

SOI *The Structure of Intellect*

ADD & SOI COUNSELING AND TESTING CENTER
MANHATTAN BEACH, CA 90266 • (310) 546-6500 • FAX (310) 546-9068 • www.addsoi.com

Welcome to SOI Counseling. We look forward to working with you. This form requests information about you and/or your family that will help us plan your care. If you have any questions, please feel free to discuss them with your provider.

Patient Name _____ Today's Date _____
Address _____ Birthdate _____
City, State, Zip _____ Age _____
Phone # (____) _____ (____) _____ (____) _____
Home OK to leave messages? Y N **Work** OK to leave messages? Y N **Cell** OK to leave messages? Y N
SSN _____ Occupation _____ E-mail _____
Emergency Contact _____
Name Relationship to patient phone number

Name & phone of primary care physician _____

Name & phone of psychiatrist (if any) _____

Who referred you? _____

Primary Insurance Information:

Insured Name: _____ Authorization No: _____
Insured SSN: _____ Copay Amount: _____
Insured DOB: _____ Maximum Visits: _____
Employer: _____
Mental Health Carrier: _____
Relationship to Insured: _____
Member No: _____
Policy/Group No: _____

Areas of Concern:

Please describe your reason(s) for seeking treatment at this time (include date the problem started): _____

Was there an event that made these issues or problems surface? ___Y ___N If yes, please describe: _____

Do you have any specific goals for treatment? What result(s) do you expect from treatment? _____

Other Information:

Please describe your interests/hobbies _____

Are you now or have you ever been involved in a lawsuit? ___Y ___N Please describe _____

Has anyone in your family had a psychiatric (nervous or mental) illness? ___Yes ___No If yes, please explain what/when: _____

Any medication? ___Y ___N What? _____ Hospitalization? ___Y ___N When? _____

Please circle the following issues or problems you would like to work on in treatment and rate the severity (1-4):

NO PROBLEM 1	MILD PROBLEM 2	MODERATE PROBLEM 3	SEVERE PROBLEM 4
___ Anger/temper	___ Diet	___ Motivation	___ Headaches
___ Depression	___ Anxiety	___ Controlling stress	___ Loss of loved one
___ Problems at school	___ Problems at work	___ Lack of friends	___ Loneliness
___ Problems coping	___ Abuse/victimization	___ Financial problems	___ Legal matters
___ Panic	___ Concentration	___ Sleep	___ Fears
___ Body Image	___ Nightmares	___ Energy	___ Divorce/Separation
___ Marriage/Relationship issues	___ Sexuality/Sexual issues	___ Family conflict	___ Behavioral problems
___ Drug/alcohol habit	___ Relaxation	___ ADD/ADHD	___ Shyness
___ Self-control	___ My thoughts	___ Eating Disorder	___ Being a parent

Are there any compulsive/repetitive behaviors or thoughts that are of concern to you and/or the people close to you? (i.e., overeating, hoarding, checking, counting, washing, illness-related, thoughts of harming someone, sexual behavior, etc.)? ___ Yes ___ No
 If yes, please describe: _____

MEDICAL

When were you last examined by a physician? _____ Outcome? _____

Medications

Type	Dosage	Start Date	Prescribing M.D.	Phone No.
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Side Effects _____

Alternative treatments _____

Allergies

Type _____ Severity _____ Treatment _____

Type _____ Severity _____ Treatment _____

Please list any over-the-counter medications you currently use such as vitamins, sleeping/diet pills, aspirin/pain relievers, etc.

IMMEDIATE FAMILY

LIST MEMBERS OF YOUR FAMILY OR OTHERS WITH WHOM YOU LIVE:

Name(s)	Age	Relationship	Occupation

Marital Status

- single, never married
- engaged ___ mos.
- married ___ yrs.
- divorced ___ yrs.
- separated ___ yrs.
- divorce in process ___ mos.
- live-in for ___ yrs.
- prior marriages (self)
- prior marriages (partner)

Intimate Relationship

- never been in serious relationship
 - not currently in relationship
 - currently in serious relationship
- Relationship satisfaction**
- very satisfied w/relationship
 - satisfied with relationship
 - somewhat satisfied w/relationship
 - dissatisfied w/relationship
 - very dissatisfied w/relationship

List minor children NOT living in same household

Name	Age	Sex	Relationship

Frequency of visitation of above: _____

Describe any part or current significant issues in **intimate** relationships: _____

Present during childhood:

	Present entire childhood	Present part of childhood	Not present at all	Family alcohol/ Drug Abuse History:	
Mother	_____	_____	_____	_____ Father	_____ Stepparent/Live-In
Father	_____	_____	_____	_____ Mother	_____ Uncle(s)/Aunt(s)
Stepmother	_____	_____	_____	_____ Grandparent	_____ Spouse/Partner
Stepfather	_____	_____	_____	_____ Sibling(s)	_____ Children
Brother(s)	_____	_____	_____	_____ Other	_____
Sister(s)	_____	_____	_____	_____	_____

Parents' current marital status:

- married to each other
- separated for ___ years
- divorced for ___ years
- mother remarried ___ times
- father remarried ___ times
- mother involved with someone
- father involved with someone
- mother deceased for ___ years
- age of patient at mother's death ___
- father deceased for ___ years
- age of patient at father's death ___

SUBSTANCE USE HISTORY (check all that apply for patient):

Self-Perception of substance use: Amount	Substances used:	First use age	Last use age	Current?	Frequency
<input type="checkbox"/> None	<input type="checkbox"/> alcohol	_____	_____	_____	_____
<input type="checkbox"/> Occasional/social	<input type="checkbox"/> amphetamines/speed	_____	_____	_____	_____
<input type="checkbox"/> Problem use	<input type="checkbox"/> barbiturates/downers	_____	_____	_____	_____
<input type="checkbox"/> Dependent	<input type="checkbox"/> cocaine/crack	_____	_____	_____	_____
<input type="checkbox"/> Don't want to stop	<input type="checkbox"/> hallucinogens (LSD,etc)	_____	_____	_____	_____
<input type="checkbox"/> Addicted/Cannot stop	<input type="checkbox"/> inhalants (glue,etc)	_____	_____	_____	_____
<input type="checkbox"/> Motivated to stop	<input type="checkbox"/> marijuana or hashish	_____	_____	_____	_____
	<input type="checkbox"/> PCP/Ecstasy	_____	_____	_____	_____
Previous treatment:	<input type="checkbox"/> prescription drugs	_____	_____	_____	_____
<input type="checkbox"/> 12-Step	<input type="checkbox"/> nicotine/cigarettes	_____	_____	_____	_____
<input type="checkbox"/> Out Patient	<input type="checkbox"/> caffeine	_____	_____	_____	_____
<input type="checkbox"/> In Patient	<input type="checkbox"/> other _____	_____	_____	_____	_____

Physical/mental consequences of substance use (check all that apply):

- | | | | | |
|---|--|-----------------------------------|---|-----------------------------------|
| <input type="checkbox"/> outpatient (age(s) _____) | <input type="checkbox"/> hangovers | <input type="checkbox"/> binges | <input type="checkbox"/> blackouts | <input type="checkbox"/> job loss |
| <input type="checkbox"/> inpatient (age(s) _____) | <input type="checkbox"/> seizures | <input type="checkbox"/> overdose | <input type="checkbox"/> arrests/DUI | <input type="checkbox"/> assaults |
| <input type="checkbox"/> 12-step program (age(s) _____) | <input type="checkbox"/> withdrawal symptoms | | <input type="checkbox"/> sleep disturbances | |
| <input type="checkbox"/> stopped on own (age(s) _____) | <input type="checkbox"/> medical conditions | | <input type="checkbox"/> tolerance changes | |
| <input type="checkbox"/> other (age(s) _____) | <input type="checkbox"/> relationship conflicts | | <input type="checkbox"/> suicidal impulse | |
| Describe: _____ | <input type="checkbox"/> loss of control of amt used | | <input type="checkbox"/> other _____ | |

The following information is provided to you so you have a better understanding of how your care will be coordinated. Please read each item carefully and sign in the appropriate spaces.

TREATMENT PHILOSOPHY

During the initial evaluation period, you and your provider will clarify together the nature of the problems for which you are seeking treatment, define some reasonable treatment goals, and develop a treatment plan that will help you achieve those goals. ***If your insurance is a managed healthcare plan, the number of sessions available to you may be severely limited.*** You are expected to be compliant with the agreed upon treatment plan between sessions and keep your appointments. Research has shown that, often times, brief, time limited therapy focusing on specific goals results in more rapid reduction of symptoms and improvement in patient functioning. The treatment plan may include attending support groups, reading selected materials, and/or completing specific written or verbal assignments.

CONFIDENTIALITY:

All information between provider and patient is held strictly confidential unless:

1. patient authorizes release of information with his/her signature.
2. patient presents a physical danger to self.
3. patient presents a danger to others.
4. child/elder abuse is suspected.
5. patient fails to pay for services rendered and formal collection becomes necessary.

We are required by law to inform potential victims and legal authorities so protective measures can be taken.

FINANCIAL TERMS

Upon verification of health plan/insurance coverage and policy limits, your insurance carrier will be billed for your treatment and your provider will be paid directly by the carrier. You will be responsible for any applicable **deductibles** and **copayments**. Copayments must be paid at the time services are rendered. If you are not eligible for benefits at the time services are rendered, you are responsible for full payment of provider's hourly rate, which is \$ _____. Your copayment for services is \$ _____. **Patient initials** _____

CANCELED/MISSED APPOINTMENTS

A scheduled appointment means that time is reserved only for you. ***If an appointment is missed or canceled with less than 24 hours notice, you will be billed directly according to the scheduled fee or according to the rules of your health plan.*** Most health plans do not cover payment for missed appointment; therefore, you are responsible for payment in full. **Patient initials** _____

APPEALS AND GRIEVANCES

I acknowledge my right to request an appeal in case that outpatient care is not certified. I understand that I would request an Appeal directly through my insurance carrier. I also understand that I may submit a grievance to my provider at any time to register a complaint about my care. I also understand the California Department of Managed Care (DMC) regulates health services. Their telephone number is 800-400-0815, and I may contact them to register a complaint against my health care plan.

EMERGENCY PROCEDURES

If you need to contact your provider, leave a message according to the instructions on the office telephone message and your call will be returned. If you experience a true life threatening emergency and need immediate attention, you should leave a message for your provider and then call 911 or go to the nearest hospital emergency room.

RELEASE OF INFORMATION TO HEALTH PLAN

I authorize release of information regarding my care to my health plan for the payment of claims, certification/case management decisions and other purposes related to the administration of benefits for my Health Plan. **Patient initials** _____

RELEASE OF INFORMATION TO PRIMARY CARE PHYSICIAN

I authorize the release of information to my Primary Care Physician (name) _____ at (telephone number) _____ for purposes related to my health care. **Patient initials** _____

CONSENT FOR TREATMENT

I further authorize and request that my treating provider carry out psychological examinations, treatments, and/or diagnostic procedures that now or during the course of my care as a patient are advisable. I understand that the purpose of these procedures will be explained to me upon my request and subject to my agreement. I also understand that, while the course of therapy is designed to be helpful, it may at times be difficult and uncomfortable.

I understand and agree to all of the above information.

Patient (or Parent/Guardian) Name – *Printed* Date

Patient (or Parent/Guardian) Name – *Signature* Date

ASSIGNMENT OF BENEFITS

I authorize payment of medical benefits to the provider for services described on Form HCFA-1500.

SIGNED _____ Date

CONSENT FOR RELEASE OF INFORMATION OR RECORDS

I hereby authorize _____ to mutually disclose records and/or information to _____, regarding _____, date of birth ____/____/____, obtained in the course of his/her diagnosis and treatment. This release will remain in effect for one year from the date below unless revoked.

These records are protected by the California Welfare and Institution Code Section 5328. Disclosure shall be limited to the information specified below (please circle):

Clinical Evaluation
Diagnosis
Discharge Summary
Diagnostic Exam
Results of Psychological/Vocational Tests
Educational Assessment & Behavioral Reports

Signature of client/parent/guardian/conservator

Date

Date consent revoked

Signature of client/parent/guardian/conservator

I UNDERSTAND THAT I HAVE A RIGHT TO RECEIVE A COPY OF THIS
AUTHORIZATION IF I SO REQUEST

PRIVACY PRACTICES ACKNOWLEDGEMENT

ACKNOWLEDGEMENT FORM

I have received the Notice of Privacy Practices and I have been provided an opportunity to review it.

Name _____ Birthdate _____

Signature _____

Date _____



HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

CARRIER

PICA										PICA																													
1. MEDICARE (Medicare #)		MEDICAID (Medicaid #)		TRICARE (ID#/DoD#)		CHAMPVA (Member ID#)		GROUP HEALTH PLAN (ID#)		FECA BLK LUNG (ID#)		OTHER (ID#)		1a. INSURED'S I.D. NUMBER (For Program in Item 1)																									
2. PATIENT'S NAME (Last Name, First Name, Middle Initial)										3. PATIENT'S BIRTH DATE MM DD YY				SEX M F		4. INSURED'S NAME (Last Name, First Name, Middle Initial)																							
5. PATIENT'S ADDRESS (No., Street)										6. PATIENT RELATIONSHIP TO INSURED Self Spouse Child Other										7. INSURED'S ADDRESS (No., Street)																			
CITY					STATE					8. RESERVED FOR NUCC USE										CITY					STATE														
ZIP CODE					TELEPHONE (Include Area Code) ()					9. RESERVED FOR NUCC USE										ZIP CODE					TELEPHONE (Include Area Code) ()														
9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)										10. IS PATIENT'S CONDITION RELATED TO:										11. INSURED'S POLICY GROUP OR FECA NUMBER																			
a. OTHER INSURED'S POLICY OR GROUP NUMBER					b. RESERVED FOR NUCC USE					c. RESERVED FOR NUCC USE					d. INSURANCE PLAN NAME OR PROGRAM NAME					a. EMPLOYMENT? (Current or Previous) YES NO					b. AUTO ACCIDENT? PLACE (State) YES NO					c. OTHER ACCIDENT? YES NO					10d. RESERVED FOR LOCAL USE				
11. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES NO If yes, complete items 9, 9a and 9d.										12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below. SIGNED DATE										13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below. SIGNED																			
14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.										15. OTHER DATE MM DD YY QUAL.										16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION FROM MM DD YY TO MM DD YY																			
17. NAME OF REFERRING PROVIDER OR OTHER SOURCE										17a. NPI					17b. NPI					18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES FROM MM DD YY TO MM DD YY																			
19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)										20. OUTSIDE LAB? YES NO \$ CHARGES										21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind. A. B. C. D. E. F. G. H. I. J. K. L.																			
22. RESUBMISSION CODE										22. ORIGINAL REF. NO.										23. PRIOR AUTHORIZATION NUMBER																			
24. A. DATE(S) OF SERVICE From MM DD YY To MM DD YY		B. PLACE OF SERVICE		C. EMG		D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS MODIFIER				E. DIAGNOSIS POINTER		F. \$ CHARGES		G. DAYS OR UNITS		H. EPSTD Family Plan		I. ID. QUAL.		J. RENDERING PROVIDER ID. #																			
1																				NPI																			
2																				NPI																			
3																				NPI																			
4																				NPI																			
5																				NPI																			
6																				NPI																			
25. FEDERAL TAX I.D. NUMBER SSN EIN					26. PATIENT'S ACCOUNT NO.					27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES NO					28. TOTAL CHARGE \$					29. AMOUNT PAID \$					30. BALANCE DUE \$														
31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.) SIGNED DATE										32. SERVICE FACILITY LOCATION INFORMATION a. b.										33. BILLING PROVIDER INFO & PH # () a. b.																			

PATIENT AND INSURED INFORMATION

PHYSICIAN OR SUPPLIER INFORMATION

Insurance Questionnaire / Payment Agreement

In order to determine what insurance benefits you have available, we *require* you to contact your insurance company at the phone number listed on your insurance card, and ask (and enter below) the following information. **Failure to fill this form out COMPLETELY will disable us from billing your insurance provider for services rendered. It is your responsibility to pay for any outstanding balance.** Psychological Services and Therapy are *confidential* processes to which we are legally and ethically bound. However, if you file for insurance benefits or reimbursement, please be aware that your confidentiality may be compromised. Once you have completed this form, please fax it with a copy of the front and back of your insurance card to 310-546-8929.

Our office must receive this information BEFORE you will be scheduled for a testing appointment.

***Be sure you call or are transferred to the Mental Health department, *not* medical. When you reach a representative please state:**

“I AM CALLING TO CHECK MY OUTPATIENT MENTAL HEALTH BENEFITS.”

- 1. Is Dr. Valerie Maxwell a provider under my plan? Yes / No
- 2. Is my mental health insurance carved out to a different insurance provider? Yes / No
 - a. (If #2 is Yes) What insurance covers mental health? _____
- 3. Is there a deductible for MENTAL HEALTH? (if none, enter “0”): \$ _____
 - a. (If #3 is *not* 0) Has the Deductible been met? Yes / No
- 4. Do I need an authorization for mental health? Yes / No
 - a. (If #3 is Yes) What is the authorization number? _____
 - b. (If you have an authorization #) How many sessions are authorized to start? _____
 - c. What is the start and end dates of the authorized sessions? Start _____ End _____
- 5. What is the MAXIMUM number of sessions I can use? _____
- 6. What is my co-payment? _____
- 7. Address to send Mental Health Claims: 7. Ph# Called: _____
(Often times *different* than address on card, please ask)

Insurance provider: _____

Date of Call: _____

Address: _____

I UNDERSTAND THAT IT IS MY RESPONSIBILITY TO PAY FOR SERVICES NOT COVERED BY MY INSURANCE, WHETHER BECAUSE I FAILED TO OBTAIN AUTHORIZATION, DENIAL, OR LIMITATION OF BENEFITS, CO-PAY, ETC. I HEREBY UNDERSTAND THAT IF I HAVE AN OUTSTANDING BALANCE, I WILL MAKE ARRANGEMENTS TO PAY THE AMOUNT DUE.

Signature

Date

Print Name

Client Name (Print)