University of Evansville

Mental Health Clinic and Emily M. Young Assessment Center

**Today's date:** ______________

# Adult Information Form

Full name: ________________________________________ Date of birth: ______________ SSN: ________________

Preferred nickname: ___________________________ Gender at birth: ____________ Gender identity:_____________

Mailing address: _____________________________ City: ___________________ State: ______ Zip: __________

Email: ____________________________________ Phone number: _____________________________

Religion/spiritual connection: __________________ Race/ethnicity: _______________ Language: _______________

**Emergency Contacts:**

Name: _________________________________ Relation: _________________ Phone: ___________________________

Name: _________________________________ Relation: _________________ Phone: ___________________________

Name: _________________________________ Relation: _________________ Phone: ___________________________

Primary Care Physician (name, address, and phone):

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Would you sign a release to allow contact with your primary physician? Yes No

**Referral Info:**

How did you hear about us? This helps us to understand how to reach out to and help more of our community.

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Current concerns/symptoms to be addressed:

_____________________________________________________________________________________________

_____________________________________________________________________________________________

_____________________________________________________________________________________________

How long have you experienced these concerns/symptoms?

_____________________________________________________________________________________________

_____________________________________________________________________________________________

Please list any past psychological treatments, medications, tests, or hospitalizations:

_____________________________________________________________________________________________

_____________________________________________________________________________________________

**Employment History:**

Please list your three most recent:

| Company Name | Dates of Employment | Reason for Leaving |
| --- | --- | --- |
| ______________________ | ______________ | ________________________ |
| ______________________ | ______________ | ________________________ |
| ______________________ | ______________ | ________________________ |

Highest school grade completed: ____________________

Degrees or Certifications: _________________________

What activities do you enjoy doing? __________________________________________________

Are you involved with any clubs, sports, or other hobbies? __________________________________

Personal strengths and talents: _____________________________________________________

**Family Information:**

Marital status: Single Married Widowed Partnership Legally Separated Divorced

If Separated or Divorced, when did this occur? ___________________

If remarried, when did this occur? ___________________________

Who is the person you feel most comfortable with sharing your secrets, worries, or feelings? ___________________

**Please list the members of your immediate family (include children/stepchildren):**

| Name | Relationship | Age | **Medical & Psychological History** (Please include difficulties with attention span, learning, emotion regulation, and substance abuse.) | Age of Diagnoses | Living? | Residing Together? |
| --- | --- | --- | --- | --- | --- | --- |
| | | | | | Y N | Y N |
| | | | | | Y N | Y N |
| | | | | | Y N | Y N |
| | | | | | Y N | Y N |
| | | | | | Y N | Y N |

**Please check any of the following stressful events that apply to you or your family:**

- ☐ Relocations
- ☐ Deaths
- ☐ Illnesses
- ☐ Marital Problems
- ☐ Job Changes
- ☐ Legal Issues
- ☐ Experienced a traumatic event
- ☐ Witnessed a traumatic event
- ☐ Physical or sexual abuse or neglect
- ☐ Social Services involvement
- ☐ Other: ________________________________________

**Your Medical History:**

| | Circle One | Ages | Describe |
|---|---|---|---|
| Allergies | Y N | | |
| Appetite/eating problems | Y N | | |
| Asthma | Y N | | |
| Clumsiness/poor motor skills | Y N | | |
| Chronic constipation | Y N | | |
| Chronic ear infections | Y N | | |
| Headaches | Y N | | |
| Hearing/ear problems | Y N | | |
| Head injury | Y N | | |
| Nightmares | Y N | | |
| Persistent high fevers | Y N | | |
| Physical disabilities | Y N | | |
| Seizures | Y N | | |
| Sleep apnea/snoring | Y N | | |
| Surgeries | Y N | | |
| Tics/twitching | Y N | | |
| Vision/eye problems | Y N | | |
| Alcohol use/abuse | Y N | | |
| Illicit drug use/abuse | Y N | | |
| Risky behaviors | Y N | | |

Additional medical and hospitalization history information: (please include age)

_______________________________________________________________

_______________________________________________________________

Are you currently being treated for anything? (describe) Yes No

_______________________________________________________________

_______________________________________________________________

**Current Prescribed and Over-the-Counter Medications:**

| Name of Medication | Dosage | Name of Prescribing Physician |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

Difficulties following doctor's advice for medication or other treatments? (describe) Yes No

_______________________________________________________________

**Please list past, or current, counselors, psychologists, psychotherapists, and psychiatrists:**

| Age | Provider Name | Service (testing, treatment, medication) | Helpful? |
|---|---|---|---|
| _______ | ________________ | _________________________________ | Yes No |
| _______ | ________________ | _________________________________ | Yes No |
| _______ | ________________ | _________________________________ | Yes No |
| _______ | ________________ | _________________________________ | Yes No |

Would you sign a release to allow contact with these providers? Yes No

Please write any additional remarks you would like to review with us and how we may be able to help.

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

Thank you for taking the time to complete this information form. Please make sure to drop it off at the reception desk when it is completed.

UE Mental Health and Wellness Clinic
& Emily M. Young Assessment Center
University of Evansville
1931 Lincoln Ave. Suite A
Evansville, IN 47722
812-488-5640

NPI: 1023769213 (Katherine Hulsey, PA-C)
Tax ID: 35-0868074

# Good Faith Estimate – Medication Management

Client Name: ______________________________ Date of Notice: _______________

Date of Birth: ________________________

| Description of Services | CPT Code | Price | Price with Self-Pay Discount |
|---|---|---|---|
| Initial Outpatient **30 min. – 60 min.** | 99203, 99204, 99205 | $150.00 – $250.00 | $90.00 - $150.00 |
| Established Outpatient **20 min.** | 99213 | $115.00 | $69.00 |
| Established Outpatient **30 min.** | 99214 | $150.00 | $90.00 |
| Established Outpatient **40 min.** | 99215 | $200.00 | $120.00 |

Diagnosis Code: TBD Location: On-site or Telehealth

I understand the following information as it pertains to the Good Faith Estimate:

1. This estimate is not a contract and does not require you to obtain the items or services listed above.
2. There may be additional items or services that are recommended as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate.
3. Information provided in the good faith estimate is only an estimate regarding items or services reasonably expected to be furnished at the time the good faith estimate is issued to the individual and that actual items, services, or charges may differ from the good faith estimate.
4. The client has the right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially in excess of the expected charges included in the good faith estimate, as specified in **§ 149.620**. Instructions for how to initiate a patient-provider dispute resolution process will be provided by request at any time to the patient. Initiation of the patient-provider dispute resolution process will not adversely affect the quality of health care services furnished to the individual.

Signature: Printed Name:

_____________________________ _______________________ _______________

Client, Parent/Guardian, Representative Date

University of Evansville
Mental Health Clinic and Emily M. Young Assessment Center

# CONSENT FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS

Client Name: ___________________________ Client DOB: ________________

**CONSENT FOR TREATMENT**

I consent to and authorize any healthcare professional who may be involved in my care at the UE Mental Health and Wellness Clinic and Emily M. Young Assessment Center to perform any evaluation procedures and/or therapy. I understand and acknowledge that within any of the treatment spaces that my care will be video and audio recorded. I understand that the recording will be used for internal educational purposes only, and that only those directly involved in training will have access to any identifying information about me.

**FINANCIAL RESPONSIBILITY**

Thank you for choosing the UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center. Your understanding of our financial policy is important to our professional relationship. If at any time you need assistance, please contact us at 812-488-5640. We accept Cash, Check, and all major credit cards

**ALL ACCOUNTS**

I agree to be responsible for payment on the account. Payment is expected to be paid at time of service unless other arrangements are made in advance.

**COMMUNICATIONS**

I authorize the UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center and any of its agents to contact me by telephone, at any of the numbers provided, including any wireless number for me and/or my spouse, which could result in charges to me/us. I acknowledge that my spouse or I may also be contacted by sending text messages, and/or emails, using any email address provided.

**INSURANCE**

UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center will file all insurance claims when applicable. **It is my responsibility to verify coverage with my insurance company. I understand that a quote of benefits from my insurance company is not a guarantee of payment.** It is my responsibility to understand my insurance coverage. Payment of deductibles, non-covered/denied services and co-payments are my responsibility. I also understand it is my responsibility to provide the insurance company with all requested information. If charges are denied due to my lack of response, the charges will become my sole responsibility. I will notify the UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center immediately of any change in my insurance. Failure to notify of any changes will result in my responsibility for all charges that may occur.

**ASSIGNMENT OF INSURANCE BENEFITS**

I authorize my signature on all insurance claim forms and assign insurance payments to be made directly to the UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center for services rendered.

**RELEASE OF INFORMATION**

I hereby authorize the release of information necessary to file claims with my insurance company. I also authorize one or all the designated parties below to request and receive the release of any protected health information regarding my treatment. UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center cannot prevent re-disclosure of your information by the person or facility who receives your records under this authorization and the information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release the UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center from any and all liability resulting from a re-disclosure by the recipient. The authorization to release medical records will expire 180 days from close of file.

**NOTICE OF PRIVACY PRACTICES ACKNOWLEGMENT**

**I have read, understand, and agree to the terms listed above. (Consent for treatment, Financial Responsibility and Release of Information) My signature also indicates that I have received a Notice of Privacy Practices from UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center.**

Signature: Printed Name:

_____________________________________ ________________________ __________________

Client, Parent/Guardian, Representative Date

Mental Health Clinic and Emily M. Young Assessment Center

# ATTENDANCE POLICY

Client Name: ___________________________________ DOB: ______ / ______ / ______

We are looking forward to working with you. Consistent attendance is required in order for clients to achieve maximal benefit from these services. Failure to maintain regular attendance can result in reduction of frequency of sessions or discharge from therapy altogether.

Clients are expected to attend all scheduled sessions. These sessions can be distinguished by the following:

**Psychological Evaluations**

Due to the demand and time of psychological testing, we may not reschedule if this appointment is a no show.

**Ongoing Therapy**

3 no shows within 6 months may result in termination of services.

**If you are unable to keep your scheduled appointment, please contact our department as soon as possible. Another client may be able to utilize this spot.**

- 812-488-5640 (Main Office)
- After hours- you can leave a message on our answering machine
- A late cancel is defined as cancelling within 4 hours of your scheduled appointment. Late cancels will be monitored and can result in a reduction of therapy sessions.

**SUPERVISION OF YOUTH DURING VISIT (AGES 0-17)**

Parents, guardians, or other adult designees bringing children (ages 0-17) to the clinic MUST remain on the property for the entire duration of the child's visit(s). If you would like to leave the lobby (while staying on the premises), you must check in at the reception window or with your provider and ensure we have updated contact information for you, should we need to get in touch with you during your visit. Please return to the lobby prior to the end of your child's visit. Your provider may require your presence in treatment at any time.

By signing below, I agree to maintain consistent attendance. I understand that therapy will be discontinued if I am unable to meet the above-listed requirements.

X ____________________________________________________ ____________________

Client (or Parent/Guardian/Representative) Signature Date