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

2020 PATIENT INFORMATION

Today's Date:			
Patient Name:	**Birthdate:**	**Age:**	**Gender:** Male Female
Street Address:			
City:	**State:**	**Zip Code:**	
Home Phone:	**Cell Phone:**	**Work Phone:**	
Preferred Contact Number: Home Cell			
Preferred Method for Appointment Reminder Calls: Text Voice			
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 Other ____________________			
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, certification and training of those mental health Providers directly supervising the services received by the patient.

PATIENT CONSENT FORM (CONT.)

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.

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.

SOCIAL MEDIA AND TECHNOLOGY:

E-MAILS, CELL PHONES, AND COMPUTERS Computer, e-mail and cell phone communications add convenience, however no form of communication is 100% guaranteed to be private, and could be accessed relatively easily by unauthorized people. If you communicate confidential or private information via SMS (text) or e-mail, our office will assume that you have made an informed decision, and will view it as your agreement to take the risk that such communication may be intercepted. Please do not use e-mail or SMS (text) for emergencies. Also note that any communication between you and our office become part of your legal record and may be revealed in cases where your records are summoned by a legal entity. If you prefer not to authorize the use of e-mail and/or SMS (text) messaging 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 e-mail and/or SMS (text) messaging

LOCATION BASED SERVICES REVEAL YOUR LOCATION We do not place our practice as a check-in location on various sites such as Foursquare or Google. However, if you have GPS tracking enabled on your device, it is possible that others may surmise that you are a client due to regular check-ins at our office. Please be aware of this risk if you are intentionally "checking in" from our office or if you have a passive LBS app enabled on your phone.

SOCIAL MEDIA SHOULD BE CONSIDERED PUBLIC COMMUNICATION Messaging and/or being linked as friends on Social Networking sites such as Facebook is not secure. It could compromise your confidentiality to use Wall postings, @replies, or other means of engaging with your Provider online if you have an established client/therapist relationship. These exchanges could also become part of your legal medical record. We discourage the use of social network sites for communication about therapeutic relationships, including scheduling issues, due to the lack of privacy protections. If you need to contact your Provider between sessions, the best way to do so is by calling our office.

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PATIENT CONSENT FORM (CONT.)

BUSINESS REVIEW SITES: You may find our practice on sites that list businesses. Some of these sites include forums in which users rate their Providers and add reviews. If you should find our office listed on any of these sites, please know that our listing is NOT a request for a testimonial or rating from you as a client. You have a right to express yourself on any site you wish, but due to confidentiality, we cannot respond personally to any review on these sites whether it is positive or negative.

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 Name (please print)	Patient Date of Birth
______________________________	______________________
Patient Signature (or signature of legal guardian)	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 to a specific individual 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 read and understand this Privacy Policy. I understand that I may, at any time, request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment, or health care operations.

______________________________	____________________________________	______________
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 _________

PATIENT CONSENT TO EXCHANGE INFORMATION

I authorize The Oasis Counseling Center LLC and the following Medical Providers 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.

Medical Provider Name: _____________________________ City/State: ____________________________

Medical Provider Name: _____________________________ City/State: ____________________________

Medical Provider Name: _____________________________ City/State: ____________________________

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

TODAY'S DATE:			
YOUR NAME:		DATE OF BIRTH:	

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

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LIST CURRENT MARRIAGES AND DISSOLUTIONS

SPOUSE'S NAME								
		Still Married		Divorced		Separated		Deceased
		Still Married		Divorced		Separated		Deceased
		Still Married		Divorced		Separated		Deceased

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