


Dr Dean & Associates

Date _____

Name _____ FIRST _____ MIDDLE _____ LAST _____ Gender _____

Preferred name _____

DOB ____/____/____ Social Security # _____ Marital Status _____

Address _____ City _____ State _____ Zip _____

P.O. Box _____

Home Phone (____) _____ - _____ Cell Phone (____) _____ - _____

E-mail Address _____ @ _____

Patient Race: White/Caucasian (3) Black (2) Hispanic (4)

Asian/Pacific Islander (1) American Indian/Alaskan Native (5) Multi-racial (10)

Your Employer _____ Work Phone (____) _____ - _____

Religious Preference _____

Insurance Co. _____ Policy# _____

Policyholder's Name _____ DOB: _____ SSN: _____ Self Spouse
Parent

Name of Spouse/Parent _____ SS # _____

Spouse/Parent Employer _____ Phone # _____

Emergency Contact:

Name _____ Relationship _____

Phone _____

Referring Doctor _____ Family Physician _____

Preferred Pharmacy: _____

PAYMENT IS DUE WHEN SERVICES ARE RENDERED FOR OFFICE PROCEDURES.

CLINICAL INTAKE ASSESSMENT
ALL INFORMATION IS CONFIDENTIAL

Patient Name _____ Date of Birth _____

List all members of your immediate family:

<u>Name</u>	<u>Age</u>	<u>Relationship</u>	<u>Quality of Relationship</u>
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Medical History (dates/type)

Current Medications _____

Allergies

Physical Health Disabilities/Limitations

Hospitalizations _____

Surgeries _____

Mental-Health

Counseling _____

Psychotherapy _____

Hospitalizations _____

Addictions/Current usage (dates/treatments)

Alcohol _____

Drug _____

Gambling _____

Nicotine _____

Caffeine _____

Problems (past/present)

Legal _____

Financial _____

Presenting Problem/Complaint _____

Important recent events in your life: _____

Goals from

Therapy: _____

PROBLEMS/SYMPTOMS

Please check any of the following that you have recently had to cope with:

- | | |
|--|--|
| <input type="checkbox"/> Addictive Behavior | <input type="checkbox"/> Lose temper easily |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Low self esteem |
| <input type="checkbox"/> Argue too much | <input type="checkbox"/> Low interest in usual activities |
| <input type="checkbox"/> Avoid contact with others | <input type="checkbox"/> Lying |
| <input type="checkbox"/> Can't concentrate | <input type="checkbox"/> Need reassurances |
| <input type="checkbox"/> Can't keep friendships | <input type="checkbox"/> Marital Problems |
| <input type="checkbox"/> Chronic pain | <input type="checkbox"/> Nightmares |
| <input type="checkbox"/> Defy requests from others | <input type="checkbox"/> Not resolving conflict |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Over-dependent |
| <input type="checkbox"/> Disorganized | <input type="checkbox"/> Panic attacks |
| <input type="checkbox"/> Divorce/Separation | <input type="checkbox"/> Phobic fears |
| <input type="checkbox"/> Doubting my abilities | <input type="checkbox"/> Physical abuse |
| <input type="checkbox"/> Eating problems | <input type="checkbox"/> Poor parenting skills |
| <input type="checkbox"/> Emotional abuse | <input type="checkbox"/> Problems initiating relationships |
| <input type="checkbox"/> Family conflicts | <input type="checkbox"/> Problems sleeping |
| <input type="checkbox"/> Fear of gaining weight | <input type="checkbox"/> Sexual abuse |
| <input type="checkbox"/> Fear of being alone | <input type="checkbox"/> Sexual dysfunction |
| <input type="checkbox"/> Feel persecuted | <input type="checkbox"/> Shame |
| <input type="checkbox"/> Few feelings | <input type="checkbox"/> Speaking problems |
| <input type="checkbox"/> Guilt | <input type="checkbox"/> Stealing |
| <input type="checkbox"/> Hallucinations | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Unable to relax |
| <input type="checkbox"/> Impulsiveness | <input type="checkbox"/> Unrealistic worrying |
| <input type="checkbox"/> Inappropriate feelings | <input type="checkbox"/> Worry about sexual identity |
| <input type="checkbox"/> Indecisive | Other _____ |
| <input type="checkbox"/> Insensitive to others | _____ |
| <input type="checkbox"/> Jealousy | _____ |
| <input type="checkbox"/> Job stress | _____ |
| <input type="checkbox"/> Lack of assertiveness | |
| <input type="checkbox"/> Loneliness | |

PATIENT/CLIENT'S INFORMED CONSENT

I have chosen to receive treatment services under Dean & Associates. My choice has been voluntary and I understand that I may terminate therapy at any time.

I understand that there is no assurance that I will feel better. Because psychotherapy is a cooperative effort between my therapist and myself and I will work with my therapist in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment, material may be discussed which will be upsetting in nature and that this may be necessary to help me resolve my problems.

I understand that records and information collected about myself will be held or released in accordance with state laws regarding confidentiality of such records and information.

I understand that state and local laws require that my therapist report all cases of abuse or neglect of minors or vulnerable adults.

I understand that state and local laws require that my therapist report all cases in which there exists a danger to self and others.

I understand that there may be other circumstances in which the law requires my therapist to disclose confidential information.

I understand that information necessary for supervision or consultation may be disclosed.

Transfer Plan: I understand that in the unlikely event that one of our providers is unable to provide ongoing services, another provider at Dean and Associates will provide those services or will refer you to the appropriate resource. Dean and Associates will maintain your records for period of (7) years. Should Dean and Associates no longer be able to provide ongoing services, _____ will provide these services or refer you to the appropriate resource. _____ will maintain your records for a period of _____ years. _____ may be contacted at _____.

Emergency Situations: In the event of a psychiatric emergency I understand that I can call this office at 712-276-6729, and if it is after business hours, the phone message will direct you to call the doctor "on call" and provide you with the appropriate phone number. I understand that I can also go to the nearest emergency room or call 911 if needed.

I have read and had explained to me the basic rights of individuals. These rights include:

1. The right to be informed of the various steps and activities involved in receiving services including medication.
2. The right to confidentiality under federal and state laws relating to the receipt of services.
3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.
6. The right to select practitioners of my choice at my expense.

I understand that I can revoke my consent at any time except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent. If I do not revoke this consent, it will expire automatically one year after all claims for treatment have been paid as provided in the benefit plan.

I have read and understand the above.

Patient/Client Signature

Date

**Parent, Guardian, Conservator or
Authorized Representative (When required)**

Date

Dean & Associates
3549 Southern Hills Drive
Sioux City, Iowa 51106
(712) 274-6729

Authorization, Consent & Acknowledgement

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I consent to the use or disclosure of my protected health information by Dean and Associates for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations of Dean and Associates.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Dean and Associates is not required to agree to the restrictions that I may request. However, if Dean and Associates agrees to a restriction that I request, the restriction is binding on Dean and Associates. I have the right to revoke this consent, in writing, at any time, except to the extent that Dean and Associates has taken action in reliance on this consent.

I have reviewed your *Notice of Patient Privacy Practices* containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its *Notice of Patient Privacy Practices* from time to time and that I may contact Dean and Associates at any time at the address above to obtain a current copy of the *Notice of Patient Privacy Practices*.

Coordination of treatment:

- ☐ I give permission for my provider at Dean and Associates to release mental health information for the purpose of coordination of care with my primary care physician and any other medical practitioners who provide care for me. (If you check this box, please complete included release of information).
- ☐ I decline to release information to my primary care physician or other medical providers at this time.

Advance Directives (Living Will)

- ☐ I currently have a Psychiatric Advance Directive.
- ☐ I do not have a Psychiatric Advance Directive. I understand I can follow-up on this option by logging on to www.nrc-pad.org. It is recommended that you seek legal counsel when completing this document. If such a document is completed, I will provide a copy to this office.

Print Patient Name: _____

Relationship to Patient: _____

Signature: _____

Date: _____

DEAN & ASSOCIATES

PO BOX 5427, SIOUX CITY, IOWA 51102

PHONE (712) 274-6729 FAX (712) 274-6744

OFFICE POLICY

It is Dean & Associate's policy that payment is made at time of service. We will accept cash, checks or credit cards. You may make payment when checking in if this is convenient, or at the end of your visit. **Be sure to stop at the front desk to make payment, schedule your next appointment and address any concerns.** Payment at time of service cuts down on the cost of billing which results in savings that allows us to keep down the cost of patient care. We do not discriminate based upon race, color, national origin, disability, religion, sex, age or sexual orientation. If you are unable to pay you will not be denied access to our services.

We will be happy to file your insurance claim. We accept most commercial insurances, Medicare and Medicaid. **All patients covered by Insurance must bring their card with them for each appointment.** Please present your card when checking in with the receptionist so we can file your insurance correctly. You are responsible for any remaining balance.

Patients with financial concerns may discuss options with the office manager, patient account representative or their clinician. To qualify for assistance an application for a sliding fee scale will be given per individual or household. For unpaid balances, we do use a collection agency. The guarantor of the account is responsible for any collection fee charged to collect the debt owed. A copy of the fee schedule is available by request at the front desk.

To best serve our clients if you cannot keep your appointment we ask for a 24-hour advance notice of cancellations. You will be charged a fee for a No Show. It is your responsibility as your insurance company does not reimburse for no shows. If you have concerns about this fee or your ability to pay please consult directly with your clinician. You must make your payment for missed appointments, before your next appointment. Parents/guardians are responsible for charges incurred by their minor child.

After 2 "NO SHOWS", it will be up to the discretion of your clinician to continue care through this clinic.

Parents/Guardian/Foster Parent or other responsible adult must be present when a child is being seen.

I HAVE READ, UNDERSTAND AND AGREE TO THE TERMS SET FORTH ABOVE.

Patient or Responsible Person

Date