PsychZen Mobile Partners

Intake Form and Consent Forms

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Patient Information				
Name:	Date of Birth:	SSN:	Gender: ☐M ☐F	Marital Status: ☐S☐M☐D☐W
Community:	Primary Phone:	☐ Home ☐ Cell	Okay to leave message?:	☐Y ☐N
Patient Address:	Email:			
Previous Primary Care:	Phone:	Fax:		

POA/Emergency Contact Information				
Power of Attorney (MPOA):	Relationship to Patient:		Active? ☐Y ☐ N	
POA Address:	Phone:	☐ Home ☐ Cell	Ok to leave message?	☐ Y ☐ N
Emergency Contact: (If same as POA write "Same")		Relationship to Patient:		
	Phone:	☐ Home ☐ Cell	Ok to leave message?	☐ Y ☐ N

Insurance Information		
Primary Insurance Company:	Member ID:	Group Number:
Secondary Insurance Company:	Member ID:	Group Number:

Preferred Pharmacy	
Pharmacy Name	Pharmacy Address

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By signing below, I _____________________ (patient or POA name) agree to the following information:

1. The information provided is true to the best of my knowledge.

2. I authorize my insurance benefits be paid directly to the provider. I understand that I am financially responsible for any remaining balance. I authorize PSYCHZEN MOBILE PARTNERS, PLLC and/or PSYCH ZENHEALTH, PLLC, or the insurance company to release information as required to process my claims.

3. I authorize the release of patient medical records to PSYCHZEN MOBILE PARTNERS, PLLC and/or PSYCH ZENHEALTH, PLLC. I will permit all secure electronic means of transmitting my medical records. A copy of this authorization may be used in place of the original. I understand that all my medical records will be kept confidential.

4. I acknowledge that I have been made aware of the Privacy Agreement-HIPPA and have been provided a copy.

5. A representative of PSYCHZEN MOBILE PARTNERS, PLLC is required to explain and inquire of every potential patient whether they have or do not have an active POA making medical decisions on their behalf. No evaluation or treatment will be provided without a signed consent form from the patient or the POA.

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Patient Name

____

Patient/POA Signature   Date

Patient Name: ______________________________

DOB: ________________

Any known Allergies?
☐ No ☐ Yes (please specify): ______________________________

Past Medical History: Check all that apply

☐ COPD/Emphysema	☐ High Cholesterol	☐ Hypertension
☐ Stroke	☐ Rheumatoid Arthritis	☐ Alcoholism
☐ Dementia	☐ HIV	☐ Seizure Disorder
☐ Seasonal Allergies	☐ Depression	☐ Hepatitis
☐ Sleep Apnea	☐ Anemia	☐ Diabetes
☐ Irritable Bowel Syndrome	☐ Anxiety	☐ Diverticulitis
☐ Lupus	☐ Thyroid Disorder	☐ Arrhythmia (irregular heartbeat)
☐ DVT (blood clot)	☐ Liver Disease	☐ Ulcerative Colitis
☐ Arthritis	☐ GERD (acid reflux)	☐ Macular Degeneration
☐ Asthma	☐ Glaucoma	☐ Neuropathy
☐ Bipolar Disorder	☐ Heart Disease	☐ Osteopenia/Osteoporosis
☐ Bladder Problems/Incontinence	☐ Heart Attack (MI)	☐ Parkinson's Disease
☐ Bleeding Problems	☐ Hiatal Hernia	☐ Peripheral Vascular Disease
☐ Cancer (please specify): ____________		☐ High Blood Pressure
☐ Peptic Ulcer	☐ Headaches	☐ Kidney Stones
☐ Psoriasis	☐ Crohn's Disease	☐ Kidney Disease
☐ Pulmonary Embolism (PE)	☐ Other (please specify): ____________	

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List **all medications** you take, including over the counter (OTC) medications and vitamins. Include specific doses and frequency.

Medication Name:	Dosage:	When Taken:

List **any previous psychiatric hospitalizations** and include approximate dates.

Inpatient Psychiatric hospitalization	Date
Did you have any injury, losing consciousness (knocked out), having symptoms of concussion (headaches, dizziness, memory problems, balance problems, ringing in ears, irritability, sleep problems, etc.)? ∗No ∗Yes Have you had a previous history of a TBI or concussion? ∗No ∗Yes	

Psychosocial history

Education Level: ☐ Elementary ☐ High School ☐ Vocational College ☐

Are there any limitations to understanding or following instructions (written or verbal) ☐ ☐

Yes Written ☐ Yes Verbal ☐ Both Written and Verbal ☐ Neither ☐

Smoking/Tobacco Use: ☐Current ☐Past ☐Never

Type: ____________________ Amount/day: __________ Number of Years: __________

Alcohol: ☐Current ☐Past ☐Never Drinks/week: ____________________

Recreational Drug Use: ☐Current ☐Past ☐Never

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Patient Name

____

Patient/POA Signature Date

HIPPA Compliance and Notice of Privacy Practices

HIPPA Compliance Patient Consent Form Our Notice of Privacy Practices provides information about how we may use or disclose protected health information. The notice contains a patient's rights section describing your rights under the law. You ascertain by your signature that you have reviewed our notice before signing this consent. The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date. You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPPA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, I understand that:

1. Protected health information may be disclosed or used for treatment, payment, or healthcare operations. The practice reserves the right to change the privacy policy as allowed by law.
2. I understand that my healthcare provider participates in Health Current, Arizona's health information exchange (HIE). I understand that my health information may be securely shared through the HIE unless I complete and return an Opt Out Form to my healthcare provider.
3. The practice has the right to restrict the use of the information, but the practice does not have to agree to those restrictions.
4. The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
5. The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? Yes No

May we leave a message on your answering machine at home or on your cell phone? Yes No

____

Patient Name

____

Patient/POA Signature Date

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