Arubah

Intake Form

Phone: (612) 284-8115 Fax: (763) 273-8892

Client Name

First Name | Last Name

Date of Birth

Month Day Year

Social Security Number

Relationship Status

Race and Ethnicity

Gender

Sexuality

Address

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Email

example@example.com

Phone

Home/Work | Cell

Preferred Method of Contact

E-mail Home Cell

Education

Employment

Place of Employment or School

Parent/ Guardian/ Emergency Contact #1

Please Fill out relevant information. If client is an adult, only fill out for an emergency contact. Four spaces are available if needed for parents and guardians.

Name

Email

example@example.com

Phone

Home / Work

Cell

Relationship to Client

Legal Custody of Client?

Parent/ Guardian #2

Name

Email

example@example.com

Phone

Home/Work

Cell

Relationship to Client

Legal Custody of Client?

Primary Insurance Information

Name of Insurance

Insurer Phone Number

Phone Number

Subscriber Name

First Name Last Name

Subscriber Relationship to Client

Group Number

Policy Number

Secondary Insurance Information

Name of Insurance

Insurer Phone Number

Phone Number

Subscriber Name

First Name Last Name

Subscriber Relationship to Client

Group Number

Policy Number

Medical History

Please check all the apply

- ☐ Allergies
- ☐ Angina
- ☐ Asthma
- ☐ Benign Prostatic
- ☐ Blood Clots
- ☐ Cerebrovascular Accident
- ☐ COPD (Emphysema)
- ☐ Depression
- ☐ Gallbladder Disease
- ☐ Hepatitis C
- ☐ Hypertension
- ☐ Liver Disease
- ☐ Myocardial Infarction
- ☐ Osteoporosis
- ☐ Renal Disease
- ☐ Thyroid Disease
- ☐ Anemia
- ☐ Arthritis
- ☐ Atrial Fibrillation
- ☐ Hypertrophy
- ☐ Cancer
- ☐ Cronary Artery Disease
- ☐ Crohn's Disease
- ☐ Diabetes
- ☐ GERD (Reflux)
- ☐ Hyperlipidemia
- ☐ Irritable Bowel Disease
- ☐ Migraine Headaches
- ☐ Osteoarthritis
- ☐ Peptic Ulcer Disease
- ☐ Seizure Disorder
- ☐

Do you use tobacco?

- ◯ No
- ◯ Daily
- ◯ Weekly
- ◯ Less
- ◯ Former User

Do you use alcohol?

- ◯ No
- ◯ Daily
- ◯ Weekly
- ◯ Less
- ◯ Former User

Caffeine use?

- ◯ No
- ◯ Daily
- ◯ Weekly
- ◯ Less
- ◯ Former User

Primary Care Name and Phone #

Are you currently taking prescription medication?

- ◯ Yes
- ◯ No

Please List Medications

Prescribing Doctor

Name

Phone Number

Have you had any surgeries in the past 5 years?

- ◯ Yes
- ◯ No

Please specify:

Family history

- ☐ Adopted
- ☐ Allergies
- ☐ Arthritis
- ☐ CAD (Heart Attack)
- ☐ CVA (Stroke)
- ☐ Developmental Delay
- ☐ Eczema
- ☐ Hyperlipidemia (High Cholesterol)
- ☐ Irritable Bowel Disease
- ☐ Mental Illness
- ☐ Obesity
- ☐ Osteoporosis
- ☐ Renal Disease
- ☐ Addiction
- ☐ Asthma
- ☐ Blood Disease
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Hearing Deficiency
- ☐ Hypertension (High Blood Pressure)
- ☐ Learning Disability
- ☐ Tuberculosis
- ☐ Osteoarthritis
- ☐ PVD
- ☐

Mental Health History

Why you are seeking treatment?

What do you expect from this counselling?

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

- ◯ Yes
- ◯ No

Therapist Name

First Name Last Name

Please explain past treatment experience:

Has the client experienced the following symptoms?

- ☐ Feeling down or depressed
- ☐ Trauma or abuse history
- ☐ Difficulty getting sleep
- ☐ Too much sleep
- ☐ Chemical or Drug abuse
- ☐ Sometimes wishing not to be alive
- ☐ Difficulties at Work/School
- ☐ Suicidal thoughts
- ☐ Family problems
- ☐ Doing things to harm self
- ☐ Problems with friends
- ☐ Crying easily or uncontrollably
- ☐ Partner/Relational issues
- ☐ Problems with concentration
- ☐ Sexual issues
- ☐ Tired, not motivated
- ☐ Thoughts about harming others
- ☐ Irritable, angry feelings, crabby
- ☐ Quick to anger/slow to calm
- ☐ Disorganized
- ☐ Threatening or fighting
- ☐ Can't sit still, restless
- ☐ Avoidant of issues/problems
- ☐ Easily distracted
- ☐ Aggression
- ☐ Lying or omitting facts
- ☐ Trouble with the law
- ☐ Acts without thinking
- ☐ Argumentative
- ☐ Difficulty following through
- ☐ Memory issues
- ☐ Hopeless
- ☐ Guilty feelings
- ☐ Gambling
- ☐ Obsessions or ruminations
- ☐ Strange or troubling thoughts
- ☐ Worried or nervous
- ☐ Not able to stand up for self
- ☐ Intense overwhelming feeling (panic)
- ☐ Feel unnoticed/unimportant
- ☐ Intense fears
- ☐ Concerns about eating/body image
- ☐ Stomachaches
- ☐ Weight changes
- ☐ Headaches
- ☐ Loneliness
- ☐ Chest pain/racing heart
- ☐ High blood pressure
- ☐ Change in appetite (more or less hungry)
- ☐ Perfectionist
- ☐ Repetitive actions/checking
- ☐ Nightmares
- ☐ Shy or timid

Please describe any other experiences you have had problems with:

Please rank the three biggest concerns:

Additional comments or concerns

Signature

_____

_____

Date

WHODAS 2.0

WORLD **H**EALTH **O**RGANIZATION
DISABILITY **A**SSESSMENT **S**CHEDULE 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	Standing for long periods such as 30 minutes?	None	Mild	Moderate	Severe	Extreme or cannot do
S2	Taking care of your household responsibilities?	None	Mild	Moderate	Severe	Extreme or cannot do
S3	Learning a new task, 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 joining in community activities (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 you been emotionally affected by your health problems?	None	Mild	Moderate	Severe	Extreme or cannot do

Please continue to next page...

WHODAS 2.0

WORLD **H**EALTH **O**RGANIZATION
DISABILITY **A**SSESSMENT **S**CHEDULE 2.0

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

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

This completes the questionnaire. Thank you.

Arubah

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.

Signed: _____ Date: _____

_____ Date: _____
Signature of parent/guardian if consent is for a minor

Witness: _____ Date: _____

Arubah

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.

Client Signature: _____ DATE: _____

Responsible Party Signature: _____DATE: _____

Arubah

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.

Signed: _____ Date: _____

_____ Date: _____
Signature of parent/guardian if consent is for a minor

Witness: _____ 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 Notic 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.

Signed: _____ Date: _____

_____ Date: _____
Signature of parent/guardian if consent is for a minor

Witness: _____ Date: _____

Arubah Emotional Health Services
AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

Client Name (Last, first, middle initial)

Street Address City State Zip

Date of Birth Day Phone # Evening Phone #

INFORMATION RELEASED FROM/ EXCHANGE WITH	INFORMATION RELEASED TO/ EXCHANGE WITH
Name (Program / Individual) Arubah Emotional Health Serives	Name (Program / Individual)
Street Address 3300 County Road 10 Suite 204b	Street Address
City Brooklyn Center State MN Zip 55429	City State Zip
Telephone: 612-284-8115 Fax: 763-273-8892	Telephone: Fax:

AUTHORIZATION TO DISCLOSE MEDICAL / BILLING INFORMATION IS LIMITED TO THE FOLLOWING: FROM: _____ TO _____

☐ Admission / Intake Summary ☐ Diagnosis & Treatment Plan ☐ Progress Notes ☐ Discharge Summary
☐ Psychiatric Assessment ☐ Chemical Dependency Evaluation /Abuse/Drug/Alcohol Treatment ☐ Psychological Assessment
☐ Prior Treatment Records ☐ Medication Management Records ☐ Medical/Physical History ☐ Education Records

☐ Progress Review ☐ HIV History ☐ Billing Records/Statements (date)_____

☐ Other _____

-OR-

☐ **The entire record** (including, if applicable, chemical dependency/drug or alcohol abuse treatment records)

AND ☐ ***including*** billing records ☐ ***excluding*** billing records ☐ ***excluding*** records from other facilities ☐ ***excluding*** HIV records

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THIS INFORMATION IS TO BE DISCLOSED FOR THE PURPOSE OF:

☐ Insurance Payment ☐ Third Party Authorization and Payment ☐ Communication regarding legal issues
☐ Coordination of Care ☐ Litigation ☐ Other _____

NOTE: A FEE MAY BE CHARGED IN ACCORDANCE WITH MN STATUTE 144.335 AND FEDERAL RULE 164.524

I understand that I may revoke this authorization at any time with written notification, but that the revocation will not have any effect on the information released prior to notification of revocation. Please see your Notice of Privacy Practices for information on how to revoke this authorization. I also understand that this authorization will automatically expire one year from the date of my signature unless I revoke it earlier. Arubah Emotional Health Services will not refuse or restrict my treatment if I choose not to sign this authorization. **A photocopy / fax of this authorization will be treated in the same manner as an original.**

Further, I realize that Arubah Emotional Health Services cannot prevent the re-disclosure of records released as a result of this request and that the records may not be subject to privacy rule protections; therefore, Headway Emotional Health Services is released from any and all liability resulting from re-disclosure.

Client / Legal Representative Signature _____ Dated _____

If you are the client's legal representative, please **attach a copy** of the document that gives you the authority to act as the legal representative. **You are entitled to a copy of this document**