Felicia Einhorn, LCSW DCSW LLC

Therapy for individuals, Couples, Families & Groups

DEMOGRAPHIC INFORMATION

Referred By:	Date:
Name:	
Address:	City, State, Zip
Home Phone#:	Cell Phone#:
Date of Birth:	
Marital Status: ☐ Married ☐ Divorced ☐ Widowed ☐ Single	Dates of Marriages:

Medical

Internist	Phone #:
Psychiatrist	Phone #:
Neurologist	Phone #:
Pain Management MD	Phone #:

PLEASE SEE MEDICATION RECORD PAGE FOR All OF THE MEDICATIONS/SUPPLIMENTS YOU ARE CURRENTLY TAKING

Emergency

Contact:	Relationship:
Home Phone:	Business Phone:
Cell Phone:	
Contact 2:	Relationship:
Home Phone:	Business Phone:
Cell Phone:	
Contact 3:	Relationship:
Home Phone:	Business Phone:
Cell Phone:	

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MEDICAL RECORD

NAME: _____

DATE	MEDICATION	DOSE GIVEN	FREQUENCY (i.e. 2X PER DAY)	TIME	AM/PM

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MENTAL HEALTH INTAKE FORM

PERSONAL INFORMATION

What is your major complaint?

When did this begin? Have you previously suffered from this complaint?

Previous therapist(s) seen for complaint:

Previous treatment for complaint:

Aggravating factors for complaint:

Relieving Factors:

CURRENT SYMPTOMS: (CHECK THAT APPLY)

☐ Anxiety	☐ Appetite Issues	☐ Avoidance	☐ Crying Spells	☐ Depression	☐ Excessive Energy
☐ Fatigue	☐ Guilt	☐ Hallucinations	☐ Impulsivity	☐ Irritability	☐ Libido Changes
☐ Panic Attacks	☐ Racing Thoughts	☐ Risky Activity	☐ Sleep Changes	☐ Suspiciousness	☐ Loss of Interest

Do you have thoughts of suicide?

Have you made any suicide attempts? If so when?

How?

Do you have thoughts of physically hurting anyone?

Who do you think about hurting?

How would you hurt them?

Have you ever physically hurt anyone?

MEDICAL HISTORY

Previous diagnosis/mental health treatment:

Previously treated by:

Previous medications:

Dates treated:

Describe any neglect you suffered(ing) and by whom?

Trauma suffered and by whom?

Abuse suffered

Have you ever served in the military? If yes, where?

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PRESENT SITUATION

Work: ☐ Full-Time ☐ Part-Time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

☐ Married ☐ Single ☐ Widowed ☐ Divorced

Prior Marriages? If yes, how many?

How is your relationship with your partner?

Are you sexually active?

Do you have children? Dates of Birth:

How is your relationship with your child(ren)?

List anyone else who lives with you:

Are you a member of a religion/spiritual group?

What is your level of involvement?

Have you been arrested? When and why?

Have you ever tried any of the following? Check that apply.

☐ Alcohol ☐ Tobacco ☐ Marijuana ☐ Hallucinogens (LSD) ☐ Heroin ☐ Methamphetamines
☐ Cocaine ☐ Stimulants (Pills) ☐ Ecstacy ☐ Methadone ☐ Tranquilizers ☐ Pain Killers

If yes to any, list frequency/dates of use:

Have you ever abused prescription drugs? If yes, which ones?

Have you ever been treated for drug/alcohol abuse? If yes, when?

For which substances?

Do you smoke cigarettes? If yes, how many per day?

Do you drink caffeinated beverages? If yes, how many per day?

What would you like to get out of this therapy?

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ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF POLICIES AND PRIVACY PRACTICES

The undersigned acknowledges receipt of a copy of the currently effective Notice of Mental Health Practitioner's Policies and Privacy Practices. A copy of this signed and dated acknowledgement shall be as effective as the original.

Signature | Print Name | Date

If you are the legal representative of the patient, please print the patient's

Name | Authority

Thank you. If you have any questions about this form, or the attached notice please contact Felicia Einhorn LCSW.

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ASSIGNMENT OF BENEFITS

Patient Name: Phone:

Address: State: Zip:

Date of Birth: Social Security:

Referred By:

I hereby authorize Felicia Einhorn LCSW to apply for Medicare/Medigap, and other health insurance benefits on my behalf. I request payment of Blue Cross/ Blue Shield and other insurance carriers be made directly to the above provider. I certify that the information I have received with regard to my insurance carrier is correct. I authorize the release of medical information about me to my health insurance carrier(s), and any and all other information to determine the benefits payable for related services.

Signature of Patient Parent or Legal Guardian Print Name of Patient Parent or Legal Guardian Date

FINACIAL POLICY

If medical insurance information is received at the time of service, as a courtesy, a claim will be submitted to your insurance company. Insurance co-payments and annual deductibles not met for the year are payable to Felicia Einhorn LCSW. When participating with an insurance carrier, services that are not fully reimbursed by your insurance and are indicated by your insurance's Explanation of Benefits to be the patient's responsibility will be due and payable upon receipt of a billing statement. Unless you are covered by a government program (Medicare, Medicaid) or a private insurance that has an agreement that prohibits members from being billed and if correct insurance information or referral documentation is not presented at the time of service, you are responsible/or the full charges incurred.

I further understand that information communicated to the insurance carrier may be through electronic transmission, written, oral or by fax. A photocopy of this assignment is to be considered as a valid original. Information released is strictly for treatment, payment or healthcare operations allowed by law under HIPPA and Florida State Regulations.

This assignment of benefit will remain in effect until revoked by me in writing.

Signature of Patient Parent or Legal Guardian Print Name of Patient Parent or Legal Guardian Date

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PATIENT RECORDS OF DISCLOSURES

In general, the HIPPA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that communication of PHI be made by alternate means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply):

☐ Home Telephone:	☐ Written Communication
☐ O.K. to leave message with detailed information	☐ O.K. to leave mail to home address
☐ Leave message with call-back number only	☐ O.K. to mail to m y work/ office
	☐ O.K. to fax to this number
☐ Work Telephone:	☐ Other:
☐ O.K. to leave message with detailed information	
☐ Leave message with call-back number on	

Signature of Patient Parent or Legal Guardian Print Name of Patient Parent or Legal Guardian Date

The Privacy Rule generally requires healthcare providers to take reasonable steps to limit the use of disclosure of, and requires the PHI to the minimum necessary to accomplish the intended purpose. These provisions do not apply to uses or disclosures made pursuant to an authorization requested by the individual. Disclosures of PHI for non-TPO reason will require a separate signed authorization. Healthcare entities must keep records of PHI disclosures, information provided below, if completed properly, will constitute an adequate record.

NOTE: Uses and Disclosures for TPO may be permitted without prior consent in an emergency.

DATE	Disclosed To	(1)	Purpose of Disclosure	By Whom Disclosed	(2)	(3)

(1) Check this box if the disclosure is authorized (2) Type key: T= Treatment P= Payment Information

(3) Enter how disclosure was made: F= Fax P= Phone E= Email M== US Postal Service 0= Other

HEALTH INSURANCE CLAIM FORM

APPROVED BY NATIONAL UNIFORM CLAIM COMMITTEE (NUCC) 02/12

PICA

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare#) MEDICAID ☐ (Medicaid#) TRICARE ☐ (ID#/DoD#) CHAMPVA ☐ (Member ID#) GROUP HEALTH PLAN ☐ (ID#) FECA BLK LUNG ☐ (ID#) OTHER ☐ (ID#)

1a. INSURED'S I.D. NUMBER (For Program in Item 1)

2. PATIENT'S NAME (Last Name, First Name, Middle Initial)

3. PATIENT'S BIRTH DATE MM DD YY SEX M ☐ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial)

5. PATIENT'S ADDRESS (No., Street)

6. PATIENT RELATIONSHIP TO INSURED Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street)

CITY | STATE

8. RESERVED FOR NUCC USE

CITY | STATE

ZIP CODE | TELEPHONE (Include Area Code) ( )

ZIP CODE | TELEPHONE (Include Area Code) ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial)

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER

a. OTHER INSURED'S POLICY OR GROUP NUMBER

a. EMPLOYMENT? (Current or Previous) ☐ YES ☐ NO

a. INSURED'S DATE OF BIRTH MM DD YY SEX M ☐ F ☐

b. RESERVED FOR NUCC USE

b. AUTO ACCIDENT? ☐ YES ☐ NO PLACE (State)

b. OTHER CLAIM ID (Designated by NUCC)

c. RESERVED FOR NUCC USE

c. OTHER ACCIDENT? ☐ YES ☐ NO

c. INSURANCE PLAN NAME OR PROGRAM NAME

d. INSURANCE PLAN NAME OR PROGRAM NAME

10d. CLAIM CODES (Designated by NUCC)

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? ☐ YES ☐ NO ***If yes***, complete items 9, 9a, and 9d.

READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT ILLNESS, INJURY, or PREGNANCY (LMP) MM DD YY QUAL.

15. OTHER DATE QUAL. MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM MM DD YY TO

17. NAME OF REFERRING PROVIDER OR OTHER SOURCE

17a.

17b. NPI

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM MM DD YY TO

19. ADDITIONAL CLAIM INFORMATION (Designated by NUCC)

20. OUTSIDE LAB? ☐ YES ☐ NO $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY Relate A-L to service line below (24E) ICD Ind.

A. B. C. D.

E. F. G. H.

I. J. K. L.

22. RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

24. A. DATE(S) OF SERVICE From MM DD YY	To MM DD YY	B. PLACE OF SERVICE	C. EMG	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS	MODIFIER	E. DIAGNOSIS POINTER	F. $ CHARGES	G. DAYS OR UNITS	H. EPSDT Family Plan	I. ID. QUAL.	J. RENDERING PROVIDER ID. #
1										NPI	
2										NPI	
3										NPI	
4										NPI	
5										NPI	
6										NPI	

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) ☐ YES ☐ NO

28. TOTAL CHARGE $

29. AMOUNT PAID $

30. Rsvd for NUCC Use

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. SERVICE FACILITY LOCATION INFORMATION

a. NPI b.

33. BILLING PROVIDER INFO & PH # ( )

a. NPI b.