☐ No	
If yes, please list medications:	
Prescribed by:	Dates taken:

OCCUPATIONAL INFORMATION

Are you currently employed? ☐ Yes: ☐ Full Time ☐ Part Time ☐ No
If yes, who is your current employer/position?
Please list any work-related stressors, if any:

RELIGIOUS / SPIRITUAL INFORMATION

Do you consider yourself to be religious? ☐ Yes ☐ No
If yes, what is your faith?
If no, do you consider yourself to be spiritual? ☐ Yes ☐ No

FAMILY MENTAL HEALTH HISTORY (Immediate Family Members Only – Do not include yourself or spouse)

Difficulty	Yes or No
Depression	
Bipolar disorder	
Anxiety disorder	
Panic disorder	
Schizophrenia	
Alcohol/Substance abuse	
Eating disorder	
Learning disability/ Special education	
Trauma history	
Chronic illness	
ADHD/ ADD	
Anger management	
Sudden cardiac death before age 50	
Birth defects	

MISSED APPOINTMENTS: In fairness to other patients and our providers, we require at least 24 hours' notice to cancel or reschedule an appointment. Monday appointment cancellations must be received by the previous Friday. A cancellation fee will apply if an appointment is cancelled or rescheduled without proper notice. This is a corporate policy and applies to all patients, please ask staff for further details and fee amounts.

Patient Signature ____________________ Date ____________________

Baker Street
Behavioral Health

Limits of Confidentiality

Contents of all therapy sessions are considered to be confidential. Both verbal information and written records about a patient cannot be shared with another party without the written consent of the patient or the patient's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect When a patient discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the patient discloses or implies a plan for suicide, the health care professional is required to notify legal authorities and make reasonable attempts to notify the family of the patient.

Abuse of Children and Vulnerable Adults If a patient states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), or a child (or vulnerable adult) is in danger of abuse, the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Minors/Guardianship Parents or legal guardians of non-emancipated minor patients have the right to access the patients' records.

Insurance Providers (when applicable) Insurance companies and other third-party payers are given information that they request regarding services to patients. Information that may be requested includes, but is not limited to: types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries. I agree to the above limits of confidentiality and understand their meanings and ramifications.

________________________________ ________________________________

Patient Signature (Patient's Parent/Guardian if under 18) Date

Baker Street
Behavioral Health

Authorization to Release Information to Your Insurance Company

We need your authorization to release your medical information to your insurance companies so that we can determine your benefits, initiate treatment, receive authorization for continued treatment, and receive payment for services rendered.

I, ______________________________, authorize Baker Street Behavioral Health to release my medical information (or information for my child, ___________________________) to Medicare and/or my insurance company to determine my benefits, initiate treatment, receive authorization for continued treatment, and receive payment for services rendered.

Coordination of Care

In addition, we may need your authorization to release information to certain professionals (e.g., physician, therapist, attorney, etc.) involved in your treatment so that we can collaborate and provide more comprehensive care. You may revoke this authorization at any time in writing, except if we have already taken action based on the authorization.

Please list the names and phone numbers of the other Providers from whom you are receiving care.

Name: ______________________________ Phone Number: ______________

Name: ______________________________ Phone Number: ______________

Name: ______________________________ Phone Number: ______________

HIPAA

I have received notice of Baker Street Behavioral Health Privacy Practices and understand the document completely.

Printed Patient Name: ______________________________

Signature of Patient: ______________________________

Printed Name of Responsible Party (if not patient): ______________________________

______________________________ ______________________________
Signature Date

HIPAA - Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 (“HIPAA”) is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. “HIPAA” provides penalties for covered entities that misuse personal health information. As required by “HIPAA”, we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

1. Treatment means providing, coordinating or managing health care and related services by one or more health care providers. An example of this would include referral to/from another physician, health care agency, dentist, school.
2. Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be providing you with a bill for your visit that you will send to your insurance company for reimbursement.
3. Health care operations include the business aspects of running our practice, conducting quality assessment and improvement activities, auditing functions, cost-management analysis and customer service. An example would be an internal assessment review, sharing your health information with staff members to assess our performance, assess quality of care and learn how to improve services.
4. To avert a serious threat to health or safety of you, the public or any other person
5. Law enforcement/national security/protective services. We may release medical information in response to a court order, a subpoena, warrant, summons or similar process; to identify or locate a suspect, fugitive, material witness or missing person; about the victim of a crime if under certain circumstances we are unable to obtain the person’s agreement; about a death we believe may be the result of criminal conduct; in emergency circumstances to report a crime.
6. As required by law. We will disclose medical information about you when required to do so by federal, state or local law. An example of this is to report information related to victims of abuse, neglect or domestic violence.
7. Appointment reminders/Treatment Alternatives/Health-Related Benefits and Services, or payment of your care.
8. Individuals involved in your care or payment of your care. If you do not wish such information be shared, please follow the procedures described in the Right to Request Restrictions.
9. Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law such as audits, investigations, inspections and licensure.
10. Worker’s Compensation. We may release information for workers’ comp or similar programs.
11. Public Health Risks for example to prevent or control disease, injury, disability; reactions to medication, food, other products; to report births, deaths, abuse, neglect, or domestic violence
12. Coroners, Medical Examiners and Funeral Directors so they can carry out their duties. We may also create and distribute de-identified health information about treatment alternatives or other health-related benefits and services that may be of interest to you. Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization. You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer, Baker Street Behavioral Health, 601 Flaghouse Drive, Hasbrouck Heights, NJ 07604
13. The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to any person identified by you. You must request a restriction in writing. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
14. The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.

15. The right to inspect and copy your protected health information, however we have the right to deny requests for psychotherapy notes and provide treatment summary in lieu of psychotherapy notes. If you request copies there is a charge of $1.00 per page, with a minimum charge of $10.00 for records of 10 or fewer pages and a maximum charge of $100.00. If you request an alternative format, we will charge a cost-based fee for providing your health information in that format. Physician's fees are based upon their hourly rate.
16. The right to amend your protected health information.
17. The right to receive an accounting of disclosures of protected health information.
18. The right to obtain a paper copy of this notice from us upon request.
19. We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.
20. This notice is effective as of 1/1/17, and we are required to abide by the terms of the Notice of Private Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices from this office. You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office or the Dept. of Health & Human Services, Office of Civil Rights about violations of provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint. For more information about HIPAA or to file a complaint:

    The U.S. Department of Health & Human Services, Office of Civil Rights
    200 Independence Ave, S.W.
    Washington, D.C. 20201 (202) 619-0257 Toll Free: 1-877-656-6775 Effective Date April 25, 2006

Baker Street
Behavioral Health

Financial Policy

Patient Name: ______________________ Date of Birth: ______________

Please understand that payment of your bill is considered part of your treatment. The following is a statement of our financial policy which we require you to read and sign prior to any treatment.

SELF-PAY & PATIENTS WITH NO MEDICAL INSURANCE:

BASIC POLICY: Payment for services is due in full at the time service is provided in our office. We accept cash and credit cards. Patient is ultimately responsible for all professional fees.

Signature: ______________________ Date: ______________

PATIENTS WITH MEDICAL INSURANCE:

We do not participate on any panels with any Medical Insurance Carrier. If your Medical Insurance carrier covers out of network benefits, we will submit claims for you. Please be advised that we will balance bill you what is usual and customary. If you receive a check from your insurance, you must forward check to Baker Street Behavioral Health.

USUAL AND CUSTOMARY RATES: Our practice is committed to providing the best treatment for our patient and we charge what is usual and customary for our area. You are responsible for payment regardless of any insurance company's arbitrary determination of usual and customary rates.

Payment in full is due at the time of each appointment and will be collected prior to appointment, the patient is ultimately responsible for all professional fees.

Signature: ______________________ Date: ______________

PATIENTS WITH AUTO INS. (MOTOR VEHICLE ACCIDENTS):

Charges for services incurred as a result of an automobile accident will be treated as a Personal Injury claim. You must provide necessary information to bill the carrier. We will bill the Auto Insurance carrier as a courtesy. If the Auto Insurance carrier determines that your condition is not as a result of your automobile-related injury, or your claim is denied for other reasons, you will be required to PAY ALL AMOUNTS DUE WITHIN 30 DAYS.

LETTER OF PROTECTION: I understand that I will not be seen unless my attorney has provided this office with a letter of protection to ensure that payment will be made for services rendered in the event the auto insurance does not pay or the policy coverage is terminated or exhausted. Patient is ultimately responsible for all professional fees.

NON-COMPLIANCE & FAILURE TO SHOW FOR TREATMENT: insurance carriers and attorneys will require continued updates on your case, which cannot be provided if the patient is non-compliant to treatment. More than two missed appointments can result in dismissal from the practice.

Signature: ______________________ Date: ______________

PATIENTS WITH WORKERS COMPENSATION INS. (WORK RELATED ACCIDENT/INJURY):

Charges for services incurred as a result of a verified work-related injury will be treated as a Workers' Compensation claim and we will bill the Workers Compensation carrier as a courtesy. If the Workers' Compensation carrier determines that your condition is not as a result of your work-related injury, or your claim is denied for other reasons, you will be required to PAY ALL AMOUNTS DUE WITHIN 30 DAYS.

LETTER OF PROTECTION: I understand that I will not be seen unless my attorney has provided this office with a letter of protection to ensure that payment will be made for services rendered in the event the auto insurance does not pay or the policy coverage is terminated or exhausted. Patient is ultimately responsible for all professional fees.

NON-COMPLIANCE & FAILURE TO SHOW FOR TREATMENT: Insurance carriers will require continued updates on your case, which cannot be provided if the patient is non-compliant to treatment. More than two missed appointments can result in dismissal from the practice.

Signature: ______________________ Date: ______________

Baker Street
Behavioral Health

Medication Refill Policy

Patient Name: ______________________________

Pharmacy Name: ______________________________

Pharmacy Address: ______________________________

Pharmacy Phone / Fax: ______________________________

Allergies: ______________________________

PLEASE READ CAREFULLY:

1. Initial Prescriptions may take up to 3 hours to process. Please verify with your pharmacy that it is filled, and do not call our office.
2. Please contact your pharmacy to request a refill, and do not call our office for refills.
3. Please allow up to 48 hours for your refill to be processed.
4. Refills are only processed during weekday office hours (10:00am thru 5:00pm Monday thru Friday).
5. Refills sent over the weekend will not be received or reviewed until the next business day.
6. Refills will not be renewed unless the patient is seen on a regular basis.
7. If you are due for an appointment and in need of a refill, you will only be given enough medication until your next scheduled appointment.
8. Any adverse reactions to medication are to be reported to the office.
9. If you are being prescribed a controlled substance and not compliant with your appointments or urine drug screening, you will not receive a refill until your next scheduled appointment.
10. For medical emergencies, call 911, or go to your nearest Hospital Emergency Room.

Please initial:

__________ I have Read and Understand the Prescription Policy and agree to abide by the policy.

__________ I have received a copy of this signed agreement.

Patient's Signature (Parent/Guardian if under 18): ______________________________

Relationship (Print): ____________________ Patient's Name: ____________________

Date: ____________________

Baker Street
Behavioral Health

Financial Service Guidelines

Credit Card Information

Name on Card: ______________________ EXP Date: ______________

Credit Card #: ______________________ CVV: ______________

☐ Visa ☐ MasterCard ☐ American Express ☐ Discover Billing Zip Code: ______________

FSA Card: ☐ Yes ☐ No SuperBill Needed: ☐ Yes ☐ No

Please initial:

________ I understand Baker Street Behavioral Health reserves the right to charge my credit card for any applicable deductible or coinsurance fees should payment not be made at the time of the appointment.

________ I understand Baker Street Behavioral Health reserves the right to charge my credit card if I am not in compliance with the cancellation policy.

________ I understand as a member of an insurance provider that reimburses the insured rather than the provider rendering the service, Baker Street Behavioral Health reserves the right to charge my credit card the reimbursement payment issued by the insurance provider if the reimbursement check is not brought to Baker Street Behavioral Health within 14 days of receipt of the payment. In the event Baker Street Behavioral Health charges my credit the reimbursement payment, the member can then keep the check issued by the insurance provider.

________ I understand Baker Street Behavioral Health reserves the right to pass on any applicable chargeback fees permitted by law associated with a disputed credit card charge.

________ I understand failure to comply with our policies may result in pause in services until your account is made current. Baker Street Behavioral Health, however, reserves the right to terminate services and forward the account to Collections if necessary

Name of Patient: ______________________ Date: ______________

Name of Patient/Guardian: ______________________

Signature of Patient/Guardian: ______________________ Date: ______________

PLEASE READ CAREFULLY

Appointment Policy

An appointment is considered a mutual commitment between you and your clinician and is subject to personal accountability and responsibility in keeping and managing the appointment. A 24 (twenty-four) hour notice is required to reschedule or cancel your appointment and to avoid automatic billing for payment of your session. Monday appointment cancellations must be received by the previous Friday. Appointments for which you arrive late will still end at the appointed time. As a courtesy, you may receive a reminder phone call, email and/or text for your appointment; however, responsibility for keeping your appointment is ultimately yours. All patients must arrive on time for their scheduled appointment. Failure to do so will result in a fee and rescheduling (if applicable) of the appointment.

Agree and Initial Here ______________

Drug Screening Policy

Drug screens are performed on patients when necessary. All new patients and patients who are prescribed controlled substance medications will have an initial drug screen and may be subjected to ongoing and/or random drug screening after. All patients who are prescribed controlled substances either by medical staff or any other third-party providers will be subject to regular drug screening. Any charges that may result from the drug screens will be the responsibility of the patient if not covered by the insurance company.

Agree and Initial Here ______________

Payment for Services

If we are not billing an insurance company for your service, the full payment is due at the time of service. Your co-payment and any deductibles and balances, which may apply, will be collected when you check-in. Baker Street Behavioral Health accepts cash, debit and all forms of credit cards. Balances and payment arrangements are the patient's responsibility and should be treated as a personal commitment and subject to personal accountability. Credit cards on file may be charged for outstanding balances.

Agree and Initial Here ______________

Confidentiality

The practice operates in a "multi-disciplinary" way, meaning that the clinician's function as a team. Therefore, it is important to understand that the information in the chart is accessible to other clinicians in the office in order to provide you with quality and consistent care. However, no information about you or your care will be released to anyone outside the office without your consent or a court order. The only exceptions include suicidal or homicidal risk factors or child/elder abuse or neglect. You will complete a Release of Information that you can use to list person(s) to whom we may have communications with about you, your care and/or financial matters concerning your account. Children (under the age of 17) have the right to confidential exchanges with clinicians. However, if there are issues that pose grave or immediate danger, these issues may be discussed with parents or legal guardians or child protective services.

Agree and Initial Here ______________

Contact and Treatment

Our office staff will take messages during regular business hours. Please allow 48-72 (business) hours for a response as clinicians have varied schedules and are not in the office each day. Please do not wait until a crisis to contact our office. We can address routine concerns much more effectively than crisis concerns. You may be asked to schedule a sooner appointment with your provider if our staff cannot address your concerns. Please note that most concerns are best addressed in sessions, and providers cannot be interrupted from treating others to take your calls. If your concern involves a safety issue, please notify our office immediately. If you have an after-hours concern, you may leave a message on our voicemail. If your need is emergent due to safety issues at any time, please call 911 or go to the nearest Emergency Department.

Agree and Initial Here ______________

Dismissal

If you are "dismissed" from the practice you can no longer schedule appointments, get medication refills, or consider us to be your physician/therapist. You must find a provider(s) in another practice. Common reasons for dismissal include failure to keep appointments, frequent no-shows, noncompliance with treatment plan or medical advice, verbally abusive or threatening behaviors to any of our staff or failure to pay your outstanding balance. We will send a letter to your last known address, notifying you that you are being dismissed. If you have a medical emergency within 30 days of the date on the letter, we may assist you with care options.

Agree and Initial Here ______________

Printed Patient Name: ____

Signature of Patient: ______________________ Date: ______________

Baker Street
Behavioral Health

Patient Consent to Treatment

By signing below, you certify that you have read and understand the terms stated in the Treatment Consent Form. You indicate that you understand the scope of services, session structure, fees, cancellation/no-show policies, payment policy, insurance reimbursement, confidentiality, the nature of my practice, and my contact information, and that you agree to abide by the terms stated above during the course of our therapeutic relationship.

______________________________ ______________________________
Signature Date

Consent for Treatment of Minors

I/We______________________________have full custodial guardianship of ______________________________. He/she is currently under the age of 18, and I/we consent that he/she may be treated as a patient by Baker Street Behavioral Health.

Parent/Guardian Name: ______________________________

Parent/Guardian Signature: ______________________________ Date: ______________

Patient Consent (if over the age of 14):______________________________ Date: ______________

OFFICE USE ONLY

Office Staff Name: ______________________________

Signature of Office Staff: ______________________________ Date:______________

Comments: