Evergreen Behavioral Health
Adolescent Patient Information Form

Please provide the following information about yourself. This information will help your provider to better understand your needs and concerns, and develop an appropriate treatment plan. If there are any items you are uncomfortable answering, leave them blank and you can discuss them further during your intake session.

Patient Identification and Contact Information
Patient Name: ______________________________ Date of Birth: ___________ Age: ____ Sex: _______
Preferred Name: ____________________________________ Preferred Pronoun: ___________________________
Home Street Address: ____
City: ____________________________ State: ____ Zip: ____________ OK to send mail? ☐ Yes ☐ No
Social Security Number: _______________________

Phone Numbers OK to leave <u>confidential</u> message?
Home Phone: __________________________ ☐ Yes ☐ No
Cell/Mobile Phone: ______________________ ☐ Yes ☐ No
Work Phone: __________________________ ☐ Yes ☐ No

Family Contact Information (complete for all adults who have parent/guardian role)
Name: ______________________________________Relationship to Above Client: _________________________
Home Street Address: ____
City: ____________________________ State: ____ Zip: _______ OK to leave message?
Home Phone: ________________________________ ☐ Yes ☐ No
Cell/Mobile Phone:____________________________ ☐ Yes ☐ No
Financially Responsible Party? ☐ Yes ☐ No

Name: ______________________________________Relationship to Above Client: _________________________
Home Street Address: ____
City: ____________________________ State: ____ Zip: _______ OK to leave message?
Home Phone: ________________________________ ☐ Yes ☐ No
Cell/Mobile Phone:____________________________ ☐ Yes ☐ No
Financially Responsible Party? ☐ Yes ☐ No

Name: ______________________________________Relationship to Above Client: _________________________
Home Street Address: ____
City: ____________________________ State: ____ Zip: _______ OK to leave message?
Home Phone: ________________________________ ☐ Yes ☐ No
Cell/Mobile Phone:____________________________ ☐ Yes ☐ No
Financially Responsible Party? ☐ Yes ☐ No

Please indicate any legal guardianship/parenting plan information relevant to the child seeking mental health care
____
____

Have any parents had their legal rights terminated? ☐ Yes ☐ No
If yes, please explain ____

Are there any pending law suits or legal action(s)? ☐ Yes ☐ No
If yes, please explain ____

Referral Information
Who referred you to EBH? ______________________ Phone: ____
Address: ____

May I contact this person to thank them for the referral? ☐ Yes ☐ No

Primary Concern

Please describe briefly the main reason you are seeking therapy:_____

_____

_____

What would you like to get out of coming to therapy?_____

_____

_____

Symptoms (Please check all of the issues that you are experiencing currently (or in the past several months)

☐ Chronic Pain	☐ Panic attacks	☐ Anxiety/Worry
☐ Medical/Health Problems	☐ Social discomfort	☐ Eating problems
☐ Sadness/Depression	☐ Perfectionism	☐ Problems with pornography
☐ Loss of Pleasure/Interest	☐ Obsessive thoughts	☐ Academic problems
☐ Hopelessness	☐ Compulsive behavior	☐ Relationship problems
☐ Guilt/Shame	☐ Aggression/Fights	☐ Difficulty completing homework
☐ Thoughts of death/self-harm	☐ Frequent arguments	☐ Alcohol/Drug use
☐ Thoughts of hurting others	☐ Irritability/Anger	☐ Legal matters
☐ Flashbacks	☐ Work problems	☐ Nightmares
☐ Recent/Past Trauma	☐ Hearing voices	☐ Financial problems
☐ Seeing things others can't see	☐ Lack of motivation	☐ Computer addiction
☐ Crying spells	☐ Suspicion/Paranoia	☐ Gambling problems
☐ Loneliness	☐ Racing thoughts	☐ Low self-worth
☐ Excessive energy	☐ Wide mood swings	☐ Withdrawal from others
☐ Chronic fatigue/low energy	☐ Sleeping problems	☐ Behavioral problems
☐ _____	☐ _____	☐ _____

To the best of your knowledge, when did the current problems begin? _____

_____

Do you have any ideas regarding what may be contributing to these problems? _____

_____

Do you have any history of attempting to harm yourself or others? If yes, please explain: _____

_____

_____

Previous Mental Health Treatment

Have you received previous psychological, psychiatric, drug and alcohol, or counseling/therapy services?

☐ Yes ☐ No If yes, please describe:

When	From Whom	For What	Results

Substance Use

- Have you felt you ought to cut down on your drinking or drug use? ☐ Yes ☐ No
- Have people annoyed you by criticizing your drinking or drug use? ☐ Yes ☐ No
- Have you felt bad or guilty about your drinking or drug use? ☐ Yes ☐ No

- Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover (eye-opener)? ☐ Yes ☐ No

Strengths, Interests, and Social Support: (Please describe your social support network)

☐ Family ☐ Community Group:_____
☐ Friends ☐ Religious/Spiritual Group: _____
☐ Neighbors ☐ Other:_____

Would you like your religious/spiritual beliefs to be incorporated into therapy? ☐ Yes ☐ No
Please describe any special skills, talents, hobbies or strengths: _____

Medications:
Please list any current medications or over the counter drugs you are taking: (You may attach a medication list)

Medications	Reason for taking?	For how long?	Who is the prescriber?

Is there anything else you would like me to know about you at this time? _____
_____
_____

Insurance Information Form

Patient Name: _____ Date of Birth: _____ Age: _____

Primary Insured Information ☐ Check if Self
Name: _____Phone: _____ Date of Birth: _____
Address: _____
Relationship to you: _____ Social Security Number: _____

Insurance Information
Insurance Company: _____ Customer Service Phone: _____
Address: _____
Primary Insured ID#: _____ Group ID#: _____

EAP Insurance Information
Are you planning to use EAP benefits? ☐ Yes ☐ No
EAP Insurance Company: _____ Authorization #_____ Number of visits:____

Evergreen Behavioral Health has my permission to bill my insurance company. I authorize Evergreen Behavioral Health to release any information necessary to process my claims. I further authorize that my insurance benefits be paid directly to Evergreen Behavioral Health.

Signature: _____ Date: _____

Insurance Verification Form

As a new patient at Evergreen Behavioral Health, you are responsible for contacting your health insurance company to confirm the details of your coverage. Being informed allows you to plan your health care accordingly and avoid unexpected bills. Please complete this verification form, and present it to the Patient Services Specialist at your first appointment.

Patient Name:_____ DOB:_____Member ID #:_____Group #:_____

Name of Insurance Company:_____Customer Service Phone #:_____

Step 1: Call the customer service number on the back of your insurance card and speak with a live representative.
Step 2: Request benefit information for, "Out-Patient Mental Health, in an Office Setting."
Step 3: Ask the Customer Service Representative the following questions:

- Representatives Name:_____
- **Deductible Amount**: $_____ **Deductible paid to date**: $_____
- **Co-pay** (due at the time of service): $_____
- **Co-Insurance**: %Insurance pays:_____ % Patient pays:_____% **Maximum # of visits per year**:_____
- Exclusions:_____
- Does my plan run on a calendar year? From (date)_____ to (date)_____
- Mailing address for claims:_____
- Is _____ (my EBH provider) **IN**-NETWORK? If not, do I have **OUT**-OF-NETWORK benefits?
    - **Out of Network Benefits**: Deductible $_____ Co-pay $_____ Co-Insurance $_____

Step 3: Because psychological testing may be recommended, ask the Customer Service Representative,

- Does my insurance cover "Psychological Testing?" ☐ Yes ☐ No
- Do I need **preauthorization**? ☐ Yes ☐ No
- Preauthorization #:_____

Step 4: Because **Physiological Monitoring** services may be recommended, ask the Customer Service Representative what procedure codes, listed below, are accepted:

(CPT) Health and Behavior Codes
___ **96150** Initial Assessment of biopsychosocial factors (1 unit = 15 minutes)
___ **96152** Individual Intervention Service (allows physiological recording (1 unit = 15 minutes)

Step 6: If you are interested in receiving **Family or Couple's therapy**, ask the Customer Service Representative,

- Does my plan cover "Family" therapy? __Y __N CPT code accepted_____
- Does my plan cover "Couples or Marital" therapy? __Y __N CPT code accepted_____

I have been informed that Evergreen Behavioral Health has not checked my benefits and I will be billed any amount my insurance company deems "patient responsibility." I understand that I am ultimately responsible for any fees incurred during my therapy at Evergreen Behavioral Health. In rare instances, I may receive an additional bill after my visit if the billing department discovers a billing discrepancy. I acknowledge any unpaid or overdue balances may be subject to collections.

_____

Signature Date