Intake Form - New Patient

Premier Health & Wellness LLC

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Patient Intake Information Sheet

Revised 3/17/2025

Doctor Name *

Last Name *

First Name *

Middle Initial

Date of Birth *

Age *

Mailing Address *

Apartment Number

City *

State *

ZIP Code *

Main Phone *

Alternate Phone

Sex/Gender *

- [ ] Male
- [ ] Female
- [ ] Other

If other, please specify.

Marital Status *

Occupation *

Employer (Put N/A if not applicable) *

Guarantor Information

Guarantor Full Name *

Relationship to Patient *

Mailing Address *

Apartment Number

City *

State *

Zip Code *

Main Phone *

Alternate Phone

Date of Birth *

Sex/Gender *

If other, please specify.

Social Security Number *

Release of Information Authorization/Emergency Contact Information

I AUTHORIZE Premier Health & Wellness LLC to release clinical and/or billing information to:

Full Name *

Phone Number *

Relationship to Patient *

Signature: * ×

Insurance Information

Primary Insurance *

Employer of Policy Holder *

Name of Policy Holder *

Date of Birth of Policy Holder *

Social Security Number of Policy Holder *

ID Number *

Group Number *

Insurance Company Phone Number *

Authorization to pay insurance benefits to Physician: I hereby authorize payment directly to Premier Health & Wellness LLC. I authorize Premier Health & Wellness to release information. I hereby authorize Premier Health & Wellness LLC to release all medical information needed to process this claim. I agree that this office may release records pertaining to my treatment to my insurance company or other third parties responsible for payment of my medical charges, including review activities related to my physician's participation with my health plan. I hereby agree to pay for services rendered to the above-mentioned patient in the event that my insurance coverage does not pay. I understand that the verbal and written exchange of information may include reference to diagnostic impressions and/or treatment of alcohol/drug use and emotional illness. I understand that my consent is subject to revocation at any time except to the extent that action has already been taken in reliance thereon. The information disclosed to the authorized parties is from treatment which confidentiality is protected by Federal Law. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations prohibit further disclosure of this information without specific written consent of the person to whom it pertains.

Signature of Patient or Parent of Minor

Signature: * ×

Date:

Financial Policy

Effective January 2, 2025

FEES: INITIAL EVAL. $450, FOLLOW UP $150, DOCUMENT REVIEW/PREPARATION $450/HR

INSURANCE: CO-PAYMENTS, CO-INSURANCE AND DEDUCTIBLES are due prior to you visit. We reserve the right to reschedule your appointment if co-payment is not paid in full at the time of appointment. You are ultimately responsible for payment of services if your insurance carrier does not pay for ANY reason. IT IS THE RESPONSIBILITY OF THE PATIENT OR THEIR RESPONSIBLE PARTY/REPRESENTATIVE TO KNOW THEIR INSURANCE COVERAGE. Please present your current and accurate insurance card at each visit. Insurance companies deny claims that are not submitted within 90 days of the date of service. If you do not submit your current insurance to the office at the time of your visit, you may be responsible for denied claims. We attempt to verify coverage before your visit with the information you provide. Verification of coverage does not guarantee the insurance company will pay for your visit. Insurance policies exclude some non-covered services; however, this does not mean services or tests are not necessary. It means the policy you have does not cover certain necessary services. Please keep in mind your insurance policy is a contract between you and the insurance company. The physician has no control over which services the insurance company does or does not cover. If your insurance delays, denies or pays and then re-coups the payment of your claims due to non-payment of the policy premium, *you* will be responsible to pay the claim in full. The patient is responsible for obtaining all necessary information regarding specialist referrals or prior authorizations. Failure to do so may result in denial or delay of payments.

NO SHOW/LATE CANCELLATION FEE: If you need to cancel your appointment, please contact our office at least 24 business hours before your appointment time. A $50.00 fee will be assessed for all missed appointments not canceled with at least 24 business hours advance notice.

Signature: * ×

Date:

Office Policies

Please plan ahead for prescription refills. It is patient responsibility to address refills at the time of the office visit. Any changes in medication, new prescription, or mail in prescription problems require an office visit. Refills may not be provided if you have missed your med check appointment. Prescriptions may not refills will be granted on weekends or after hours. After-hours on call services are only available for urgent matters.

Our staff is authorized to check your medication history via the Controlled Substance Prescription Monitoring Program (CSPMP) to ensure safe prescribing practices. This is done with full confidentiality and in compliance with HIPAA regulations.

Arrive/check-in on time for your appointment. If you are more than 10 minutes late for your appointment, you may be asked to reschedule.

Phone messages will be returned by the end of the next business day. If there is an urgent need you can call 911, the crises line (988) or visit your nearest ER.

For Telemedicine visits:, patient must be physically located in Arizona, conduct the session in a private, quiet setting and not be in a moving vehicle during the appointment.

Signature: * ×

Concerns and Goals

Please describe why you are establishing treatment. *

Describe goals you want to accomplish with treatment. *

Please Select Concerns *

- [ ] Concentration
- [ ] Harm To Self
- [ ] Harm To Others
- [ ] Legal Matters
- [ ] Trauma
- [ ] Anxiety
- [ ] Social Anxiety
- [ ] Self-Esteem
- [ ] Suicidal Concerns
- [ ] Hyperactive
- [ ] Finances
- [ ] Abuse
- [ ] Health Problems
- [ ] Making Decisions
- [ ] Hoplessness
- [ ] Impulsivity
- [ ] Motivation
- [ ] Work
- [ ] Career Choices
- [ ] Unresolved Grief
- [ ] Eating/Food Trouble
- [ ] Anger
- [ ] Guilt

- [ ] High Energy
- [ ] Low Energy
- [ ] Attention Difficulties
- [ ] Education
- [ ] Appetite/Weight
- [ ] Depressed
- [ ] Memory
- [ ] Sleep Problems
- [ ] Nightmares
- [ ] Sexual Problems

List all current medications and doses: *

List all current and past health problems: *

Medication Allergies: *

Have you been hospitalized due to your mental health? If yes, please specify details including dates and locations. *

List previous psychiatrists you have had treatment from and dates. *

List previous psychiatric medications tried and response. *

Drug and Alcohol Assessment

Is your drug or alcohol use causing negative issues for you? *

- [ ] Yes
- [ ] No

Frequency of Alcohol Use *

Usual Alcohol Consumption *

Frequency of use to levels of Intoxication *

- [ ] Never
- [ ] Less than 1 time/month
- [ ] 1-4 times per month
- [ ] 2-3 times per week
- [ ] Daily

Marijuana use *

Please explain with frequency and amount if used currently or in the past.

Sedative use *

Please explain with frequency and dosage if used currently or in the past.

Stimulant use *

Please explain with frequency and dosage if used currently or in the past.

Cocaine use *

Please explain with frequency and dosage if used currently or in the past.

Opiates use *

Please explain with frequency and dosage if used currently or in the past.

Hallucinogens use *

Please explain with frequency and dosage if used currently or in the past.

Perscription drug use *

Please explain with frequency and dosage if used currently or in the past.

Methamphetamine use *

Please explain with frequency and dosage if used currently or in the past.

Tobacco/E-cigarretes/Vaping *

Please explain with frequency and dosage if used currently or in the past.

Legal Information

Do you have a probation officer or case worker? *

- [ ] Yes
- [ ] No

If yes, what is his/her phone number and address?

Social Information

List the names, ages, and relationships of all persons living in your home. *

List the names, ages, and relationships of any immediate family members not listed above. *

Are spiritual issues of concern to you? *

- [ ] Yes
- [ ] NO

What is your religious information if any? *

Verbal and Writing Disclosure Authorization

I do hereby request and authorize Premier Health and Wellness, LLC to be able to contact the following people or organizations for the purpose of "Facilitation of Treatment."

Names and relationships of who may be contacted are:

Name/Relationship *

Phone Number *

Name/Relationship *

Phone Number *

Name/Relationship

Phone Number

Primary Care Information

Name of Primary Care Doctor *

Phone Number *

When were you last seen? *

I GIVE MY CONSENT FOR MY PHYSICIAN TO RELEASE MY RECORD TO MY PRIMARY CARE DOCTOR SO THAT THEY CAN DISCUSS MY TREATMENT:

I understand that the verbal and written exchange of information may include reference to diagnostic impressions and/or treatment of alcohol/drug use and emotional illness. I understand that my consent is subject to revocation at any time except to the extent that action has already been taken in reliance thereon.

The information disclosed to the authorization parties is from treatment which confidentiality is protected by Federal Law. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) regulations prohibit further disclosure of this information without specific written consent of the person to whom it pertains.

Signature: * ×

Date:

Acknowledgement Of Receipt Of Privacy Policy (HIPAA) Agreement

Purpose

This document serves to inform you of our practice's commitment to protecting your health information in compliance with the Health Insurance Portability and Accountability Act (HIPAA). We are required by law to maintain the privacy and security of your Protected Health Information (PHI).

Our Commitment to Your Privacy

- We will not use or disclose your health information without your authorization, except as described in our Notice of Privacy Practices.
- We are committed to safeguarding your health information and ensuring its confidentiality.
- We will provide you with access to your health information upon request and the opportunity to request amendments.

Your Rights

- You have the right to receive a copy of our Notice of Privacy Practices.
- You have the right to request restrictions on certain uses and disclosures of your health information.
- You have the right to receive confidential communications regarding your health information.

Acknowledgment of Receipt

By signing below, you acknowledge that you have received a copy of our Notice of Privacy Practices and have been given the opportunity to ask any questions you may have regarding our privacy practices.

Signature: * ×

Date: