PEAK BALANCE
Mental Health

WELCOME TO OUR OFFICE

PATIENT INFORMATION

Patient _____
Last Name First Name Middle Name

Address _____ _____
Street P.O. Box

_____
City State Zip

Mark the preferred **contact number:**

☐ **Home** (____) _____

☐ **Cell** (____) _____

E-mail _____

*Used for appointment reminders, newsletters, billing inquiries, and the Patient Portal

Marital Status ☐ Single ☐ Married ☐ Widowed ☐ Divorced

Sex ☐ M ☐ F **Birth Date** _____

Social Security Number _____

***Required:** Medicare, Medicaid, or Military

Preferred Language? _____

Ethnicity or Race:

☐ Hispanic / Latino
☐ Asian
☐ White
☐ Pacific Islander / Hawaiian
☐ American Indian / Alaska Native
☐ Black or African American
☐ Other Race

BILLING ADDRESS (If different than above)

_____ _____
Street P.O. Box

_____
City State Zip

RESPONSIBLE PARTY / POLICY HOLDER

Name _____ **DOB** _____

Relationship to Insured _____

Phone (____) _____

Cell (____) _____

PHYSICAL INFORMATION

Height _____ **Weight** _____

Please rate yourself in each of the following areas with 10 being the highest.

___ / 10 Happiness
___ / 10 Anxiety; Stress
___ / 10 Suicidal thoughts
___ / 10 Depression
___ / 10 Energy Level
___ / 10 Sleep
___ / 10 Impulsivity
___ / 10 Mania
___ / 10 Psychotic Symptoms
___ # of hours of sleep a night

ALLERGIES

☐ **No Known Drug Allergies**
☐ Adhesive Tape
☐ Anticoagulant
☐ Aspirin
☐ Penicillin
☐ Codeine
☐ Latex
☐ Iodine
☐ Local Anesthetic
☐ Sulva

PREFERRED PHARMACY

Pharmacy Name _____

Address _____

City, State _____

Phone _____

PSYCHIATRIC MEDICATION HISTORY

SSRIs
☐ Prozac
☐ Celexa
☐ Lexapro
☐ Zoloft
☐ Viibryd
☐ Paxil
☐ Luvox

SNRIs
☐ Effexor
☐ Pristiq
☐ Cymbalta
☐ Fetzima

NaSSAs
☐ Remron

NDRIs
☐ Wellbutrin

TCA's SECONDARY
☐ Norpramine (Desip)
☐ Pamelor (Nortrip)
☐ Vivacil (Protryp)

SARI
☐ Trazodone

MAOIs
☐ Emsam
☐ Nardil
☐ Parnate

ATYPICAL
☐ Trintellix
☐ Lyrica

MOOD STABILIZER
☐ Lithium
☐ Depakote
☐ Lamictal
☐ Tegretol/Trileptal
☐ Neurontin
☐ Topomax
☐ Keppra

TCA's TERTIARY
☐ Elavil (Amitrip)
☐ Anafranil (Clomipr)
☐ Doxepin (Sinequan)
☐ Tofranil (Imipr)

ATYPICAL
☐ Clozaril
☐ Risperdal
☐ Zyprexa
☐ Seroquel
☐Geodon
☐ Abilify
☐ Invega
☐ Saphris
☐ Latuda
☐ Fanapt
☐ Rexulti
☐ Vraylar
☐ Nuplazid

ANTI-TD
☐ Ingrezza
☐ Austedo

TYPICAL
☐ Trilafon
☐ Haldol
☐ Thorazine
☐ Prolixin
☐ Orap (Pimozide)

HYPNOTICS
☐ Prazosin
☐ Restoril
☐ Lunesta
☐ Ambien

OTHER
☐ Propranolol
☐ Clonidine

DEPENDENCY
☐ Chantix
☐ Naltrexone
☐ Campral
☐ Antabuse
☐ Suboxone
☐ Methadone

ANTIANXIETY
☐ Vistaril
☐ Buspar
☐ Xanax
☐ Antivan
☐ Klonopin
☐ Librium
☐Valium

STIMULANTS
☐ Strattera
☐ Ritalin
☐ Adderall
☐ Vyvanse
☐ Focalin
☐ Provigil
☐ Nuvigil

DEMENTIA
☐ Aricept
☐ Namenda
☐ Exelon
☐ Galantamine

INJECTIBLE
☐ Prolixin
☐ Haldol
☐ Risperdal
☐ Invega
☐ Abilify
☐ Aristada
☐ Vivitrol

KETAMINE
☐ Ketamine
☐ Spravato

NUTRITIONAL
☐ Vitamin E
☐ Melatonis
☐ Deplin
☐ NAC

HOMEOPATHIC
☐ Nerve Tonic
☐ Calm Forte

MENTAL HEALTH HISTORY

What was the age your mental health symptoms first began? _____
How old were you when you first made an attempt to receive psychiatric care? _____

Select any prior diagnosis:

☐ No prior diagnosis
☐ Unknown
☐ Bipolar
☐ Dementia
☐ None reported
☐ Schizophrenia
☐ Head injury
☐ Depression
☐ PTSD
☐ Personality disorder(s)
☐ Anxiety
☐ Addiction
☐ Developmental Disorder(s)

Select previous treatment modalities you have tried:

☐ None
☐ Outpatient
☐ Counseling
☐ Residential
☐ Only inpatient
☐ Intensive outpatient
☐ Partial hospitalization
☐ Drug rehabilitation

Number of lifetime suicide attempts: _____ ☐ Unknown ☐ None reported

Date of last suicide attempt: _____

Method used during suicide attempt: _____

Triggers that caused suicide attempt(s): _____

Number of lifetime psychiatric hospitalizations: _____

Date of last psychiatric hospitalization: _____

Select all that resulted from your past psychiatric care:

☐ Unknown – None Reported
☐ Symptom resolution/stabilization failure to stabilize reconstitution of functional capacity
☐ Significant threat to self/others
☐ Continued incapacity treatment resistance

Add additional comments pertaining to your previous psychiatric history. We advise adding all necessary information you feel your provider needs to know.

_____

_____

_____

MEDICAL HISTORY

What medical problems do you have?
Select all medical diagnosis that apply to you (previous diagnoses, current diagnoses, and those being treated with medication)

☐ No history of medical problems
☐ AIDS/Related Complex
☐ Alcoholism
☐ Anemia
☐ Arthritis (Osteo)
☐ Arthritis (Rheumatoid)
☐ Asthma
☐ Autoimmune Disorder
☐ Back Pain
☐ Bariatric Surgery Status
☐ Cancer – Type: _____
☐ Chronic Fatigue
☐ Chronic Pain
☐ Congenital Abnormality – Type: _____
☐ Congestive Heart Failure
☐ Contraceptives
☐ COPD
☐ Coronary Heart Disease
☐ Cushings Syndrome
☐ Diabetes Type I
☐ Diabetes Type II
☐ Emphysema
☐ Epilepsy
☐ Fibromyalgia
☐ Head Injury
☐ Headaches (Frequent)
☐ Heart Attack
☐ Hepatitis
☐ Hypercholesterolemia
☐ Hyperlipidemia
☐ Hypertension (Essential Primary)
☐ IBD (Inflammatory Bowel)
☐ IBS (Irritable Bowel)
☐ Kidney Disease
☐ Liver Disease
☐ Lupux
☐ Lyme Disease
☐ Menopause
☐ Metabolic Syndrome
☐ Migraines
☐ Multiple Sclerosis
☐ Morbid Obesity
☐ Obesity (30+ BMI)
☐ Parkinson's
☐ PCOS
☐ Premenstrual Syndrome
☐ Restless Leg Syndrome
☐ RSD
☐ Seizure Disorder
☐ Sleep Apnea
☐ Stroke/Paralysis
☐ Thyroid Disease (Hyperthyroidism)
☐ Thyroid Disease (Hypothyroidism)
☐ Thyroidectomy

SURGICAL HISTORY

☐ No history of previous surgeries
☐ Appendectomy
☐ C-Section
☐ Carpel Tunnel Surgery
☐ Cholesytectomy
☐ Gastric Bypass
☐ Heart Bypass
☐ Hysterectomy
☐ Joint Replacement
☐ Lap Band System
☐ Tonsillectomy
☐ Vasectomy

HIPAA NOTICE OF PRIVACY PRACTICES

I acknowledge that, upon request, I was provided access to a copy of the **Notice of Privacy Practices** and that I have read (or had the opportunity to read if I so choose) and understand the notice.

X _____ Date: _____

Signature of Patient or Parent/Authorized Representative

HOW DID YOU HEAR ABOUT US?

☐ Google Search ☐ Doctor Referral (please specify)_____

☐ Facebook Ad/Video ☐ Patient Referral (please specify) _____

☐ Insurance Referral ☐ Employee Referral (please specify) _____

ASSIGNMENT, RELEASE, AND CONSENT

I request that payment of authorized insurance benefits be made either to me on my behalf to PEAK BALANCE for any service furnished. I authorize the release of medical information about me needed to determine these benefits or the benefits payable for related services. I understand that my signature requests that payment be made and authorizes the release of medical information necessary to pay the claim.

Your insurance policy is a contract that exists between you and your insurance company. Our relationship is with you, the patient, and not the insurance company. If you have questions about your policy, please call the phone number provided on the back of your insurance card. The patient or responsible party is responsible for their bill being paid in full. Please inform us at every visit of any changes to your insurance coverage.

Please initial each line indicating your understanding of our policies:

_____ **COPAYMENTS:** It is a requirement of your insurance company that we collect your co-pay. Payment is required before meeting with the provider.

_____ **SELF-PAY: (for non-covered products and services and for patients without insurance coverage):** Full payment is due at time of service. A down payment will be required before seeing the provider. **At a minimum, an evaluation and management fee will be charged.** Additional procedures/services may be recommended by the provider. You will be informed of these charges before proceeding with treatment.

_____ **REFERRAL:** If your insurance plan requires a referral from your primary care provider, this will be required at the time of your visit. Without a referral available, we may need to reschedule your appointment.

_____ **NO SHOW (failure to present for your appointment):** Our office requires 24-hour notice for appointment cancellations. We understand that some circumstances are unavoidable. Please understand that due to appointment demand, failure to notify our office 24 hours in advance may subject you to a charge of **$50** for a scheduled visit.

_____ **FMLA/DISABILITY/MEDICAL RECORDS:** There is a **$25** charge for having the provider complete these forms. Requested forms will be completed within 72 hours of diagnosis and care plan.

_____ **BALANCES/COLLECTION FEES:** If payment of an outstanding balance is not received within 30 days from the postmark date of a mailed statement or e-statement time stamp, a **$10** re-billing fee may be added to each additional statement. Our patient portal offers the ability to view statements and submit payments conveniently and securely. Patients with balances more than 90 days overdue will be turned over to collections and a 40**%** administrative fee will be applied along with all legal fees, with or without suit, including attorney fees and court costs.

ELECTRONIC STATEMENTS/COMMUNICATION: We want to stay in touch with you regarding your account and its collection status regarding past due balances. In order for us to contact you regarding all past due accounts and any collection status they may have, **you expressly authorize us to contact you by telephone, by sending text messages, or e-mails at any number or email you have listed**. You acknowledge that such contact could result in charges to you by your telephone carrier. Methods of contact may include the use of pre-recorded/artificial voice messages and/or the use of an automatic telephone dialing system, as applicable. You acknowledge and agree that this authorization shall extend to any billing or collection company or companies which may be assigned.

☐ Yes, I authorize this
☐ No, I do not authorize this

X _____ Date: _____

Signature of Patient or Parent/Authorized Representative