



RESTORATION to SOUND HEALTH

# INTAKE FORM

Phone: (612) 284-8115 Email: intake@arubahemotionalhealth.com

**Client Name:**  
**Date of Birth:**  
**Social Security Number:**  
**Ethnicity:**  
**Gender:**  
**Sexuality:**

**Home Address:**

**Email Address:**  
**Phone Number:**

**Parent/Guardian/Emergency Contact #1**

**Name:**  
**Contact Number:**  
**Email Address:**  
**Relationship to client:**  
**Legal Custody Status:**  
Yes    No    N/A

**Parent/Guardian/Emergency Contact #2**

**Name:**  
**Contact Number:**  
**Email Address:**  
**Relationship to client:**  
**Legal Custody Status: Legal Custody Status:**  
Yes    No    N/A

**Referral Source:**

**Partnership Site:**

**Primary Insurance**

**Name of Insurance:**

**Type of Insurance - Commercial                      State**

**Subscriber ID:**

**Group Number:**

**Policy Number:**

**Secondary Insurance**

**Name of Insurance:**

**Type of Insurance - Commercial                      State**

**Subscriber ID:**

**Group Number:**

**Policy Number:**

**Tertiary Insurance**

**Name of Insurance:**

**Type of Insurance - Commercial                      State**

**Subscriber ID:**

**Group Number:**

**Policy Number:**

**Reason for seeking treatment:**

**Expectations from therapy:**

**Have you seen a counselor, psychologist, psychiatrist or other mental health professional before?**

**Describe your current mental health symptoms:**

**Please rank the three biggest concerns:**

**Are you currently taking prescription medication?**

**Please List Medications:**

**Signature:**

**Date:**



**THIS DOCUMENT IS FOR CONSENT FOR TREATMENT  
PLEASE SIGN AFTER EACH SECTION.**

CONSENT FOR TREATMENT

This is a general consent for treatment at Arubah Emotional Health Services.  
I give my consent for services at Arubah Emotional Health Services and by associated profession staff. This consent will include evaluation, therapy, medication management or testing (if indicated).  
A treatment plan will be designed between you and your assigned therapist(s). This consent is an agreement to be involved in the treatment planning process.  
I understand that I may decline a specific treatment recommendation.

Signature

Guardian Signature

Witness Signature

Date



**THIS DOCUMENT IS FOR CONSENT FOR TREATMENT AND  
ACKNOWLEDGMENT OF RECEIPT OF  
CLIENT RIGHTS and NOTICE OF PRIVACY PRACTICES.  
PLEASE SIGN AFTER EACH SECTION.**

**ACKNOWLEDGMENT OF RECEIPT OF CLIENTS RIGHTS BROCHURE**

I have received and read Arubah Emotional Health Service's description of my rights as a receipt of service, entitled "Clients Rights and Responsibilities."

I understand that I may receive another copy of this statement at any time and that I may direct any complaints about my service to the agency Director or owner

Signature

Guardian Signature

Witness Signature

Date

**ACKNOWLEDGMENT OF RECEIPT OF THE NOTICE OF PRIVACY PRACTICES**

Consistent with the Health Insurance Portability and Accountability Act (1996), I have been provided with a copy of the Notice of Privacy Practices.

My signature below indicates that I have received a copy of the Notice of Privacy Practices. Arubah Emotional Health Services strongly encourages all clients to carefully read this document.

Signature

Guardian Signature

Witness Signature

Date



## OUR FINANCIAL POLICY

We appreciate you for choosing Arubah Emotional Health Services as your mental health provider. We have committed ourselves to ensuring the best quality service for your treatment. Our financial policy is a part of our agreement for services. The statement should be read and signed prior to treatment. By signing this form you are agreeing to the terms of this financial policy.

Full Payment for fees or co-pays is due at the time of service. Fees may be paid with cash or check. All outstanding balances are the responsibility of the client, regardless of whether or not insurance covers the services. It is imperative that client notify us of any insurance changes. Failure to do so can cause billing inaccuracies that could result in full payment responsibility to the client.

Insurance Coverage - Insurance coverage is a contract between the insurance company and the covered person. Providers of health care are NOT a part of the contract. Instead, healthcare providers accept the assignment of benefits. This assignment can only happen with a client's signed authorization. Further, if the insurance company requires a referral, the client must obtain the referral prior to receipt of any care. Fees not covered by insurance after 45 days become the responsibility of the client.

Medicare and Medical Assistance - We are an authorized provider for Medicare and Medical Assistance and accept assignment of benefits. Eligibility for Medical Assistance is verified each month. Please have your Medical Assistance card available to assist us in verifying this coverage.

Reduced Fees/Sliding scale fees - We may be able to reduce fees in certain circumstances. Please speak with your therapist. Payment plans may also be arranged.

Missed Appointments – A 24-hour notice for cancellations is required. This enables us to arrange care for another client. Failure to cancel 24-hours ahead of a scheduled appointment will automatically result in charges (outlined below) regardless of reason. Your treatment provider will not be able to prevent or reverse charges for missed appointments.

Fees for Missed Appointment and Late Cancellation:  
Individual, Couples and Family Sessions: \$ 50.00  
Group Sessions Any Length \$ 50.00

PLEASE NOTE: FAILURE TO ATTEND A GROUP - is an automatic charge, regardless of notice. This is because another client can not fill the vacancy of an absent group member.

My signature below is authorization for the release of any medical information necessary to process the claim for benefits. Any release of medical information is understood to follow the standards set by HIPAA and the Data Privacy Act. I authorize payment of all benefits directly to Arubah Emotional Health Services. I acknowledge that I have read, understand and agree to the above Financial Policy

Signature

Guardian Signature

Date



# WHODAS 2.0

WORLD HEALTH ORGANIZATION  
DISABILITY ASSESSMENT SCHEDULE 2.0

## 12-item version, self-administered

This questionnaire asks about difficulties due to health conditions. Health conditions include diseases or illnesses, other health problems that may be short or long lasting, injuries, mental or emotional problems, and problems with alcohol or drugs.

Think back over the past 30 days and answer these questions, thinking about how much difficulty you had doing the following activities. For each question, please circle only one response.

In the past 30 days, how much difficulty did you have in:						
S1	<u>Standing for long periods</u> such as <u>30 minutes</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S2	Taking care of your <u>household responsibilities</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S3	<u>Learning a new task</u> , for example, learning how to get to a new place?	None	Mild	Moderate	Severe	Extreme or cannot do
S4	How much of a problem did you have <u>joining in community activities</u> (for example, festivities, religious or other activities) in the same way as anyone else can?	None	Mild	Moderate	Severe	Extreme or cannot do
S5	How much have <u>you</u> been <u>emotionally affected</u> by your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do

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# WHODAS 2.0

WORLD HEALTH ORGANIZATION  
DISABILITY ASSESSMENT SCHEDULE 2.0

In the past 30 days, how much difficulty did you have in:						
S6	<u>Concentrating</u> on doing something for <u>ten minutes</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S7	<u>Walking a long distance</u> such as a <u>kilometre</u> [or equivalent]?	None	Mild	Moderate	Severe	Extreme or cannot do
S8	<u>Washing your whole body</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S9	Getting <u>dressed</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S10	<u>Dealing</u> with people <u>you do not know</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S11	<u>Maintaining a friendship</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do
S12	Your day-to-day <u>work</u> ?	None	Mild	Moderate	Severe	Extreme or cannot do

H1	Overall, in the past 30 days, <u>how many days</u> were these difficulties present?	<b>Record number of days</b> ____
H2	In the past 30 days, for how many days were you <u>totally unable</u> to carry out your usual activities or work because of any health condition?	<b>Record number of days</b> ____
H3	In the past 30 days, not counting the days that you were totally unable, for how many days did you <u>cut back</u> or <u>reduce</u> your usual activities or work because of any health condition?	<b>Record number of days</b> ____

This completes the questionnaire. Thank you.