Pearl Health Clinic, PLLC

2705 E 17TH ST • Ammon, ID 83406 • 208.346.7500 • fax 208.346.7501

NEW PATIENT INTAKE PACKET

Patients Information: **Today's Date: _____**

First Name: _____ Middle Name: _____ Last Name: _____

Note: Please spell name exactly as spelled on your insurance card.

Street Address: _____ City: _____ State: _____ Zip: _____

Home Phone: _____ Cell Phone: _____ Email: _____

DOB: _____Age: ____ Gender: _____ Gender Identity: _____ Sexual Orientation: _____

SS#: _____Primary Language: _____ Do you need an interpreter? Y ____ N ____

Marital Status - Single: ____ Married: ____ Divorced: ____ Separated: ____ Partner: ____ Widow: ____ Other: _____

Note: If divorced, please supply Pearl Health Clinic with legal documentation of custody to ensure that privacy rights can be enforced.

Ethnicity: Native American ____ African American ____ Latino ____ Asian ____ Pacific ____ Caucasian ____ Other _____.

Parent(s)/Guardian(s): **The person completing the intake packet must be listed first**

1st Parent/Guardian Full Name: _____ DOB: _____ SS#: _____

Are you the Insured Party? Y ____ N ____ Relationship to Client: _____Employer: _____

2nd Parent/Guardian Full Name: _____ DOB: _____ SS#: _____

Are you the Insured Party? Y ____ N ____ Relationship to Client: _____Employer: _____

Emergency Contact: _____ Home Phone: _____ Cell Phone: _____

Insurance Information: **Accurate information is essential to providing timely care**
Please bring insurance cards to 1st appointment**

If you have more than two insurance carriers, please bring that information with to your 1st appointment.

Primary Insurance Carrier:

Name: _____

Phone: _____

Policy Holder (PH): _____

Relationship of PH to you: _____

PH DOB: _____ PH SS#_____

Policy ID#: _____

Group#: _____

Secondary Insurance Carrier:

Name: _____

Phone: _____

Policy Holder (PH): _____

Relationship of PH to you: _____

PH DOB: _____ PH SS#_____

Policy ID#: _____

Group#: _____

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Sliding Scale Plan:

*If you are without insurance, you may opt to see an Intern (based on availability) or apply for our sliding scale program. To apply for the Sliding Scale Plan please complete the **Sliding Scale Application**, **print and sign and attach any of the following financial documents to the application**. *

1. **Last current tax filing information (First three pages), if you filed.**
2. **Two current months of Payroll Stubs, if employed.**
3. **Two current months of Bank Statements.**

We must have **"total family income"** so if submitting payroll stubs; we need both spouses' copies. If you're on SSDI and your spouse is employed, we will need the **SSDI Letter** and other parties' payroll stubs. All income requirements are based on the Federal Poverty Guidelines. Upon signing the Insurance Release, you are acknowledging that you are aware of PHC's Sliding Scale plan. * Please note applications returned unsigned or without financial documents will not be processed.

Medical Information: **Accurate information assists the providers with determining appropriate care**

Patient's Primary Care Physician: _____ Most recent visit: _____

Who referred patient to Pearl? _____ What reason? _____

Are there any other medical providers treating patient at this time? Y____ N ____ Who is treating? _____

What are they being treated for? _____

Have you ever been a patient/client at Pearl Health Clinic? _____ When? _____ Which Provider? _____

Current Problem: (Please explain why the patient needs to be seen in our office?) If you need help describing the current problem, please go to www.nlm.nih.gov/healthtopics.html for a list of health topics.

_____

_____

Medications Currently Prescribed: **Accurate information will expedite assignment of medical provider**

Physical Health Medications

Medication	Dose

Mental Health Medications

Medication	Dose

Pharmacy: _____ Address: _____ Phone: _____

If you have Providers at other agencies: **Case Managers should accompany developmentally or severely mentally ill clients. **

If you or the patient is receiving mental health services (i.e. Counseling, Med Mgt, Case Management, CBRS, etc) with another clinic and / or agency, please list service(s) and location(s): _____

Case Manager Phone Number: _____ Case Manger Name: _____

Legal Services Disclaimer:

Pearl Health Clinic staff does not complete parental fitness or custody exams. Assessments for legal purposes are typically not covered by most insurance companies and are associated with a fee schedule separate from the mental health fee schedule. All requests for services in legal contexts will be reviewed and may be declined at discretion of the Pearl Health Clinic Clinical Director or individual clinicians. Pearl Health Clinic staff charge for any testimony provided in a legal context, even when original services were rendered as part of mental health treatment.

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Services Requested: **Please check all services that the patient is interested in**

__ **Psychiatric Medicine** – Psychiatry is the medical specialty devoted to the study, diagnosis, treatment, and prevention of mental disorders. These include various affective, behavioral, cognitive and perceptual abnormalities.

__ **Transcranial Magnetic Stimulation** – Transcranial Magnetic Stimulation is a safe and effective, non-drug depression treatment. Patients receive treatment 5 days per week, usually for 4 to 6 weeks.

__ **Neuropsychological/Psychological Testing** – Measure and evaluate neuropsychological factors, such as memory, and psychological factors, such as personality. Testing aids in diagnosing conditions such as developmental disability, dementia, and personality disorder. It helps differentiate between diagnoses, such as ADHD and bipolar. Testing aids in developing treatment plans.

__ **Counseling** – A relatively short term, interpersonal, theory-based process of helping persons who are basically psychologically healthy, but need help in resolving developmental and situational problems.

__ **Neuro-feedback Therapy** – A non-invasive alternative way of improving your quality of life. The electrical activity of your brain is monitored through a software program that lets you, the client; see the activity of your brain on a monitor.

__ **Eating Disorder Therapy** – We offer individual, family, and group therapy for bulimia, binge eating disorder, and anorexia. Additionally, we offer weekly Mindful Movement and monthly Mindful Eating groups.

__ **PTSD Clinic** – PTSD Assessment; Individual and family therapy; Different groups: Trauma Recovery, Anger Management, Trauma and Substance Use Disorder Recovery.

__ **Substance Abuse Program** – This outpatient program involves weekly group therapy sessions, weekly, biweekly or monthly individualized counseling as determined by treatment plan, and regular medication management appointments. ****Must have Perspective Patient packet completed by Primary Care Provider****

__ **Adult/Adolescent Mental Health Intensive Outpatient** – IOP is an intensive program with an emphasis on group therapy. Individual and family therapy, medication management, and case management are also included. The Adolescent program requires 6 hours of services per week, the adult 9 hours per week. The average admission lasts 1-2 months.

__ **Community Based Rehabilitation Services (CBRS)** – CBRS assists individuals to gain and utilize skills necessary to function adaptively in home and community settings and attain or retain capability for independence. **(Medicaid Insurance Only)**

__ **Case Management** – Assists people with mental illnesses in obtaining the basic services required to live as independently as possible in their communities. The goal is to ensure an individual is receiving the support they need while working to increase the individual's ability for self-support. **(Medicaid Insurance Only)**

__ **Peer Support** – An individual, with related mental health experiences, who is specialized to support individuals who struggle with issues pertaining to mental health, psychological trauma, and / or substance abuse. **(MUST BE 18 OR OLDER AND MUST HAVE MEDICAID).**

__ **Family Support** – A parent or care giver who has cared for a child with severe emotional disorders or substance abuse and has successfully navigated the system. This service helps to engage the family in their own strengths and be able to make their family the best it can be.

__ Respite Care – A service that provides a break for parents who have a child with a *serious emotional disturbance*. Trained behavioral health workers take care of the child for a brief period of time to give families relief from the strain of caring for the child.

Is there a specific medical provider or counselor you would like to request? **_____**

New Patients' will be scheduled for a Comprehensive Diagnostic Assessment (CDA) which is approximately 1 ½ hours in duration, with a Licensed Mental Health Counselor. This appointment is a set of evaluation procedures administered to obtain information about the person's development, learning, memory, academics, behavior, and mental health. This assessment is vital in allowing your provider(s) the ability to establish an accurate treatment plan.

What to expect on your first appointment.

1. This is an assessment only and no medications will be prescribed.
2. Children 17 and younger need to be accompanied by a Parent and / or Legal Guardian. **NO EXCEPTIONS**
3. Please arrive 15 minutes prior to new patient appointments to sign consents and verify accuracy of patient information.

Any questions regarding new patient appointments should be directed to the Client Care Coordinators. 208-346-7500

For Administrative Use Only:

Date Received: _____ Received a copy of Insurance Card? _____Staff Initials: _____