Elite DNA
Therapy Services
a comprehensive approach

Adult Intake Form

Patient Name: ___________________________________ Date of Birth: ____________ SS Number: _________________

M F Other Ethnicity: ____________________________ Preferred Language: ________________________________

Current Diagnosis (if any): ____

Name (Person completing this form): ________________________________ Relationship to Patient: _______________

Home Address: ___________________________________ Primary Phone: ___________________________________

___________________________________ Secondary Phone: _________________________________

Emergency Contact: __________________________ Relationship: __________________ Phone: ___________________

Referring Physician Name: __________________________________ Specialty: _________________________________

Primary Care Physician Name: _____________________________________ Phone: ___________________________

Insurance Information Section

Primary Insurance Type: _____________________________ Policy Holder's Name: ______________________________

Patient Social Security Number: ______________________ Policy Holder's DOB: _______________________________

Member ID Number: _______________________________ Policy Holder's Social Security Number: _______________

Group Number: ___________________________________

Group Number: ___________________________________

Secondary Insurance Type: __________________________ Policy Holder's Name: ______________________________

Patient Social Security Number: ______________________ Policy Holder's DOB: _______________________________

Member ID Number: _______________________________ Policy Holder's Social Security Number: _______________

Presenting Concerns

Please describe your primary concerns: ____

____

____

How long have you noticed this? ____

What have you already done to address these concerns and how effective were these efforts? ____________________

____

____

Was there an event that caused you to seek treatment now? ____

____

____

Fort Myers	**Naples**	**Cape Coral**	**Port Charlotte**	**Port Charlotte North**	**Venice**
6360 Techster Blvd.	2230 Venetian Ct.	2721 Del Prado Blvd.	3191 Harbor Blvd.	19531 Cochran Blvd.	1287 US-41 Bypass S.
Suite 1	Suite 1	Suite 200	Suite A	Pt. Charlotte, FL 33948	Venice, FL 34292
Fort Myers, FL 33966	Naples, FL 34109	Cape Coral, FL 33904	Pt. Charlotte, FL 33952		

Patient Name: _______________________________ DOB: __________________

Current Symptoms Checklist

[ ] Depressed mood
[ ] Unable to enjoy activities
[ ] Sleep pattern disturbance
[ ] Loss of interest
[ ] Decreased concentration / forgetfulness
[ ] Racing thoughts
[ ] Impulsivity
[ ] Excessive energy
[ ] Increased risky behavior
[ ] Increased libido
[ ] Decreased need for sleep
[ ] Increased irritability
[ ] Crying spells
[ ] Excessive worry
[ ] Anxiety attacks
[ ] Avoidance
[ ] Repetitive behaviors
[ ] Thoughts of harming someone else
[ ] Other: ______________________

Have you ever had feelings or thoughts that you didn't want to live? [ ] No [ ] Yes:

If YES, please answer the following.

If NO, please skip to the next section.

Do you currently feel that you don't want to live? [ ] No [ ] Yes
How often do you have these thoughts? ____
When was the last time you had thoughts of dying? ____
Has anything happened recently to make you feel this way? ____
Would anything make it better? ____
Have you ever thought about how you would kill yourself? ____
Is the method you would use readily available? ____
Have you planned a time for this? ____
Is there anything that would stop you from killing yourself? ____
Have you ever tried to kill or harm yourself before? ____
Do you have access to guns? [ ] No [ ] Yes

If YES, please explain: ____

Medical History

Allergies: List all (if none, write "none")

____
____
____

List all current **prescription medications** and how often you take them: (if none, write "none")

____
____
____
____
____

Patient Name: ______________________________ DOB: __________________

Medical History (cont.)

List all current **over-the-counter medications or supplements** and how often you take them: (if none, write "none")

____
____
____
____
____

Current medical problems: (if none, write "none")

____
____
____
____
____

Past medical problems, non-psychiatric hospitalizations, illnesses, injuries, or surgeries: (if none, write "none")

____
____
____
____
____

For Women Only

Are you currently pregnant or do you think you might be pregnant? [ ] No [ ] Yes

Are you planning to get pregnant in the near future? [ ] No [ ] Yes

Birth control method: ____

Patient Name: ______________________________ DOB: __________________

Past Psychiatric Medications

Please mark all ***past*** psychiatric medications.

Antidepressants

[ ] Prozac (fluoxetine)
[ ] Zoloft (sertraline)
[ ] Luvox (fluvoxamine)
[ ] Celexa (citalopram)
[ ] Lexapro (escitalopram)
[ ] Paxil (paroxetine)
[ ] Pristiq (desvenlafaxine)
[ ] Cymbalta (duloxetine)
[ ] Effexor (venlafaxine)
[ ] Wellbutrin (Bupropion)
[ ] Remeron (mirtazapine)
[ ] Viibryd (vilazodone)
[ ] Trintellix (vortioxetine)
[ ] Elavil (amitriptyline)
[ ] Anafranil (clomipramine)
[ ] Sinequan (doxepin)
[ ] Tofranil (imipramine)
[ ] Pamelor (nortriptyline)
[ ] Other: ____________________

Mood Stabilizers

[ ] Tegretol (carbamazepine)
[ ] Lamictal (lamotrigine)
[ ] Trileptal (oxcarbazepine)
[ ] Depakote (valproate)
[ ] Other: ____________________

Anti-Anxiety (Anxiolytics)

[ ] Xanax (alprazolam)
[ ] Buspar (buspirone)
[ ] Ativan (lorazepam)
[ ] Vistaril (hydroxyzine)
[ ] Klonopin (clonaxepam)
[ ] Valium (diazepam)
[ ] Chlordiazepoxide
[ ] Tranxene (clorazepate)
[ ] Other: ____________________

Atypical Antipsychotics/Mood Stabilizers

[ ] Abilify (aripiprazole)
[ ] Clozaril (clozapine)
[ ] Latuda (lurasidone)
[ ] Zyprexa (olanzapine)
[ ] Seroquel (quetiapine)
[ ] Risperdal (risperidone)
[ ] Geodon (ziprasidone)
[ ] Haldol (haloperidol)
[ ] Prolixin (fluphenazine)
[ ] Other: ____________________

Typical Antipsychotics

[ ] Thorazine (chlorpromazine)
[ ] Haldol (haloperidol)
[ ] Other: ____________________

Sedatives/Sleep Aides

[ ] Ambien (zolpidem)
[ ] Sonata (zaleplon)
[ ] Rozerem (ramelteon)
[ ] Restoril (temazepam)
[ ] Desyrel (trazodone)
[ ] Other: ____________________

ADHD Medications

[ ] Adderall (amphetamine)
[ ] Adderall XR
[ ] Concerta (methylphenidate)
[ ] Ritalin (methylphenidate)
[ ] Daytrana (methylphenidate)
[ ] Metadate(methylphenidate)
[ ] Evekeo
[ ] Dyanavel XR
[ ] Strattera (atomoxetine)
[ ] Quillivant XR
[ ] Vyvanse (lisdexamfetamine)
[ ] Focalin (dexmethylphenidate)
[ ] Other: ____________________

Other

[ ] Lithium
[ ] Neurontin (gabapentin)
[ ] Topamax (topiramate)

Patient Name: ______________________________ DOB: __________________

Family History

Please indicate if any family members have been diagnosed or experience any of the following:

	Mother	Father	Sibling	Maternal Grandparents	Paternal Grandparents	Other
Depression						
Anxiety						
Substance abuse						
Learning disability						
ADHD						
Bipolar disorder						
Psychosis/Schizophrenia						
OCD						
Suicidal behavior						
Self-harm/cutting						
Seizure disorder						
Autism spectrum						
Intellectual disability						
Abuse						
Thyroid problem						
Other						

Psychiatric History

Have you ever had outpatient treatment or psychological testing?
[ ] No [ ] Yes

If yes, please describe when, by whom and nature of services:
____
____
____
____

Inpatient Psychiatric Hospitalization?
[ ] No [ ] Yes

If yes, please describe when, by whom and nature of services:
____
____
____
____

Patient Name: ______________________________ DOB: __________________

Substance Abuse

Is substance abuse a primary treatment concern? [ ] No [ ] Yes
Have you ever been treated for alcohol or drug use or abuse? [ ] No [ ] Yes

____
____

Have many days per week do you drink any alcohol? ____
What is the least number of drinks you will drink in a day? ____
What is the most number of drinks you will drink in a day? ____
In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day? _____________
Have you ever felt you ought to cut down on your drinking or drug use? [ ] No [ ] Yes
Have people annoyed you by criticizing your drinking or drug use? [ ] No [ ] Yes
Have you ever felt bad or guilty about your drinking or drug use? [ ] No [ ] Yes
Have you ever had a drink or used drugs first thing in the morning to steady your nerves? [ ] No [ ] Yes
Have you ever had a drink or used drugs first thing in the morning to get rid of a hangover? [ ] No [ ] Yes
Do you think you may have a problem with alcohol or drug use? [ ] No [ ] Yes
Have you used any street drugs in the past 3 months? [ ] No [ ] Yes

If yes, which ones?

____
____

Have you ever abused prescription medication? [ ] No [ ] Yes

If yes, which ones and for how long?

____
____

Tobacco History

Have you ever smoked cigarettes? [ ] No [ ] Yes
Do you currently smoke cigarettes? [ ] No [ ] Yes

How many packs per day on average? __________

Trauma History

Do you have a history of being abused emotionally, sexually, physically or by neglect ? [ ] No [ ] Yes

If yes, please explain when and by whom? ____
____

Educational History

What is the highest-grade level / degree of education you have completed? ___________________________________

Patient Name: ______________________________ DOB: __________________

Work History

Are you currently: [ ] Working [ ] Student [ ] Unemployment [ ] Disabled [ ] Retired

How long have you been in your present position? ____

What is / was your occupation? ______________________________

Where do you work? ____________________________________

What are your hours? ___________________________________

Relationship History and Current Family

Are you currently: [ ] Married [ ] Partnered [ ] Divorced [ ] Single [ ] Widowed

How long have you been in your present relationship status? ____

If not married, are you currently in a relationship? [ ] No [ ] Yes

If yes, how long? ____

Are you sexually active? [ ] No [ ] Yes

How would you identify your sexual orientation? ___________________________________ [ ] Prefer Not To Answer

Have you had any prior marriages? [ ] No [ ] Yes

If yes, how many and for how long? ____

Do you have children? [ ] No [ ] Yes

What are their ages and whom do they live with?

____

____

____

Whom do you currently live with? ____

Legal History

Have you ever been arrested? [ ] No [ ] Yes

If yes, why? ____

Have you ever been to jail? [ ] No [ ] Yes

If yes, when and for how long? ____

Do you have any pending legal problems? [ ] No [ ] Yes

If yes, what? ____

Spiritual Life

Do you belong to a religion or spiritual group? [ ] No [ ] Yes [ ] Prefer not to answer

If yes, what is the level of your involvement? ____

Patient Name: _______________________________ DOB: __________________

Any other information you wish the provider to know: ____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____
____

____
Printed Name of Patient or Guardian

____ _______________________
Signature of Patient or Guardian Date

Consent to Treat, Insurance Assignments, Financial Agreement, Authorization to Release Information, Privacy Notice Acknowledgement and General Policies

Consent to Medical Services and Procedures

By signing this form, the patient or the patient's legal representative hereby consents to general and medical care, including but not limited to psychiatric services, psychological services, medical services, laboratory examinations rendered to the patient by or under the general or special instructions of the provider(s) practicing within Elite DNA Therapy Services. ___________ (initials)

Assignment of Insurance Benefits

In consideration of services rendered, I hereby transfer and assign to Elite DNA Therapy Services all rights, title and interest in any payment due to me for services described herein as provided in the above-mentioned policy or policies of insurance. ___________ (initials)

Financial Agreement

The undersigned agrees, whether he/she signs as agent or as patient, that in consideration of the services to be rendered to the patient, he/she obligates himself/herself to pay the account of the clinic in accordance with the regular rates and terms of the clinic. Should the account be referred to an attorney for collections, the undersigned should pay reasonable attorney's fees and collection expense. The undersigned certifies that he/she has read the foregoing, receiving a copy thereof and is the patient or is duly authorized by the patient as patient's general agent to execute the above and accepts its terms. ___________ (initials)

Medicare / Medicaid

Patient's authorization to release information and certification to allow payment. I certify that the information given to me in applying for payment under Title XVIII/XIX of the Social Security Act is correct. I authorize that any holder of medical or other information about me may send to responsible carriers, or their intermediaries, any information needed for this or a related Medicare/Medicaid claim. I hereby certify all insurance pertaining to treatment shall be assigned to the clinic treating me. ___________ (initials)

Use of Copies

I permit a copy of these authorizations and assignments to be used in place of the original, which will remain on file at the clinic. ___________ (initials)

Payment Responsibility

I understand that insurance claims are filed as a courtesy. If a claim is denied for any reason, I am responsible for payment. Insurance is considered a method of reimbursing the provider for services rendered to the patient. Some companies pay fixed allowances for certain procedures and others pay a percentage of the charges. I understand that it is my responsibility to pay any ***co-pay, deductible, co-insurance, or any other balance not paid for by insurance or third-party payor within a reasonable period of time not to exceed 30 days.*** ___________ (initials)

Financial Agreement

It is a patient's responsibility to know his/her insurance coverage for services, as some services and general medical coverage may be provided by two separate plans. Our office staff is happy to help answer questions and help with this process. Patients in poor credit standing with Elite DNA Therapy Services will make their co-payments or payment in full at the time of their visit. We reserve the right to assign unpaid bills to a collection agency. If you have any questions not covered by this statement, please feel free to ask for clarification. The undersigned certifies that he or she has read, understands, and accepts the terms and conditions of this form. The undersigned is either the patient or is duly authorized to sign this form and receive a copy. ___________ (initials)

Fees for Clinical Services
At Elite DNA Therapy Services, we accept many of the major insurance plans, single case agreements, and private pay. Please inquire about our fees, as the rates may be different depending on which provider you are seeing. Please know that you may be billed for telephone calls, written reports or other services that specifically require the provider's time outside of the scheduled appointment. ___________ (initials)

Missed/Cancelled Appointments
A patient who fails to appear at, or cancels less than 24 hours in advance of, an appointment may be subject to a $75 fee and/or may be discharged from the clinic. Please remember to reschedule ahead of time and we will try our best to accommodate you. Since "things happen," patients will be permitted to miss one appointment without being penalized per 6 months. However, please know that repeated "no-shows" may jeopardize your ability to receive treatment.
___________ (initials)

Lateness
Due to stringent billing requirements, we will be unable to see patients who are more than 15 minutes late for their appointment. Please call to let us know if you are running late and we will be happy to reschedule your appointment, as needed. However, you may be subject to a $75 fee or cancellation of services if you are not able to maintain your appointments. ___________ (initials)

Emergency Services (for all therapy services)
For non-life-threatening after-hours services, please call the office and follow the prompts. Please note, **we are not a 24-clinic** and for emergencies call 911 or go to the nearest emergency room. ___________ (initials)

Confidentiality and Release of Information
All information disclosed within sessions is confidential and may not be revealed to anyone outside of the Elite DNA Therapy Services without your written permission, except for disclosures as required by law. The law does require clinicians to report to the authorities any reasonable suspicions of child or elder abuse, or danger of harm to self and/or to others unless protective measures are taken. To the extent necessary to determine insurance benefits or liability for payment and to obtain reimbursement, Elite DNA Therapy Services may disclose portions of the patient's medical record and account file to any person or corporation that may be liable for all or any portion of the patient's charges, including but not limited to insurance companies, health care service plans or workers' compensation carriers. ________ (initials)

____
Printed Name of Patient or Guardian

____ ______________________
Signature of Patient or Guardian Date

Patient Name: ______________________________ DOB: __________________

Preliminary Treatment Plan

Desired Services and long-term goals: ____
____
____
____
____

Short term goals: I will attend the initial assessment at Elite DNA Therapy Services and will follow through with treatment recommendations. I will give input into the assessment and will work with the provider to develop specific ongoing goals.

Goal date: 45 days from today's date

Interventions:
Biopsychosocial evaluation (1x annually)
Treatment plan development (1x annually)
If referred to therapy, individual or family therapy (1x per week, 4 units)
If referred to psychiatry, psychiatry medication management (1x/month)

____ ______________________
Signature of Patient or Guardian Date

____ ______________________
Signature of Intake Clinician Date

____ ______________________
Licensed practitioner signature (if applicable) Date

Authorization to Discuss Health Information

Patient Name: _________________________________ Date of Birth: _________________________________

I hereby authorize Elite DNA Therapy Services to use or disclose the specific information described below, only for the purposes and parties also described below.

Description of the specific information to be discussed:

[ ] Appointment Date/Times
[ ] Medications Lab Tests/Results
[ ] Care Plan
[ ] Diagnosis
[ ] Summary of Medical Record
[ ] Genetic Testing Results
[ ] Other (specify): _____________

Indicate Confidential Information:

[ ] Mental Health
[ ] HIV information
[ ] Alcohol/Drug Information

Information to be given to:

Full Name: _______________________________________

Address: _______________________________________

____

Phone: _______________________________________

Relationship to Patient: ____________________________

This authorization shall remain in effect from the date signed below until (please check one):

[ ] ______________________ (specify expiration date or event)
[ ] NO EXPIRATION DATE

I understand that:

- I may inspect or copy the protected health information to be used or disclosed.
- I may revoke this authorization in writing by contacting the Privacy Officer.
- This authorization is giving Elite DNA Therapy Services the right to discuss my medical information with the one or more people listed above.
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.
- I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization.

____
Printed Name of Patient or Guardian

____ ______________________
Signature of Patient Date

Summary Notice of Privacy Practices

This is a summary of our Notice of Privacy Practices, which describes how medical information about you may be used and disclosed and how you can get access to this information. By signing this form, you acknowledge an understanding of Elite DNA Therapy Services privacy practices.

Our pledge to protect your privacy:
Elite DNA Therapy Services is committed to protecting the privacy of your medical information. Your care and treatment is recorded in a medical record. To ensure that we can best meet your medical needs, we share your medical record with the providers involved in your care. We share your information only to the extent necessary to collect payment for the services we provide, to conduct our business operations, and to comply with the laws that govern health care. We will not use or disclose your information for any other purpose without your permission.

Patient Rights - You have the following rights regarding your medical information:

- to request to inspect and obtain a copy of your medical records, subject to certain limited exceptions;
- to request to add an addendum to or correct your medical record;
- to request an accounting of Elite DNA Therapy Services' disclosures of your medical information;
- to request restrictions on certain uses or disclosures of your medical information;
- to request that we communicate with you in a certain way or at a certain location;
- and to receive a copy of the full version of our Notice of Privacy Practices.

We may use and disclose medical information about you for the following purposes:

- to provide you with medical treatment and services;
- to bill and receive payment for the treatment and services you receive;
- for functions, necessary to run Elite DNA Therapy Services, and assure that our patients receive quality care;
- to provide basic contact information (no medical information is provided) to our Administrative office for purposes contacting patients about events and new services;
- to support our standing as an AHCA qualified health center;
- and as required or permitted by law.

There are additional situations where we may disclose medical information about you without your authorization, such as:

- for workers' compensation or similar programs;
- for public health activities (e.g., reporting abuse or reactions to medications);
- to a health oversight agency, such as the Florida Department of Health;
- in response to a court or administrative order, subpoena, warrant or similar process;
- to law enforcement officials in certain limited circumstances;
- to a coroner, medical examiner or funeral director; and
- to organizations that handle organ, eye, or tissue procurement or transplantation.

Our Notice may be revised or updated from time to time. Please see our full Notice of Privacy Practices for a more detailed description of our privacy practices, your rights regarding your medical information, andpertinent contact information.

For further information about the full Notice of Privacy Practices, please contact: Elite DNA Therapy Services, LLC's Privacy Officer at (239) 223-2751 or privacy@elitednatherapy.com.

____
Printed Name of Patient or Guardian

______________________________________ ____________________
Signature of Patient Date