Med Management
Adult
Private / Medicare

Client Name:_____

Winchester Community Mental Health Center, Inc.

MR#_____

Date_____

Client Name_____
Cell Phone: (____)_____ Email: _____ Home Phone (___) _____
Can we leave a message on your cell phone: Yes___ No__ Can we leave a message on your home phone: Yes___No__
Address_____City_____Zip Code_____
Gender: M/F Age____ Date of Birth _____/_____/_____ Social Security # _____
Occupation _____ Employer/ School _____
Work Phone (____) _____ Martial Status _____
Spouse's Name _____ Social Security # _____
Age _____ Date of Birth ____/____/____ Employer: _____
Occupation _____ Cell (____) _____ Work phone: _____
PRIMARY INSURANCE INFORMATION:
Insurance Company_____ ID/ Member # _____
Group # _____ Policy/ Plan # _____
Name of Insured _____ Insured's SSN_____
Insured's DOB_____
SECONDARY INSURACE INFORMATION:
Insurance Company_____ ID/ Member # _____
Group # _____ Policy/ Plan # _____
Name of Insured _____ Insured's SSN_____
Insured's DOB_____
EMERGENCY CONTACT _____ **Phone** (___)_____ **Relationship:** _____
Parent Information (IF PATIENT IS A MINOR)
Father_____**Home Phone** _____
Address _____ City _____ Zip _____
Date of Birth _____/_____/_____ Social Security # _____
Employer _____ Work Phone _____
Mother_____ **Home Phone:** _____
Address _____ City _____ Zip _____
Date of Birth _____/_____/_____ Social Security # _____
Employer _____ Work Phone _____
I was referred by _____ ***Relationship to you*** _____

<u>If you want us to bill your insurance:</u>

**** Please provide the Receptionist with your insurance card(s) and a picture ID. Insurance is billed as a courtesy. It is important that you understand the following: (Please check ✓ <u>and</u> initial _ the following statements.)**

- ☐ __ I will be charged a $40.00 fee for any missed appointments and for cancellations received less than 48-72 hours prior to my scheduled appointment time. **Insurance will not pay for these and they are my sole responsibility.**
- ☐ __ I am responsible to obtain any preauthorization from my insurance company. If failure to do so results in non- payment from my insurance company. I understand I am financially responsible to pay for these sessions. I am responsible to pay for all deductibles, any and all co-pays, co-insurance and any balance remaining after insurance has paid their portion and contractual adjustments have been made.
- ☐ __ I understand that the ultimate financial responsibility is mine and verification is not a guarantee of payment.
- ☐ __ I have read & understand the above. I authorize payment of benefits be made on my behalf to Winchester CMHC, INC. for any services
- ☐ __ **I have been offered a copy of HIPPA- Notice of Privacy Practices. I would like a copy. (Circle One) Yes or No**

Client/ Parent Signature _____ Date_____

Authorized Staff Signature _____ Date _____

36 Ricketts Drive
Winchester, VA 22601
&
123 Hovatter Drive
Inwood, WV 25428

Client Name:_____

MR#_____

Winchester Community
Mental Health Center, Inc.

Assignments of Benefits: Release of Liability & Medical Information

I hereby authorize and request that insurance benefit payments by my insurance company

_____

(Name of insurance company)

be made directly to Winchester Community Mental Health Center ("Facility") for services provided to me or my dependent by the facility. I understand that my insurance company may only cover a portion of the total bill and that I may be responsible for all charges not covered by this assignment.

In addition, I authorize Winchester Community Mental Health Center, Inc. to disclose any and all written information to the above-named insurance company and/or its designated representatives, at the determination of the facility. Such disclosure shall be for reimbursement purposes for services provided by the facility.

I hereby release the facility, its officers, agents, employees and any clinician associated with my treatment, from all liability that may arise as a result of discloser of information to the above named insurance company or their designated representatives.

By signing this assignment of benefits and release of information I acknowledge:

1. I am aware and understand that this authorization will not be used unless the above-named insurance company or their designated representatives request records of information for reimbursement purposes.
2. I agree to participate and assist the facility or its designated representatives with any appeal process necessary to collect payment for services rendered. I hereby appoint the facility as my appointed representatives in any insurance provider or fiscal intermediary case reconsideration and/or appeal procedure to act on my behalf.
3. I am aware and have been advised of the provisions of Federal and State Statutes, rules and regulations that provide for my right to confidentiality of these records.
4. I understand that this assignment and authorization is subject to revocation at any time except to the extent that action has been taken in reliance thereof. In any event, this authorization will expire once reimbursement for services rendered is complete.
5. I understand that the ultimate financial responsibility is mine and verification of insurance is **not** a guarantee of payment
    - Billing may be done by a firm contracted by the facility for billing and collection purposes.
    - Should an overpayment take place, a refund check will be mailed to the authorized party that is due the overpayment.
    - The facility shall be entitled to the full amount of its charges without offset.

I acknowledge receipt of a completed and signed copy of this assignment and release form.

_____ _____

Client Signature **Legal Guardian** **Insured Policyholder Name & D.O.B.**

_____ _____

Witness Signature **Date of Signatures**

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Winchester Community Mental Health Center, Inc.

Private Insurance/Medicare Appointment Responsibility Contract

Date: _____

I, _____, understand and agree to the following:
(Client/Legal Guardian Name - Please Print)

- I am responsible for keeping my appointments.
- I am responsible for being on time.
- I will give at least 48-72 hours notice by calling WCMHC, Inc if I cannot keep my appointment. My appointment will be considered a "No-Show" if 48-72 hours notice is not provided.
- I will be charged a cancellation fee of **$40.00** if I do not call to cancel an appointment at least 48 hours prior to the appointment date.
- I will receive a warning letter if I "no-show" to **2 appointments,** or have excessive rescheduled or cancelled appointments.
- I will be discharged if I "no-show" to **(3)** appointments, or have excessive rescheduled or canceled appointments. If I receive a discharge letter, I will not be eligible to receive services at WCMHC for 6 months.

_____ _____
Signature of Client Date Signature of Parent/ Advocate Date

_____
Witness Signature Date

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Winchester Community
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Acknowledgment of Receipt of HIPAA Notice of Privacy Practices
("Acknowledgement")

I acknowledge that I have received a copy of WCMHC's HIPAA Notice of Privacy Practices

_____
Printed Client Name

_____ _____
Signature of Client Date

OR

_____
Signature of Personal Representative

Authority of Personal Representative to Sign for Client **(Circle One):**

Parent Guardian Power of Attorney Other:_____

Please note: It is your right to refuse to sign this Acknowledgement

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Patient Quick Reference Data Sheet

Are you allergic to any medications or other items? Yes No

If yes, please list ALL things you are ALLERGIC to and identify the reaction you have:

Medication or other allergen:	Description of Allergic Reaction:

(If you are allergic to more items, please continue to list them on back of this sheet, including the reaction)

If any of your allergic reactions are anaphylactic, do you carry an EPI-pen on you at all times? YES NO

Please list ALL medications you are CURRENTLY taking

Medication: Dosage: When was it started? Why prescribed? Is the medication effective?

_____
_____
_____
_____
_____
_____
_____
_____

Previous medications you have taken (PSYCHIATRIC ONLY):

Medication: Dosage: When was it taken? How long was it taken? Why did you stop taking?

_____
_____
_____
_____

Do you currently have any illness/infection or are you being treated for any ongoing medication? YES NO

If yes, please describe the illness/condition as well as the name of the physician that is treating you:

_____
_____
_____
_____
_____

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Personal History Form - Adult

Please answer the following questions about the client scheduled to be seen: parents & caregivers may assist:

Name:_____ DOB:_____ Age:_____ Today's Date: _____
Home Address:_____
Home Telephone: _____ Cell Phone:_____ Work Phone:_____
Occupation:_____ Referral Source:_____

Briefly describe the recent concerns/problems that have led to you making this evaluation/treatment?

_____
_____
_____
_____
_____

What are three biggest stressors in your life at this time?

1. _____
2. _____
3. _____

Psychiatric History:

Have you ever before had treatment for a psychiatric disorder? Yes No

If so, do you know any previous diagnoses? _____

Was your previous treatment an outpatient setting? Yes No What services were provided? _____

Was your previous treatment in a psychiatric hospital? Yes No If so, Where and when? _____

If you're currently receiving psychiatric counseling, please give name and phone number of counselor:
Name:_____ Phone Number:_____

Are you now or have you ever taken psychiatric medications? Yes No

If so, please list the medications below (if you cannot remember the exact dates or reason it was prescribed that is ok- but the names of the medications and the reason or reaction is important.)

Medication: Dose: When was it taken? How long was it taken? Why did you stop taking?

_____
_____
_____
_____
_____

(If you have been on more than 5 medications in your life, please use the back of this form or a separate sheet of paper to continue listing medications)

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Have you ever experienced feelings of wanting to harm yourself or kill yourself? Yes No

IF YES, please answer the following. **IF NO,** please skip to the next section (Brief Screening Questions)

How often have you had these thoughts? _____

Has anything happened recently to make you feel like this?_____

_____

Have you ever tried to kill or harm yourself before? _____

If so, what method did you use? _____

Brief Screening Questions

Are you having difficulty with sleep (hard to fall asleep or stay asleep, early awakening)? YES NO

Has your appetite been significantly greater or less than usual? YES NO

Are you bothered by hearing voices/sounds or seeing things others cannot see? YES NO

Do you have difficulty with focusing or following through on tasks? YES NO

Medical Information:

ALLERGIES: YES NO

If yes, please list each thing you are allergic to and what your reaction is (rash, throat swelling, ect.)

_____

_____

_____

Any prescription medications taken for medical problems and how often you take them (or if non, please write "none")

_____

Any over-the- counter medications or dietary supplements:

_____

Please circle any of the medical problems listed that currently have or have had in the past:

Asthma	Acid Reflux	Anemia	Depression	High Blood Pressure
Chest pain	Heart Disease	Chronic Pain	Head Trauma	Bipolar Disorder
High Cholesterol	Fibromyalgia	Diabetes	Kidney Disease	Carpal Tunnel
Thyroid Disease	Liver Disease	Seizures	Chronic Fatigue	Cancer (type?)
Headaches	Dizziness	Vision Problems	Hearing problems	Anxiety/Panic Attacks
Urinary Problems	Arthritis	Intestinal Problem	COPD	Autoimmune Disorder (which one?)

Any other not listed medical conditions not listed?

_____

Are you currently having any cold or flu like symptoms or any other acute illness?

_____

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Have you ever suffered a head injury? **YES** **NO** When? _____

What happened? _____

Did you lose consciousness? **YES** **NO** Was a CT scan or MRI of your head done? **YES** **NO**

If yes, when? _____ Where? _____ Are you aware of any results? _____

Past Hospitalizations/surgeries:

_____

Your mother's name: _____ Age: _____
If deceased, date of death, age at time of death and cause if known:

_____

Your father's name: _____ Age: _____
If deceased, date of death, age at time of death and cause if known:

_____

Name of your primary health care doctor: _____ Phone: _____

When was your last physical exam? _____ Have you ever had an EKG? YES NO Date: _____

Have you ever had routine blood work? YES NO Date: _____

Were any of the results from your physical exam/ EKG/or blood work abnormal to your knowledge? YES NO

If Yes, Explain:

_____

For women only:

Date of last menstrual period: _____
Are you currently pregnant or is there a possibility that you could be pregnant? YES NO
Do you think you will be planning to get pregnant in the near future? YES NO

How many times have you been pregnant? _____ How many live births have you had? _____

Developmental History:

Please answer the following to the best of you knowledge
When your mother was pregnant with you, were there any complications and if so, what were they?

_____

Did you meet all developmental milestones on time? (walking, talking, toilet training)? YES NO

If not, please explain: _____

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Who were your primary caregivers during your first two years of life? After that? _____
_____

Were you ever exposed to abuse at any time during your life? YES NO

If yes, was it physical? _____ Sexual? _____ Emotional? _____ Neglect? _____

Who was involved? _____

Substance Abuse:

Have you ever been treated for alcohol or drug use or abuse? YES NO

If yes which substance(s)? _____

Where were you treated and when? _____

How many alcoholic beverages do you consume each week? _____
Tobacco use: Current? YES NO In the past? YES NO Date of last use: _____

If yes to either, what form of tobacco (cigarettes, snuff, cigars, ect.) _____

How many per day? _____ For how long? _____

If applicable, please circle the names of any of the following substances that you have ever or currently use:

Marijuana	Cocaine/Crack	Heroin	Opiates/Pain Medication	Ecstasy
Stimulants	LSD/PCP/Mushrooms	Inhalants	"Speed"	Other: _____

Have you used any of the above listed substances in the last 3 months? YES NO
If yes, which ones? _____
If applicable, please list duration/ dates for the use for the substances circled above:
_____
_____

Educational History
What is the highest grade level you achieved? _____
If you completed any schooling after high school, what did you study/ major in? _____

Family History:
Your mother's name: _____ Age: _____
If deceased, date of death, age at time of death and cause if known:
_____

Your father's name: _____ Age: _____
If deceased, date of death, age at time of death and cause if known:
_____

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Please list any siblings, including their age, illnesses of significance (psychiatric and medical) and how often you interact with them currently:

_____
_____
_____
_____
_____
_____
_____
_____
_____

Social History:

What is your current marital status? Single Engaged Married Separated Divorced Widowed
If married, how many years have you been? _____
Spouse's name: _____ Occupation: _____
If widowed, how long ago was the death of your spouse? _____
If divorced, how long and what was the reason for divorce? _____
If you have children please list them below:
Name: Age: Location: Biological child?

_____
_____
_____
_____
_____

(if you have more than 5 children you identify as your child, please use the back of the paper or a separate sheet)

Please identify who all is living in your household currently, how they are related to you and how everyone is getting along:

_____
_____
_____
_____
_____
_____
_____
_____

Have you had a history of legal problems or any current legal problems/ charges pending?

_____
_____

Have you ever struggled with violent behaviors/ aggression towards others or property?

_____
_____

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Occupational/Work History?

Are you currently employed? YES NO
If so, what is your current job title?
_____

How would you describe your job satisfaction (fulfilled, unsatisfied, finding work, stay at home parent, ect.)
_____

If not, please indicate the reason for unemployment (disability, difficulty finding work, stay at home parent, etc.)
_____
Have you ever held a job outside of the home? YES NO
What was your job title at your last job? _____
What was the reason for the job ending? _____
What was the approximate date you were last working? _____

Do you have a history of military service? If so, what branch did you service in? How many years were you enlisted and what was the nature of your discharge?
_____
_____
_____
_____
_____

Personal Accomplishment/ Interests and Hobbies:

What stresses/ struggles have you overcome in the past?
_____
_____

How did you do it?
_____
_____

What was the best period of your life?
_____
_____

What is your biggest accomplishment?
_____
_____

What are your personal strengths?
_____
_____

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What are some hobbies or activities that you enjoy doing?

_____
_____

Is there any information not asked on this personal history form that you would like the Doctor/ Nurse Practitioner to be aware of and/or be certain is addressed during your appointment? Or if you would like to further explain and area that was asked, but you feel more information for the MD/NP is helpful, please provide it below.

_____
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If you receive this prior to your scheduled appointment, please complete it and return it to the office as soon as it is most convenient for you that it can be reviewed by the clinician you will be seeing and more time during the initial appointment can be spend on discussing the current problem areas and/or treatment options rather that obtaining the information in this packet.

Thank you and we will see you soon.