Indy Behavioral Health, LLC
2611 Waterfront Parkway East Drive, Suite 370
Indianapolis, IN 46214
317.978.0257
indybehavioralhealth.com

Physical and Mental Health Intake

General Health History /Medical Problems

_____

_____

_____

_____

Current Medication(s) **Supplement/Vitamins**

_____ _____

_____ _____

_____ _____

Please attach another sheet if necessary.

Allergies to Medication(s): _____

Family Health History: _____

Religious Affiliation: _____

Relationship Status: Please Circle.

Married Single Divorced Widowed In a long term relationship

Education and Employment

Circle highest level of education

High School **Middle School**

Some College **Elementary School**

College Degree **If currently student, grade in school _____**

Masters/Graduate Degree **Name of school _____**

Please circle your current employment status.

Full Time **Homemaker**

Part Time **Unemployed**

Self Employed **Disabled**

Retired **Looking for Employment**

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INTAKE FORM

Please provide the following information and answer the questions below.

Please note: Information you provide is protected as confidential information.

Name:

_____

(Last) (First) (Middle Initial)

Name of parent/guardian (if under 18 years):

_____

(Last) (First) (Middle Initial)

Birth Date: _____/_____/_____ Age: _____ Gender: Male Female

Patient Social Security Number: _____-_____-_____

Parent Social Security Number (if patient under 18) _____-_____-_____

Address: _____

(Street and Number)

_____

(City) (State) (Zip)

Cell/Other Phone:

_____

May we leave a detailed message? Yes No

E-mail:

_____

May we email you? Yes No

***Please note: Email correspondence is not considered to be a confidential medium of communication.**

Emergency Contact

_____

Name Phone Relationship

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Preferred Pharmacy and Phone Number:

_____

Name **Number**

What are your goals for seeking treatment?

1. _____
2. _____
3. _____

Treatment Preference(s) Please check one or all of the following treatment methods you are most interested in exploring.

***Medication**

***Genetic testing for assistance in psychiatric medication selection**

Mental Health History

Please list CURRENT psychiatric medications

_____

_____

_____

_____

PAST Psychiatric Medications

_____ _____

_____ _____

_____ _____

Past Psychiatric Problems or Diagnosis

_____ _____

_____ _____

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Please provide the date and reason for your most recent psychiatric hospitalization. If not applicable, write N/A.

_____

Have you ever gone to therapy? If so, please list name(s) of therapist(s) and approximate dates of treatment.

_____

_____

Current Symptoms

Please circle symptoms currently experienced.

Insomnia	**Anxiety**	**Mood Swings**
Depression	**Impulsivity**	**Obsessive Thoughts**
Sadness	**Panic attacks**	**Sexual Difficulties**
Anger	**Change in Weight**	**Relationship Issues**
Irritability	**Problems with Focus**	**Trouble with work**
Fear	**Low Self-esteem**	

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Consent to Treatment

Patient Name:

_____

DOB: _____

Date: _____

I voluntarily consent to outpatient care with Sonya Ruedlinger, NP

- I understand Sonya Ruedlinger, NP uses an integrative psychiatry and mental health approach with limited use of medications.
- I understand that the care I receive from Sonya Ruedlinger, NP may be considered non-conventional. Such services are commonly referred to as integrative, complementary, alternative or holistic services. This can include nutritional and supplement recommendations, mindfulness and breathing practices, and other mind-body approaches to care. While many of these techniques have been long practiced and researched and found to be effective, many are still considered "investigative" or "experimental". The treatment plan is a collaborative effort and I recognize it is my responsibility to let Sonya know which approaches I would like to try and those with which I do not feel comfortable. I recognize it is entirely my choice. By accepting these treatments I agree to accept the risks explained to me about these treatments.

I have read and understand the foregoing and understand that it is my responsibility to discuss any concerns I have about any and all parts of my treatment plan. I understand the nature of these health care methods and consent to counseling and treatment.

Patient Name:

_____

Patient Signature:

_____

Signature of Guardian if Patient is under 18:

_____

Date: _____

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

1) The patient authorizes release of information with a signature;

2) The provider is ordered by a court to release information;

3) The patient presents a physical danger to self or others;

4) Child abuse/neglect is suspected. In the two latter cases, we are required by law to inform potential victims and legal authorities so that protective measures can be taken.

I have read the foregoing, understand its content, and agree to the conditions stipulated herein.

Patient Name:

_____

Patient Signature:

_____

Signature of Guardian if Patient is under 18:

_____

Date: _____

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Authorization to Bill Insurance

Insurance: Our office will kindly bill your insurance company. We participate with a number of medical insurance plans that we will contact to verify eligibility and benefits. Please realize that you have the ultimate responsibility of verifying the coverage with your insurance. You acknowledge that we may be an out of network provider with your insurance. You are also aware that in some circumstances your insurer will send payment directly to you. You agree to endorse the insurance check and forward funds to the appropriate entity above within **30 days** of receipt. You will be responsible for any balance not paid or denied by your insurance carrier. Patients who do not supply accurate insurance information will be considered self-pay. You must inform our office of any changes in your insurance, as you are the policyholder and it is your responsibility.

Insurance Referrals: If your plan requires a referral from your Primary Care provider, it is your responsibility to obtain it before seeking treatment from us. If a claim is denied due to a lack of referral you will be responsible for charges. You understand that you are financially responsible for claims denied or not covered by your insurance carrier for failure to obtain a referral.

I authorize release of information, including treatment and protected health information to my insurance company that is needed to process payment for services. I authorize my insurance carrier to pay benefits for services rendered, directly to Indy Behavioral Health, LLC or any of its affiliates. I have read and agree to the terms of the above information. I understand payment is expected at the time services are rendered and that I am responsible for any balance.

Patient Name:

_____

Patient Signature:

_____

Signature of Guardian if Patient is under 18:

_____

Date: _____

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OFFICE APPOINTMENTS, FEES, AND CANCELLATION POLICY

Our office tries to meet the needs of all of our patients but in particular our patients in crises that need our urgent attention. To open up appointment slots for patients in crises, the following scheduling policies are implemented:

1. To schedule an appointment, please call our office at 317-978-0257 or schedule online at indybehavioralhealth.com _____ **(initial)**

2. One day prior to the appointment, the office will try to reach you directly to confirm the appointment. If we are unable to reach you, we will try your alternate contact information. Please be aware, though, that this reminder service is a **courtesy** to our patients and that they are ultimately responsible for charges incurred due to a missed appointment. _____ **(initial)**

3. We understand that there may be circumstances that are beyond your control and we will try to accommodate them as best we can. However, there is a **24 hour cancellation** policy. You can cancel or re-schedule your appointment anytime 24 hours **before** your appointment. If the appointment is cancelled less than the 24 hour period or missed completely without notification the following consequences apply:

Cancellations: We ask that you provide 24 hour notice for appointments that must be cancelled and or rescheduled. Less than 24 hour notice and/or not showing for appointment will result in a missed appointment fee of $50.00. Appointments must be cancelled by calling the front office at 317-978-0257

PAYMENT POLICY

Payment is to be paid in full at the time of appointment. Accepted forms of payment include credit or debit cards. If for some reason your balance is not paid in full within 90 days, we reserve the right to turn your account over to collections. I do not participate in Medicare or Medicaid. Please contact your health insurance carrier about your mental health benefits. _____ **(initial)**

WRITTEN REPORTS

Occasionally, requests are received for reports, treatment reports for insurance companies, and written evaluations to be sent to individuals or agencies. You will be billed for the time required to complete such reports, as well as clerical costs.

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FMLA or Short Term Disability Forms

In order for us to thoroughly assess the extent of your symptoms, we must see you in the office on at least four occasions before we will consider completing FMLA or short term disability paperwork. Completion of these forms is at our discretion and is based on our assessment of functional impairment. The cost for completion of FMLA paperwork is $50. Forms will be completed within 5 business days of receipt. If forms are needed in less than 5 days, there will be a $25 expediting fee. Again, we will not consider completing FMLA or short term disability paperwork unless we have seen you in the office at least four times.
_____ **(initial)**

I have read the above and agree to its terms and conditions.

_____
Signature of Patient or Guardian if patient is under 18. Date

_____
Printed Name

COMMUNICATIONS

Email

Email is not a secure form of communication.

Email messages may be read by staff when handling routine, non-clinical matters.

Email may be printed and placed in your medical record. Employers may choose to read email sent from work and have the legal right to do so.

Email may be forwarded to staff for handling, if appropriate.

If you have a question about changing your medication, you will need to schedule an appointment. Email cannot adequately inform you of the risks and benefits of changes in treatment.

Email is NEVER appropriate for urgent or emergency problems! In an emergency, call 9-1-1 or go to the nearest emergency room.

Text Messaging is also to be limited due to lack of security and confidentiality. Text messaging may be used to inform of appointment date/time or other non-clinical, routine information. It should not be used to discuss lengthy concerns including side effects, medication changes, treatment planning, etc. Questions/concerns related to

medication or treatment planning deserve a greater level of attention and care. These issues should be addressed by scheduling an appointment.

After-Hours Emergencies

This clinic does not have an after-hours service. If you think you may be in an emergency situation (thinking or planning to harm yourself or someone else, medication side effects or withdrawals, etc.), then this is an Emergency and you should call 9-1-1 or go to the closest Emergency Department.

COMMUNICATIONS

_____ (Initial) I do want to communicate with Sonya Ruedlinger, NP electronically. I have read the above information and understand the limitations of security of information transmitted.

Email Address

_____

_____(Initial)I do NOT want to communicate with my physician electronically. However, if I do email Sonya Ruedlinger, NP I am automatically authorizing Sonya Ruedlinger, NP to email me in return.

Patient Signature

_____

Date

_____

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STANDARD FEE SCHEDULE

Thank you for choosing our office for your psychiatric needs. We strive to provide a warm and compassionate environment while addressing the presenting psychiatric issues with the utmost level of professionalism and sensitivity.

Cash Prices (without insurance) are as follows:

1. **INITIAL EVALUATION**: **$200** (60 minutes)
2. **EXTENDED MEDICATION MANAGEMENT** **$170** (60 minutes)
3. **MEDICATION MANAGEMENT** (uncomplicated) **$90** (30 minutes)

We will be happy to bill your insurance. Please bring our insurance card to your first visit.

*** PAYMENT IS EXPECTED AT THE TIME OF EACH VISIT. _____ (INITIAL)**

I have read the above and agree to its terms and conditions.

_____

Patient Signature or Parent/Guardian Date

_____

Printed Name

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MEDICATION REFILLS
INCLUDING TRIPLICATE PRESCRIPTIONS

The following policies are designed to improve the efficiency of the office and communication between you and the staff. Please **read, initial each statement** and **sign** at the bottom of the page to indicate **your understanding** of the policies.

It is your responsibility to fill your prescription before you run out of medications, and to protect your medications and controlled substances as carefully as you would your money or jewelry.

Triplicate prescriptions for controlled substances constitute an even more burdensome medico-legal and administrative responsibility. I do not prescribe addicting medications (medication with high abuse potential) for patients with a history of substance abuse, particularly those that the patient has already abused. Also, we do not refill lost, misplaced, stolen or otherwise unavailable addicting medication except under very special circumstances, and even then we make only one exception. It is your responsibility to fill your prescription before it expires. _____ **(initial)**

Reasons such as:

1. "I went out of town and left my medication behind when I returned home."
2. "The airlines lost my luggage which contained my medications."
3. "My spouse/roommate/girl or boy/friend/son/daughter/pet etc... stole my medication."
4. "I gave a few pills to my spouse/significant other .... because he or she needed them."
5. "I opened my medication above the sink / toilet/ pool/ lake .... and it fell in."

are not valid reasons for early refills of medication, so please do not ask! (initial)

Refill of prescriptions require periodic office visits with the doctor. It is important to comply with your scheduled doctor's visit to have a successful treatment plan. Standard medication management and follow-up is every 2 to 4 weeks or otherwise specified. Scheduled visits must be followed in order for the prescription(s) to be filled. _____ **(initial)**

Thank you for your anticipated cooperation.

I understand and will comply with these policies. _____ **(initial)**

_____
Signature of Patient or Guardian if patient is under 18. Date

_____
Printed Name

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NOTICE OF PRIVACY PRACTICES (MEDICAL)

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAYBE USED AND DISCLOSED
AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.
PLEASE REVIEW IT CAREFULLY.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the patient, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal health information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information.

We may use and disclose your medical records only for each of the following purposes: treatment, payment and health care operations.

- Treatment means providing, coordination, or managing health care and related services by one or more health care professionals. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment.
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement activities, auditing functions, cost-management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de-identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.

- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to protected health information.

This notice is effective as of _____, 20____ and we are required to abide by the terms of the Notice of Privacy Practices currently in effect. We reserve the right to change the terms of our Notice of Privacy Practices and to make the new notice provisions effective for all protected health information that we maintain. We will post and you may request a written copy of a revised Notice of Privacy Practices form this office.

You have recourse if you feel that your protections have been violated. You have the right to file written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
Indy Behavioral Health
Phone: 317.987.0257. Fax: 317.732.1431
Address: 2611 Waterfront Parkway East Drive, Suite 370, Indianapolis, IN 46214

For more information about HIPAA or to file a complaint:
The U.S. Department of Health & Human Services
Office of Civil Rights
200 Independence Avenue, S.W.
Washington, D.C., 20201
Phone: 202.619.0257
Toll Free: 877.696.6775

I have read the above and agree to its terms and conditions.

_____

Signature of Patient or Guardian if patient is under 18 Date

_____

Printed Name

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Authorization for Use or Disclosure of Protected Health Information

Client Information

Client Last Name _____ First Name _____
DOB: _____/_____/_____

Client Address
_____
_____

Client Phone:_____

Client Email Address: _____

I, _____, do hereby request and authorize

Indy Behavioral Health
2611 Waterfront Parkway East Drive, Suite 370
Indianapolis, IN 46214
Phone: 317.978.0257 Fax: 317.974.9077

to ____ receive/_____ disclose a copy of my mental health information to the person or agency below:

Name: _____
Phone: _____ Fax: _____
Address: _____
Date of Authorization: _____/_____/_____
This consent is subject to revocation at any time except to the extent that the individual/agency which is to make the disclosure has already taken action in reliance on it. If not previously revoked, this consent will terminate upon: _____/_____/_____ or upon termination of treatment.

Information to be Released *(Note: Requests for release of psychotherapy notes cannot be combined with any other type of request.)*

☐ Yes ☐ No I authorize the release of my entire record, including those regarding drug, alcohol, or mental health treatment to the person(s) listed above.

☐ Only those portions pertaining to:
_____
(Specific provider name and/or dates of treatment)
☐ Authorization for Psychotherapy Notes ONLY (Important: If this authorization is for Psychotherapy Notes, you must not use it as an authorization for any other type of protected health information.)

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☐ Other:

_____

Purpose of Information Release:

☐ Further mental health care ☐ Payment of insurance claim ☐ Legal investigation
☐ Applying for insurance determination ☐ Vocational rehab, evaluation ☐ Disability
☐ At the request of the individual ☐ Other (specify):

Authorization and Signature

I authorize the release of my confidential protected health information, as described in my directions above.

_____

Signature Date

If signed by a personal representative:

(a) Print your name:_____

(b) Indicate your relationship to the client and/or reason and legal authority for signing:

Patient is: ☐ minor ☐ incompetent ☐ disabled ☐ deceased

Legal authority: ☐ parent ☐ legal guardian ☐ representative of deceased

_____

Witness Date

**** This information has been disclosed from records protected by federal confidentiality rules (42 CFR part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.**