

SUMMIT CENTER FOR MENTAL HEALTH

Adult Form

CLIENT INFORMATION:

Today's Date: _____ Summit Clinician: _____
First Name: _____ Middle: _____ Last: _____ Preferred name: _____
Address: _____ City: _____ State: _____ Zip: _____
Home Phone: _____ **OK to Leave message? (circle one) Yes No**
Cell Phone: _____ **OK to Leave message? (circle one) Yes No**
Social Security Number: _____ Sex: _____ I identify as: _____ Preferred Pronouns: _____
Email Address _____ **OK to email sensitive info? Yes No**
Circle one: Married Divorced Single Widow/erSeparated Date of Birth: _____

PRIMARY INSURANCE INFORMATION:

Insurance Company: _____ Policy ID#: _____
Group #: _____ Provider's Line #: _____ Employer Name: _____
Insured's Name: _____ Insured's SS#: _____
Insured's Birthdate: _____ Insured's Address: _____
City, State, Zip: _____ Patient's Relationship to the Insured: Self ___ Spouse ___ Child ___ Other ___

SECONDARY INSURANCE INFORMATION:

Insurance Company: _____ Policy ID#: _____
Group #: _____ Provider's Line #: _____ Employer Name: _____
Insured's Name: _____ Insured's SS#: _____
Insured's Birthdate: _____ Insured's Address: _____
City, State, Zip: _____ Patient's Relationship to the Insured: Self ___ Spouse ___ Child ___ Other ___

AUTHORIZATION

I authorize the release of any medical or other information necessary to process this claim. I also request payment of government/ insurance benefits to myself or to *The Summit Center for Mental Health*.

Signed: _____ Date: _____

I authorize payment of medical benefits to *The Summit Center for Mental Health* for services provided.

Signed: _____ Date: _____

GUARANTOR / RESPONSIBLE PARTY INFORMATION

If the guarantor is different than the patient, please complete and sign:

Guarantor Name: _____ DOB: _____
Address: _____ City/State/Zip: _____
Home Phone: _____ Cell Phone: _____
Soc Sec Number: _____ Relationship to Patient: _____
E-mail Address _____

As the responsible party, I understand that I am responsible for payment of any outstanding charges on this account.

Signature _____ Date _____

This authorization will remain in effect until revoked in writing by myself or The Summit Center for Mental Health.

Summit Center Psychiatric Adult Intake Form

Name _____ Date _____ Date of Birth _____

OFFICE POLICIES

Appointments:

There is a 24hour cancellation fee. The clinician reserves that time for me, **if I cannot attend I must give 24hours notice or I will be charged.**

The initial visit is considered to be evaluation only and not a guarantee that treatment will be the result. This includes the prescribing of medication.

Initials

If I am scheduled for a medication management appointment with a psychiatrist, I understand that I am required to be on time. If I am late, I understand that I will be required to reschedule appointment.

Medication Refills:

All requests for prescription refills must be made at least 3 business days before I run out of medication. The psychiatrist may require me to be seen before refilling a prescription.

Payments and Billing:

-Payment at time of service is expected unless other arrangements have been made. If health insurance covers my sessions, The Summit Center will help me seek reimbursement from the insurance company. **ANY unpaid balance after insurance is MY responsibility to pay.**

-I agree that The Summit Center for Mental Health may release to my insurance company any information needed to secure payment for service.

-If I do not pay my account then it may be turned over to collections.

-In the event that any check I write is returned NSF (insufficient funds) I agree to pay a **\$25.00 service fee.**

Signed: _____ Date: _____

D. AUTHORIZATION TO DISCUSS MY MEDICAL INFORMATION AND ACCOUNT:

You may discuss my medical information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

You may discuss my appointment information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

You may discuss my account information with:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signed: _____ Date: _____

CONSENT TO RELEASE INFORMATION TO PRIMARY CARE PHYSICIAN

Communication between Summit Center and your primary care physician can be important to help ensure that you receive comprehensive and quality health care. This information may include diagnosis, treatment plans, progress and medication. You may revoke this consent at any time in writing

I, _____
Name Date of Birth

I agree to release mental health/substance abuse information to my Primary Care Physician.

I do NOT give my consent to release any information to my Primary Care Physician.

Physician Name: _____

Physician Phone: _____ Fax: _____

Signature of Patient/Client _____ Date _____

* Signature of Parent, Guardian or Personal Representative _____ Relationship/Authority _____ Date _____

This authorization will remain in effect until revoked in writing by myself or The Summit Center for Mental Health.

Summit Center Psychiatric Adult Intake Form

Name _____

Date _____

Date of Birth _____

Problems are you seeking help with today: _____

Current Symptoms

- Depression Mood swings Anger/Irritability/Temper Thoughts of death/dying Suicidal thoughts Crying spells
 Hearing Voices Loss of Motivation Hopelessness Withdrawal/Avoidance Fatigue Increase energy Sleep Problems
 Self-injury Racing thoughts Anxiety or Panic attacks Suicidal Thoughts Hearing voices Agitation
 Impulsivity Suspiciousness Increase in risky behavior Change in libido Appetite Change Seeing Things
 ADHD Problems with attention/concentration/focus Gender Disphoria Problems with memory Worry
 Other – please describe: _____

Suicide Risk Assessment

- Have you had thoughts that you don't want to live? No Yes Do you have those thoughts now? No Yes
Have you ever tried to kill yourself? No Yes Number of times _____ When was most recent attempt? _____
Has anyone in your family died by suicide? No Yes Who? _____

Past Treatment History

Have you received treatment in the past for mental health problems? No Yes Type of treatment: Talk therapy Medications Inpatient:
times? _____ When most recent _____ Past Diagnosis, if known: _____

Family Psychiatric History

Please check if family members have (or might have) of any of the following problems and indicate relationship/self

- Depression: _____ Bipolar: _____
 Anxiety: _____ ADHD/ADD: _____
 Schizophrenia: _____ Addictions: _____
 PTSD: _____ Other: _____

Substance Use/Addiction History

- Do you use tobacco products? No Yes – what do you use, and how much? _____
Do you have problems with alcohol, drugs or prescription drugs? No Yes – Describe _____
Have you been treated for problems with alcohol or drugs? No Yes -Describe: _____

Social History

- Where did you grow up? _____ Quality of childhood Great Adequate Difficult
Raised by _____ # Brothers _____ # Sisters _____
Abuse in the home? No Yes- check all that apply: Physical Emotional Sexual Neglect
Marital Status: Single, never married Married/Partnered for _____ years Divorced Widowed # past marriages _____
Relationship with spouse/partner: Great Adequate Difficult Do you have children? No Yes – what are their ages: _____
How far did you go in school? _____ How did you do in school: _____
Occupation: Employed _____ Not working by choice Unemployed Retired Disabled
Military History: No Yes: Branch _____ When _____ Type discharge _____
Legal History: Have you ever been arrested No Yes: describe _____
Current legal issues? No Yes Describe: _____

Summit Center Psychiatric Adult Intake Form

Name _____

Date _____

Date of Birth _____

Medical History

Primary Care Physician: _____ Approximate Date of last exam: _____

How would you describe your physical health? _____

Please check any of the following health conditions for which you are being treated:

- High blood pressure Diabetes Liver Disease Heart Disease Thyroid Problem Stomach/Intestinal
 High Cholesterol Seizures Sleep Apnea Stroke Headache/Migraines Seizures
 Pain where: _____ Asthma COPD/Bronchitis Cancer type: _____

Medical problems not included above: _____

Past surgeries: _____

Allergies (medications or other): _____

Current Medications: _____

Review of Systems

Please check if you are having any of the following problems/symptoms:

- Physical pain Dizziness/Passing out Chest pain Shortness of breath Cough Night sweats
 Too hot/cold Movement/balance issues Vision problems Hearing loss Taste problems Urinary problems
 Nausea/Vomiting Diarrhea/Constipation Bloody stools Menstrual problems

Past Medication Trials

Check any of the following medications that you have been prescribed in the past. Please comment about how a medication worked for you.

- Antidepressants:** Prozac/fluoxetine Cymbalta/duloxetine Pristiq/desvenlaxine Lexapro/escitalopram
 Celexa/citalopram Luvox/fluvoxamine Effexor/venlaxine Wellbutrin/bupropion Paxil/paroxetine
 Zoloft/sertraline Remeron/mirtazapine Viibryd/vilazodone Elavil/ amitriptyline Pamelor/nortriptyline

How did the medication(s) affect you? _____

- Mood Stabilizer:** Tegretol/carbamazepine Lamictal/lamotrigine Depakote/valproate Topamax/topiramate
 Lithium Trileptal/oxcarbazepine

How did the medication(s) affect you? _____

- Antipsychotic/Mood stabilizer:** Seroquel/quetiapine Geodon/ziprasidone Abilify/aripiprazole
 Latuda/lurasidone Risperdal/risperidone Invega/paliperidone Zyprexa/olanzapine Fanapt/Iloperidone
 Clozaril/clozapine

How did the medication(s) affect you? _____

- Sleep Aids:** Sonata/zaleplon Lunesta/eszopiclone Restoril/temazepam Trazodone Ambien/zolpidem

How did the medication(s) affect you? _____

- Antianxiety Medications:** BuSpar/Buspirone Vistaril/hydroxyzine Xanax/alprazolam
 Ativan/lorazepam Klonopin/clonazepam Valium/diazepam Tranxene/clorazepate

How did the medication(s) affect you? _____

- Treatment of ADHD/ADD:** Stimulant (eg, Adderall, Ritalin, Concerta, Focalin, Metadate, Daytrona, Vyvanse)
 Strattera Tenex Clonidine Other _____

How did the medication(s) affect you? _____

For each of the following questions indicate "Yes" or "No"		Yes	No
1	Do you feel you are a normal drinker ("normal"- drink as much or less than most people)		
2	Have you ever awakened in the morning after drinking the night before and found you couldn't remember a part of the evening?		
3	Does any near relative or close friend ever worry or complain about your drinking?		
4	Can you stop drinking without difficulty after one or two drinks?		
5	Do you ever feel guilty about your drinking?		
6	Have you ever attended an Alcoholics Anonymous (AA) meeting?		
7	Have you ever gotten into physical fights when drinking?		
8	Has drinking ever caused problems between you and a near relative or close friend?		
9	Has any family member or close friend gone to anyone for help about your drinking?		
10	Have you ever lost friends because of your drinking?		
11	Have you ever gotten into trouble at work because of your drinking?		
12	Have you ever lost a job because of drinking?		
13	Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?		
14	Do you drink before noon fairly often?		
15	Have you ever been told you have liver trouble such as cirrhosis?		
16	After heavy drinking have you ever had delirium tremens (DTs), severe shaking, visual or auditory (hearing) hallucinations?		
17	Have you ever gone to anyone for help with your drinking?		
18	Have you ever been hospitalized because of drinking?		
19	Has your drinking ever resulted in your being hospitalized on a psychiatric ward?		
20	Have you ever gone to any doctor, social worker, clergy, or mental health clinic for help with any emotional problems in which drinking was a part of the problem?		
21	Have you ever been arrested more than once for drinking under the influence of alcohol?		
22	Have you ever been arrested, even for a few hours, because of other behavior while drinking?		

	Age of 1 st Use	When was Your Last Use	Type of Use (eg, heavy, recreational)
Alcohol			
Cocaine			
Methamphetamine			
Other Amphetamines (eg, Ritalin)			
Bath Salts			
Hallucinogens (eg, LSD, Mushrooms, PCP, salvia, ketamine)			
Heroin			
Prescription Pain Pills			
Benzodiazepines (Xanax, Valium, Klonopin, etc)			
Other Prescription Medications			
Inhalants			
Cold Medicines			
Marijuana			
K2/Spice ("Synthetic Marijuana")			
MDMA (Ecstasy/Molly)			
Other Club Drugs			
Steroids (Anabolic)			
Other:			



the
Summit
Center

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Fax: 815-773-0771

1801 North Mill Street
Suite J
Naperville, IL 60563
Telephone: 800-786-3033
Fax: 630-357-3093

Credit Card Authorization

For internal use only.

I, _____, authorize The Summit Center to keep my signature on file and to charge my credit card listed below for:

All patient balances (less than \$250) for services rendered once the claim has been processed by my insurance company. I understand that The Summit Center will charge my card for any outstanding balances at the end of each month, when the monthly billing cycle is completed. I also understand that The Summit Center will contact me by telephone for all patient balances exceeding \$250 prior to charging my card.

Recurring charges for services rendered for the following family members:

Patient Name: _____	DOB: _____
Patient Name: _____	DOB: _____
Patient Name: _____	DOB: _____
Patient Name: _____	DOB: _____

Check One: Visa _____ Master Card _____ Discover _____
(Sorry, we do not accept American Express)

Billing Address: _____ City: _____ State: _____ Zip: _____

Credit Card Number: _____ Expiration Date: _____ CVV: _____ (on back)

Cardholder Signature: _____ Date: _____ Cardholder contact number: _____

I have the right to terminate this authorization at any time and agree to do so by contacting The Summit Center at (815)773-0772.