# NEW PATIENT INTAKE

Noetic Psychiatry

## WELCOME

We are pleased that you have chosen Noetic Psychiatry as your mental health care provider. To ensure that you receive the best mental health care possible, please provide the following information for your first visit.

If you have this information, please bring the following items with you to your first visit:

- Your insurance card and photo identification.
- The attached "New Patient Intake" packet fully filled out.
- Any history or mental health records and lab test results that you may have in your possession that are pertinent to the current medical issue.
    - If you do not have copies of these records, we can request them from previous providers if you sign the proper release, which you can obtain from our front office.
- Any psychological test results you may have.
    - These test results will aid your mental health provider determine the best course of treatment including medication options.

**Please arrive 15 minutes prior to your scheduled appointment time to check in.**
Initial evaluations require a minimum appointment length of 45 minutes, if you are late to this appointment you may not be seen.
If you are late to your appointment you will be charged a $75.00 fee and your appointment will be rescheduled. If you have excessive No Shows or Late Cancellations you may be discharged from our clinic.
You are required to make your payment or copayment at the time that services are rendered.

We thank you for choosing Noetic Psychiatry and look forward to providing you with optimal mental health care.

# NEW PATIENT INTAKE

Noetic Psychiatry

## New Patient Information & Responsibility for Payment

This form is intended to inform you of our basic policies and procedures. If you have any questions regarding this form, please do not hesitate to ask the staff. We are always here to assist you.

## Confidentiality:

Communication between you and your doctor/therapist is considered privileged and confidential. We will not release any information without your written release. The billing information we give to you for your insurance carrier provides only information about the dates of services, diagnosis, and procedure codes. The only exception to these conditions may occur in situations such as child abuse, danger to life, worker's compensation, or where legal action is permitted. Neither the patient or the provider are to record any sessions.

## Office Hours:

Office staff is available from 9:00 a.m. to 5:00 p.m. Monday through Thursday. When the office staff is not available, please leave a message. Your well-being is our priority and primary concern. In an emergency, please go to the nearest hospital emergency room (ER) or call 911.

## Scheduling Appointments:

An appointment can be scheduled by calling (801)368-8989 during regular office hours or by emailing us at contact@noeticpsychiatry.com. We understand that your time and money is valuable, for this reason our office staff will call, email, or text you to remind you of your scheduled appointments.

## Appointment Length:

Initial evaluations and appointments including individuals, couples, group, and family therapy are billed by the session, which are typically 15 to 60 minutes, depending on the type of appointment. If an appointment runs longer, you will be charged for that additional time. The charge will be determined and prorated on 15-minute increments of time. If your doctor/therapist feels that further assessments or testing are appropriate and necessary, all fees associated with the recommended treatments will be discussed with you at this time.

## Missed Appointments:

A late cancellation or "no show" to your appointment occupies a significant portion of our professional time. A late cancellation or "no show" to your appointment keeps us from seeing someone else in need. Therefore, except in the case of an emergency or extenuating circumstances, we require a two (2) business day notice of cancellation by phone or email, otherwise your account

will be charged $75.00 for the visit. Please note that because we are unable to bill insurance for missed appointments, you will be held financially responsible for these charges. If you have missed three or more appointments without proper cancellation, you will be discharged from our care. If our office is closed, please leave a message to inform us of the cancellation.

## Fees:

All patients are expected to take care of their fees at the time of services rendered. Any other arrangement is considered a special arrangement and must be discussed in advance. Delinquent accounts may be referred to a collection agency. Collection of insurance benefits or any other arrangement regarding third-party payment is the responsibility of the client, parent, or guardian.

By physically or electronically signing, I acknowledge that I have read and understand these polices and I acknowledge responsibility for all fees incurred.

Patient/Parent Signature:_____

Printed Name:_____ Date:_____

# NEW PATIENT INTAKE

Noetic Psychiatry

## Patient Information

Patient Name:_____
*(Last)* *(First)* *(Middle Initial)*

Relationship to Patient: [ ] Self [ ] Spouse [ ] Guardian [ ] Parent [ ] Temporary Caregiver

Name of Parent/Guardian/Temporary Caregiver:_____
*(Last)* *(First)* *(Middle Initial)*

Patient Social Security Number:_____

Patient Birthdate: ___/___/_____ Gender: [ ] Male [ ] Female [ ] Transgender

Marital Status: [ ] Never Married [ ] Partnered [ ] Married [ ] Separated [ ] Divorced [ ] Widowed

Address: _____
*(Street and Apartment Number)* *(City, State)* *(Zip Code)*

Mailing Address: _____
*(P.O. Box, Street, or Apartment Number)* *(City, State)* *(Zip Code)*

Home Phone: (___)____-_____ May we leave a message? [ ] Yes [ ] No

Mobile Phone: (___)____-_____ May we leave a message or send a text? [ ] Yes [ ] No

Email Address:_____@_____ May we send an email? [ ] Yes [ ] No

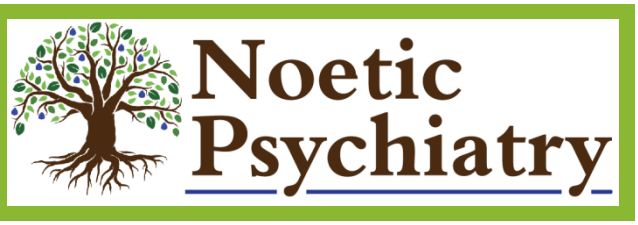
How did you hear about us?_____

## Emergency Information

Emergency Contact Name:_____
*(Last)* *(First)* *(Middle Initial)*

Relationship to Patient: [ ] Spouse [ ] Guardian [ ] Parent [ ] Temporary Caregiver

Address: _____
*(Street and Apartment Number)* *(City, State)* *(Zip Code)*




Emergency Phone: (___)____-_____ May we leave a message? [ ] Yes [ ] No

## Primary Insurance Information

Insurance Company Name:_____Phone: (___)____-_____

Member/ID#:_____ Group#:_____

Primary Insured Name:_____

*(Last) (First) (Middle Initial)*

Primary Insured Address: _____

*(Street and Apartment Number) (City, State) (Zip Code)*

Primary Insured Phone: (___)____-_____ Primary Insured Date of Birth: ___/___/_____

Primary Insured Relationship to Patient:_____

## Secondary/Supplemental Insurance Information

Insurance Company Name:_____Phone: (___)____-_____

Member/ID#:_____ Group#:_____

Primary Insured Name:_____

*(Last) (First) (Middle Initial)*

Primary Insured Address: _____

*(Street and Apartment Number) (City, State) (Zip Code)*

Primary Insured Phone: (___)____-_____ Primary Insured Date of Birth: ___/___/_____

Primary Insured Relationship to Patient:_____

# INFORMED CONSENT FOR PSYCHIATRIC SERVICES

Noetic Psychiatry

I am voluntarily seeking psychiatric services, including medication management and/or psychotherapy, from Noetic Psychiatry for the purpose of mental diagnosis and treatment. I consent to such examinations, treatments, and/or diagnostic procedures as may be deemed advisable by my treating provider.

I understand that Noetic Psychiatry's providers include psychiatrists, psychologists, licensed clinical social workers, physicians, and physician's assistants. I understand that there are both risks and benefits to psychiatric treatment and I am aware that all medical care, including psychiatric care and psychotherapy, is not an exact science. I acknowledge that no guarantees have been made as to the result of such examinations, treatments, and/or diagnostic procedures. Additionally, I understand that while the course of my treatment is designed to be helpful, it may at times be difficult or uncomfortable.

I understand that if the patient is a minor and I am consenting to the treatment on the minor's behalf, I must indicate my authority and sign below. I also understand that if I share legal custody of the minor patient, by signing this consent form I am representing that all parties who have legal custody of the minor have been made aware of, and consent to the minor's treatment.

I understand that potential risks may include possible disagreement with any professional opinions offered, possible emotional distress when addressing my difficulties, and limitations in the ability to make predictions based upon the results of psychological assessments (when applicable). I understand that alternative procedures may include services provided by another psychotherapist, psychiatrist, or mental health professional. I understand that I may ask for a referral to another mental health professional if I am dissatisfied with my services.

I understand and acknowledge that disclosures and communications that are provided to you by Noetic Psychiatry are considered privileged and confidential unless I authorize a release of information or under certain other conditions listed below:

- Where abuse or harmful neglect of children, the elderly, the disabled, or an incompetent individual is known or reasonably suspected.
- Where such information is necessary for the practitioner to defend against a malpractice and litigation action brought by the patient.
- Where an immediate threat of physical violence or suicide against a readily identifiable victim is disclosed to the practitioner.

The undersigned understands that he/she has the right to:

- Be informed of and participate in the selection of treatment modalities.
- Receive a copy of this consent.
- Withdraw this consent at any time.

Patient/Parent Signature:_____

Printed Name:_____ Date:_____

Patient Name (if different from above):_____

Relationship to Patient: [ ] Self [ ] Spouse [ ] Guardian [ ] Parent [ ] Temporary Caregiver

# AUTHORIZATION FOR ELECTRONIC COMMUNICATION

Noetic Psychiatry

I understand that there are inherent risks in the telephonic and electronic transmission of information including email, the internet, or any other available means of electronic communication. The communications may be lost, delayed, intercepted, corrupted, altered, rendered incomplete, or fail to be delivered to the intended recipient. This information includes any requested communication between Noetic Psychiatry, my treating physician, myself, or any other persons or entities. This information may include appointments, billing, insurance information, diagnosis, medications, personal progress, and individually identifiable information about my treatment via electronic communications.

I further understand that any protected health information transmitted via electronic communications pursuant to this authorization will not be encrypted. As the electronic transmission of information cannot be guaranteed to be secure or error-free its confidentiality may be vulnerable to access by unauthorized third parties. Neither Noetic Psychiatry nor any treating physicians shall have any responsibility or liability with respect to any error, omission, claim, or loss arising from or in connection with the telephonic or electronic communication of my protected health information.

After being provided notice of risks inherent to the use of telephonic or electronic communications, I hereby expressly authorize Noetic Psychiatry to communicate with me telephonically and electronically regarding my protected health information. I agree that Noetic Psychiatry and my physician may do so until I revoke this authorization by submitting notice to Noetic Psychiatry in writing.

I hereby authorize the transmission of my protected health information telephonically and electronically as described above.

Patient Name:_____
*(Last)* *(First)* *(Middle Initial)*

Relationship to Patient: [ ] Self [ ] Spouse [ ] Guardian [ ] Parent [ ] Temporary Caregiver

Patient/Parent Signature:_____
*(Last)* *(First)* *(Middle Initial)*

Printed Name:_____ Date:_____

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# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

## Patient Information

Patient Name:_____

*(Last)* *(First)* *(Middle Initial)*

## Authorized Persons

I hereby authorize Noetic Psychiatry, its staff, and providers to disclose my protected health information to:

Person/Organization:_____

Email Address:_____@_____Phone Number:(___)_____-_____

Address: _____

*(Street and Apartment Number)* *(City, State)* *(Zip Code)*

[ ] All of my medication, health information, and records, including medical and mental health history, lab results, diagnoses, treatment, and prescriptions *(excluding psychotherapy notes, for which a separate disclosure authorization must be obtained, and is at the discretion of Noetic Psychiatry and their providers).*

[ ] Only my billing, payment, appointment scheduling, and appointment history information.

[ ] Alcohol/Drug history, use, diagnosis, and treatment.

[ ] Only the following information:_____

## Authorized Persons

I hereby authorize Noetic Psychiatry, it's staff, and providers to disclose my protected health information to:

Person/Organization:_____

Email Address:_____@_____Phone Number:(___)_____-_____

Address: _____

*(Street and Apartment Number)* *(City, State)* *(Zip Code)*

[ ] All of my medication, health information, and records, including medical and mental health history, lab results, diagnoses, treatment, and prescriptions *(excluding psychotherapy notes, for which a separate disclosure authorization must be obtained, and is at the discretion of Noetic Psychiatry and their providers).*

[ ] Only my billing, payment, appointment scheduling, and appointment history information.

[ ] Alcohol/Drug history, use, diagnosis, and treatment.

[ ] Only the following information:_____

# AUTHORIZATION FOR USE OR DISCLOSURE OF HEALTH INFORMATION

## Authorized Persons

I hereby authorize Noetic Psychiatry, it's staff, and providers to disclose my protected health information to:

Person/Organization:_____

Email Address:_____@_____Phone Number:(___)_____-_____

Address: _____

*(Street and Apartment Number)* *(City, State)* *(Zip Code)*

[ ] All of my medication, health information, and records, including medical and mental health history, lab results, diagnoses, treatment, and prescriptions *(excluding psychotherapy notes, for which a separate disclosure authorization must be obtained, and is at the discretion of Noetic Psychiatry and their providers).*

[ ] Only my billing, payment, appointment scheduling, and appointment history information.

[ ] Alcohol/Drug history, use, diagnosis, and treatment.

[ ] Only the following information:_____

## Expiration and Revocation

I understand that Noetic Psychiatry cannot condition my treatment, payment, enrollment, or eligibility for benefits on my provision of this authorization.

I understand that information disclosed pursuant to this authorization, may be subject to redisclosure by the recipient and no longer protected by HIPAA.

I understand that I have the right to receive a copy of this authorization.

Patient/Parent Signature:_____

Printed Name:_____ Date:_____

If not signed by the patient, please indicate your relationship to the patient:

[ ] Parent or guardian of an unemancipated minor patient

[ ] Health care surrogate or conservator of an incompetent adult or emancipated minor patient

[ ] Beneficiary or conservator of a deceased patient