Diane Eden, M.D. and Associates, Inc.

Personal Information

Name		Date of Birth	Today's Date
Chart Number	Sex	SSN	Marital Status
Address			Driver's License #
City		State	Zip Code
Email Address		Primary Phone	Secondary Phone

Primary Care Physician	Physician Phone	Date Last Seen	May we contact your PCP? ☐ Yes ☐ No
Pharmacy Name	Pharmacy Phone		
Pharmacy Address	City	State/Zip Code	
Ethnicity ☐ Hispanic / Latino ☐ Non-Hispanic / Latino	Race ☐ Caucasian ☐ African American ☐ Asian ☐ Other		
Languages Spoken: ☐ English ☐ Spanish ☐ Other			

Insurance Information

Primary Insurance		Are you insured? ☐ Yes ☐ No
Subscriber Name	Relationship to Insured	
Phone	Gender ☐ Male ☐ Female	DOB
Address		
Policy ID	Group ID	
Secondary Insurance		Are you insured? ☐ Yes ☐ No
Subscriber Name	Relationship to Insured	
Phone	Gender ☐ Male ☐ Female	DOB
Address		
Policy ID	Group ID	

Emergency Contact Information

Primary Contact	Relationship	Contact Phone

Secondary Contact	Relationship	Contact Phone
Do you have advanced directives? ☐ Yes ☐ No		

Personal History

How did you find out about our practice? ☐ Physician ☐ Internet ☐ Family / Friend ☐ Other
What is the reason for your visit today?
How long has this been bothering you?
What treatments have you tried and have they been successful?
What is your occupation?
Are you in school? ☐ Yes ☐ No
What is your highest level achieved?
What are your hobbies and interests?
Do you exercise regularly? ☐ Yes ☐ No

Social History

Do you smoke?	Do you drink alcohol?	Have you ever had a substance abuse problem?
☐ Current every day smoker ☐ Current occasional smoker ☐ Former smoker ☐ Never smoked For how long?	☐ Yes, 5-7 days per week ☐ Yes, occasionally/socially ☐ No / Rarely	☐ No, never ☐ Yes (Please specify):

Caffeine use: ☐ Never ☐ Occasional ☐ Frequent ☐ Daily	
Have you ever had thoughts of harming yourself?	☐ Yes ☐ No
Do you have a plan?	☐ Yes ☐ No
If so, please specify:	
History of intentional harm to yourself:	
Do you have a history of abuse?	☐ Sexual ☐ Physical ☐ Emotional
Please explain:	
Are you safe now?	☐ Yes ☐ No

Immunizations

Did you have a flu shot this year?	☐ Yes	☐ No
Have you had a pneumonia shot?	☐ Yes	☐ No
Are you over 60 and have had shingles?	☐ Yes	☐ No
Are you up to date on your immunizations?	☐ Yes	☐ No

Past Medical History

☐ Anemia ☐ Arthritis ☐ Diabetes ☐ Stroke / High Blood Pressure ☐ Sexually Transmitted Disease ☐ Heart Attack / Disease ☐ Headaches ☐ Liver Disease ☐ High Cholesterol / Triglyceride	☐ Obesity / Weight Change ☐ Depression ☐ Mania ☐ Anxiety ☐ Psychosis ☐ Suicide Attempt ☐ Eating Disorder ☐ Hoarding / OCD ☐ Other:	Past Psychiatric Treatment ☐ Inpatient ☐ Outpatient ☐ Rehabilitation Center Explain: Previous psychiatric medications:
Are you pregnant? ☐ Yes ☐ No		Are you nursing? ☐ Yes ☐ No
Medical Allergies ☐ None / Unknown ☐ Yes (please list below):	Surgery ☐ None ☐ Lung ☐ Abdominal ☐ Neurological ☐ Heart ☐ Other	Current Medications ☐ None ☐ Yes (please list below):

Family Medical History

☐ Diabetes ☐ High Blood Pressure ☐ Stroke ☐ Heart Attack / Disease ☐ High Cholesterol	☐ Drug Abuse ☐ Easy Bleeding ☐ Liver Disease ☐ Anemia ☐ Obesity	☐ Alcoholism ☐ Psychiatric Illness ☐ Arthritis ☐ Asthma ☐ Allergy:	☐ Cancer: ☐ Other:

Review of Body Systems

Constitutional	☐ Fever ☐ Weight Loss
Eyes	☐ Glaucoma ☐ Cataracts ☐ Lazy Eye ☐ Retina Problems
Ears / Nose / Throat / Mouth	☐ Hearing Loss ☐ Sinus Problems ☐ Sore Throat
Cardiovascular	☐ Heart Problems ☐ Chest Pain ☐ Irregular Heartbeat
Respiratory	☐ Asthma ☐ Shortness of Breath ☐ Wheezing ☐ Coughing
Gastrointestinal	☐ Heartburn ☐ Abdominal Pain ☐ Diarrhea ☐ Vomiting
Genitourinary	☐ Urinary Problems ☐ Blood in Urine
Skin	☐ Skin Rashes ☐ Excessive Dryness
Musculoskeletal	☐ Muscle Aches ☐ Joint Pain ☐ Swollen Joints
Neurological	☐ Numbness ☐ Weakness ☐ Headaches ☐ Paralysis
Hematologic / Lymphatic	☐ Blood Disorders ☐ Leukemia
Allergic / Immunologic	☐ Hay Fever ☐ Allergies
Endocrine	☐ Thyroid ☐ Diabetes
Additional Comments:	

Signature

The information provided within this packet is correct to the best of my knowledge. I understand that throughout my treatment, I am responsible to notify the physician and/or medical staff of any and all updates to the information.

(Patient Signature)

Patient Name_____

Diane Eden MD and Associates Inc. Date_____

ASSIGNMENT & RELEASE – TREATMENT AND RECORDS DOB _____

I agree to permit authorized personnel of Diane Eden MD and Associates (DEA) to perform routine psychiatric medical treatment, examinations, laboratory tests and emergency procedures as well as psychological services and testing as deemed necessary by the clinicians in this office.

I hereby assign my insurance benefits to be paid directly to my clinician at DEA. I also authorize my clinician and his/her designee to release information acquired in the course of my examination and treatment necessary to process claims and/or provide care.

I acknowledge a copy of the *Notice of Privacy Practices* ☐ yes ☐ no if no, explain _____

I agree that this authorization is valid for as long as I continue to be a patient and receive services at this office, and that I am the patient or the individual authorized to sign this document.

X_____ _____

Patient of Authorized Party Signature Date

FINANCIAL AND MANAGED CARE POLICY STATEMENT

DEA adheres to the following policies. The patient/responsible party assumes the responsibility to ensure that the financial obligation is fulfilled for the health care received. We ask that you read and sign the Policy Statement before you see your clinician.

- All co-payments are due at the time of service. Patients with an insurance co-payment are expected to make payment when checking in for their appointment.
- Patients with insurance are expected to pay any personal balance that is due immediately after their primary insurance company remits payment. If insurance does not remit payment within 60 days, the patient is held responsible for the payment in full. If you receive an insurance payment at your home for an outstanding balance, this payment must be forwarded to us immediately upon its receipt.
- Not all services are covered benefits of all insurance plans. The patient/responsible party maintains the responsibility of verification of applicable coverage.
- The patient is responsible for payment of any unpaid deductibles, co-insurance, co-pays and any other known non-covered services at the time the service is provided. Uninsured patients are expected to pay in full at the time of the service.
- Patients are requested to provide the staff with sufficient notice to complete any referral forms, pre-certification or other forms required by your insurance company to process payment for services. Retroactive referrals will be completed only for emergencies. The patient is responsible for notifying staff of the need for a referral and will be responsible for any financial penalty incurred by failure to secure the proper referral for any services.
- Patients are responsible to notify the staff of any changes in insurance, name, address, phone number or any other information pertinent to providing services or billing for services provided.
- Patients must verify provider eligibility and obtain knowledge about their insurance coverage

We accept cash, personal checks, and credit cards (Master Card and Visa.) Returned checks and balances older than 45-days may be subject to additional collection fees. Fees may be charged for appointments not canceled with 24-business-hour notice.

We encourage you to communicate with our billing staff about temporary financial problems which may affect timely payment of monies owed so that we can assist you with the management of your account. We can best serve you before or after your appointment.

Services will not be provided to anyone who changes or alters the terms or language of this consent form. This form must be signed to receive treatment in our office.
I have read & understand the Policies stated in this document & I agree to accept full responsibility as described herein.

Responsible Party Signature _____Name_____ Date / /

Name_____

Diane Eden MD and Associates Inc.

General Consent

Services will not be provided to anyone who changes or alters the terms or language of this consent form. This form must be signed to receive treatment in our office.

Authorization for Treatment

(Patient/Patient's legal representative) agree to permit authorized personnel of Diane Eden, M.D. and Associates, Inc. (DEA) to perform such diagnostic and therapeutic procedures that my treating clinician(s) deem necessary for care. By signing below I agree to permit laboratory tests, photographs for treatment purposes, routine medical treatment (for example, medications, injections, psychological testing, drawing blood for tests), emergency procedures as necessary and hospital services performed at the request of physicians arising in my care. I understand that in the event of an emergency, full disclosure of the material risks and benefits of a prescribed treatment or procedure may not be possible and I authorize and consent to such emergency treatment(s) as may be deemed necessary by the clinicians at DEA, and further understand that I may designate a person with the healthcare power of attorney to make treatment decisions on my behalf.

I recognize and understand that the clinicians, including who provide services at DEA are independent practitioners and not employees or agents of DEA. DEA is not responsible for the acts or omissions of clinicians who are not directly controlled by DEA.

Authorization to Release Information

The undersigned hereby permits DEA, its affiliated health care providers, and/or their authorized personnel to access and/or release all or any part of the patient information (including information regarding substance abuse, HIV testing, AIDS and psychiatric treatment) to, including but not limited to, the appropriate healthcare insurer(s), employers for work-related injuries, third party payor(s), students receiving education or training in healthcare and/or the DEA agent(s), attorney(s), collection agents(s), and/or consultant(s) for purposes including treatment of the patient, billing (or collecting payment) for services and healthcare operations including improving patient care, training or education students, performance improvement initiatives, discharge planning, risk management and/or as required by law. The undersigned hereby permits its affiliated healthcare providers and/or their authorized personnel to access electronic prescription data.

Assignment of Benefits

In consideration of the clinical and/or physician(s)'s services received or to be received for psychiatric/psychological/counseling/social work services, I assign to the DEA and/or my clinician(s), all benefits herein specified, not to exceed the above DEA/clinician charges. I direct such insurer(s) to pay such benefits directly the DEA and/or my physician(s). I hereby agree to pay any and all DEA and/or clinician(s) fees that exceed or that are not covered by my insurance coverage and waive any and all notices and demands in the event of non-payment.

Medicare/TRICARE/Champus Payment/Notice of Privacy Practices

I certify that the information I gave if applying for payment under Title XVIII of the Social Security Act (Medicare) is correct. I authorize any holder of medical or other information about me to release to the Social Security Administration or its intermediaries or carriers any information needed for this or a related Medicare claim (including TRICARE/Champus claims). I request that payment of authorized benefits be made on my behalf. I assign the benefits payable for physician/clinician services to the physician/clinician or organization furnishing the services or authorize such physician/clinician or organization to submit a claim to Medicare for payment to me.

If seen by a clinician requiring supervision:

I understand that if I am seeing a counselor-in-training or a clinician not independently licensed, that my clinician is working under the supervision of another clinician, and that aspects of my therapy and personal information will be shared with that supervising clinician.

Record Retention Policy Name_____

Each clinician at DEA retains patient medical records in accordance with applicable law and pursuant to its record retention policies.

Computer Data

I understand that my medical records will be accessible to authorized DEA personnel through paper charts and/or computers, and that DEA will comply with certain safeguards established by federal state and local law as well as DEA policy.

Certification

I certify that to the best of my knowledge and belief the information provided is complete and correct. In understand that this consent is subject to revocation by me at any time except if the person or entity authorized to make a disclosure has already acted in reliance on the form. Otherwise, subject to applicable law, this consent will expire at the same time DEA's record retention period for this document expires.

Patient Personal Property/Payment for Non-Reimbursable Items

I understand the DEA is not responsible for loss or damage to money and valuables brought into the offices of DEA. I understand agree to pay the charges incurred by me or on my behalf for personal use and/or convenience items and hereby authorized DEA to bill me or an applicable party for such use and I agree to pay or otherwise arrange for and ensure payment of the same.

Other Uses of Medical Information

The undersigned hereby understands and recognized that DEA, its affiliated health care providers, and/or their authorized personnel have access to medical information which may be used by DEA and its research personnel for research related purposes. The use of medical information for research related purposes is subject to Federal and State laws and regulations; as well as DEA policies regarding research studies.

Additional Permitted Uses and Disclosures of Confidential Medical Information

The undersigned understands and consents to disclosure of confidential medical information to a State or Federal Health Oversight Agency/ an appropriate Public Health Authority; for purposes required by State and/or Federal Law; in cooperation with a Law Enforcement Investigation; in cooperation with a domestic or child abuse investigation, to organ procurement organizations; and for any other permissible purpose as outline in DEA Notice of Privacy Practices.

Notice of Privacy Practices – Acknowledgement

PLEASE CHECK THE APPROPRIATE BOX:

☐ Yes ☐ NO ☐ N/A I acknowledge receipt of a copy of the Notice of Privacy Practices

If no, explain _____

I am the patient or authorized person to sign this document. I have read all of the above and understand its terms.

_____	_____	_____
Printed Patient Name	Signature of Patient	Date
_____	_____	_____
Printed Name of Legal Representative	Signature of Legal Representative if Patient is Unavailable	Date
_____	_____	_____
Printed Witness Name	Signature of Witness	Date

Addendum (children 18 and under)

Mother's pregnancy (e.g., complications, adoption, foster child, etc.,)

Child's development (e.g., issues, concerns and/or problems during the following ages)
(0-5)

(5-10)

(10-18)

Child's grade level, teacher and school, learning issues (e.g. academic decline, IEP, gifted programs, sensory processing issues, etc.)

Child's social skills (e.g. extraverted/introverted)

Do parents' approve of friends?

Is client sexually active (Is the client using protection)?

Client's family constellation

Who lives in client's home?

Any major stressors within the past five years (e.g., losses, divorce, moves, parental illness, marital conflict, physical abuse/sexual abuse, domestic violence, parental substance abuse, parental legal problems , etc.)?

What is visitation schedule if applicable?

Who is the custodial parent?

What type of discipline is used? Who disciplines? Does the current mode of discipline work?

Client's eating habits (disordered eating)

Sleeping habits (e.g., nightmares/night terrors)

Risky behaviors (e.g., alcohol and/or drug abuse, truancy, self-mutilation)

Acting-out behaviors (e.g., tantrums, rages, attention seeking behaviors, etc.)

Client's self-soothing strategies

Client's activities of interest, extracurricular activities, part time employment if applicable