Enlightened Interventions, LLC
51 Union Street, Suite 222
Worcester, MA 01608
Ph: (508)317-2323
enlightenedinterventions@gmail.com

ClientInformation

Client's Name: ______________________________
Last *First* *M.I.*

Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Home Phone: () ______________ Alternate Phone: () ______________

Birth Date: ______________ Marital Status: ______________

Parent or Guardian Information

Parent/
Guardian: ______________________________
Last *First* *M.I.*

Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Home Phone: ( ) ______________ Alternate Phone: () ______________

Medical Information

PCP: ______________________________

Address: ______________________________
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Primary Phone: () ______________ Fax Phone: () ______________

Date of last
Physical: ______________________________

Allergies: ______________________________

Emergency Contact

Full Name: ______________________________
Last *First* *M.I.*

Relationship: ______________________________

____
Street Address *Apartment/Unit #*

____
City *State* *ZIP Code*

Primary Phone: ( ) ______________ Alternate Phone: ( ) ______________

Date: ______________

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INFORMED CONSENT FOR TREATMENT

I hereby request that (client)____
born on ________________be accepted for mental health treatment as described to me.

- I give my authorization and consent to receive outpatient mental health counseling treatment services from Enlightened Interventions, LLC or my therapist: ______________.
- I have been given information regarding my rights and responsibilities as a client (Members Rights)
- I have been given information regarding the limits of confidentiality (HIPPA)
- I have been given the Office Policies and General Agreement for Psychotherapy Services
- I have been given information regarding the cost of service. I understand that I am responsible to pay any amount owed each time I come for treatment.
- I understand that I may address any concerns or grievances with my therapist. I understand that I may also contact the licensing board, which regulates my therapist's professional practice.
- I am freely choosing to enter treatment, and I understand that I may discontinue treatment at any time.
- I have been given information about the advantages and disadvantages of treatment recommended as well as other potential alternatives.

____ ______________________
Signature of client or legal consenter Date

____
Printed Name

Minor (Emancipated Minors Only)
Due to the following reason____, I have the legal capacity under applicable Massachusetts's law to apply for consent to such treatment and services mentioned in this form, without parental consent.

____ ______________________
Signature of client or legal consenter Date

____
Printed Name

Parent or Guardian:

I, ___________________________________, do herby state that I am the natural parent or legal guardian of the client; therefore, I am authorized to make this request for and give my consent to the treatment and services mentioned in the form.

____ ______________________
Signature of client or legal consenter Date

____
Printed Name

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Therapist: ______________________________

Cancellation/No Show Policy

Patients who are not able to keep their appointments are required to provide timely notice of cancellation prior to their appointment time. Providing the required noticegives me the opportunity to schedule patients who may need to be seen urgently or froma wait list so they may be seen sooner.

Due to the nature of my practice, a 24-hour cancellation is required. Patients who DO NOT provide the required notification for cancellation aresubject to a **$50.00** fee that is NOT covered by insurance.

Patients who fail to pay the above fee will not be allowed to schedule futureappointments until the fee is paid. Multiple Cancellations or No Shows may result indismissal from therapy.

By signing below, I am agreeing that I have read and agree to the above stated policy.

______________________________ ______________________

Signature of client or legal consenter Date

____

Printed Name

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CONSENT TO RELEASE INFORMATION & AUTHORIZATION OF BENEFITS

Name______________________________________Age:________ DOB:_______________________
Parent or Guardian Name:____
Address:____________________City:___________________ State: _____ Zip Code________
Home phone no. ______________Cell: _________________Other:_______________________

Insurance Company____
Insurance ID: _________________________________ Co-Payment_________________________
Subscriber's name: ____ Relationship____________

RELEASE OF INFORMATION:

I hereby authorize Enlightened Interventions, LLC to release information as may be required by my insurance company, their reimbursing insurance or billing agency, or as may be otherwise necessary for payment of claims resulting from my mental health treatment.

I understand information will be disclosed for processing claims for treatment I have received, quality review and continuity or care purposes. This may include information contained in my records that concerns medical illness, mental illness or substance abuse and/or domestic violence.

____ ________________________

Signature of client or legal consenter Date

____

Printed Name

ASSIGNMENT OF HEALTH INSURANCE BENEFITS:

My signature below authorizes payment directly to Enlightened Interventions, LLC, of benefits payable under my policy. I understand that such payments will be credited to my account with this provider. I further understand that I am financially responsible to this provider for charges not covered or reimbursed by my policy, up to the fee the provider has agreed to accept.
I understand that I may revoke this release at any time, but must notify clinician of my revocation in writing.

____ ________________________

Signature of client or legal consenter Date

____

Printed Name

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AUTHORIZATION FOR THE USE OR DISCLOSURE OF HEALTH INFORMATION

When you complete this form, you are authorizing the disclosure and/or use of individually identifiable health information, as set forth below, consistent with state and federal laws concerning the privacy of such information. If you do not provide all the information requested, this Authorization may not be valid.

Member/Individual Name: ____________________
Member/Individual Date of Birth: ____________________

Authorization for Disclosure of Health Information

I hereby authorize ____________________ to release my health information to:

(Persons or organizations to whom information may be disclosed)

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________
6. ____________________
7. ____________________
8. ____________________

Purpose of Requested Use or Disclosure

- ❑ Coordination of care or case management
- ❑ Appeal or grievance resolution
- ❑ Treatment and follow up
- ❑ Assessing compliance with testing
- ❑ Response to HHS or other government agency
- ❑ Response to court order or subpoena
- ❑ At the request of the Member
- ❑ Other ____________________

Information to Which the Authorization Applies

- ❑ Claims information (from _______ to________)
- ❑ All claims information
- ❑ Clinical information (from _______ to________)
- ❑ All clinical information
- ❑ Appeal and review information (from _______ to________)
- ❑ All appeal and review information
- ❑ Designated record set (from _______ to________)
- ❑ The entire designated record set

Exceptions: ____________________
This authorization expires (date or event): ____________________

Name ______________________________

Medical Record # ____________________

Information to Which This Authorization Applies

☐ All health information pertaining to any medical history, mental or physical condition, and treatment received.

☐ All health information pertaining to any medical history, mental or physical condition, and treatment received, except:

Date: ________________________ Time: ________________ am / pm

Signature: x____

Individual/Member/Authorized Representative

☐ I specifically authorize the release of personal health information relating to drug and/or alcohol abuse. The recipient of drug and/or alcohol abuse information disclosed as a result of this Authorization will need my further written authorization to redisclose this information.

Signature: x____

☐ I specifically authorize the release of information relating to acquired immunodeficiency syndrome (AIDS) or human immunodeficiency virus (HIV).

Signature: x____

Notice of Rights and Other Information

I may refuse to sign this Authorization. Treatment, payment, enrollment, or eligibility for benefits will not be conditioned on my providing or refusing to provide this Authorization. I may take back ("revoke") this Authorization at any time. To revoke this Authorization, I must send a letter, which has been signed by me or on my behalf to: ________________________. My revocation will be effective upon receipt, but will not affect disclosures already made in reliance on prior consent.

Except as described above with respect to drug and alcohol abuse records, information disclosed as a result of this Authorization could be redisclosed by the recipient and might no longer be protected by federal confidentiality laws.

I may inspect or obtain a copy of the health information be used or disclosed as permitted under federal or state law.

Signature

Date: ________________________ Time: ________________ am / pm

Signature: x____

Individual/Member/Authorized Representative

If signed by someone other than the individual or Member, state your legal relationship to the individual or Member:

____

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Authorization Request for Medical Information

I, ______________________ for ______________________ ______________
Parent or guardian name — Client name — Date of Birth

hereby give permission to ______________________

and ______________________ ______________________
Primary Care Physician — Institution name:

______________________ ______ ______________ ______________
Address — Suite — City — Zip

______________________ ______ ______________ ______________
Phone no. — Ext. — Fax No. — Other

to share information about my diagnosis and/or treatment related to substance abuse, mental health, or medical history, not including the results of blood test for antibodies to the human immunodeficiency virus (HIV). The purpose of this sharing of information is to help me receive better care.

______________________ ______________
Client /Parent or guardian Signature — Date

______________________ ______________
Witness — Date

Member Refusal To Request Medical Information

I, ______________________ for ______________________ ______________
Parent or guardian name — Client name — Date of Birth

Have been asked by clinician to share information with:

______________________ ______________________
Primary Care Physician — Institution name

______________________ ______ ______________ ______________
Address — Suite — City — Zip

______________________ ______ ______________ ______________
Phone no. — Ext. — Fax No. — Other

about my diagnosis and treatment plan. My therapist has explained to me that sharing this information may lead to improved care. I understand that *my refusal* to sign does not affect my insurance coverage.

______________________ ______________
Client /Parent or guardian name — Date

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PHYSICAL HEALTH SCREENING

Client's Name ______________________ AGE ________ D.O.B __________ Sex ☐ M ☐ F

Parent or Guardian Name: ______________________

Physician's Name: ______________________

Address: ______________________ City: __________ State: ________ Zip Code: __________

Phone no. ______________________ Fax: __________ Date of last Physical __________

QUESTIONNAIRE

Do you have now or have ever had:

A history of heart problem? ☐ Y ☐ N
A history of lung/ Respiratory problems (breathing problems)? ☐Y ☐N
If yes? ______________
Seizure Disorder? ☐Y ☐ N
Asthma? ☐ Y ☐ N
Chest, neck, and/or jaw pains/ discomforts? ☐Y ☐N
Allergies?☐Y ☐N If yes, what? ______________
Tuberculosis? ☐Y ☐ N
DTS (Delirium Tremors)? ☐Y ☐N
Venereal Disease (Herpes, Gonorrhea, STDs, Hepatitis)? ☐Y ☐N
Blackout? ☐Y ☐ N
Numbness? ☐Y ☐N
Tingling? ☐Y ☐N
Headaches?☐Y ☐N
Memory Problems? ☐Y ☐N
Visual Problems? ☐Y ☐N
Hearing Problems? ☐Y ☐N
Dizziness? ☐Y ☐N
Fainting? ☐Y ☐N
Previous Pregnancies ________
Are you or could you be pregnant now? ☐Y ☐N
Any history of surgeries? ☐Y ☐N If yes, ______________

Muscle, joint, back pain or other pain?☐Y ☐N
Severe pain? ☐Y ☐ N Rate1-10
(1- no pain & 10-severe pain) __________
Circulatory disorders?☐Y ☐N
Walking problems?☐Y ☐N
Poor balance?☐Y ☐N
Chronic illness? ☐Y ☐N
Menstruation Problems?☐Y ☐N
Breast Problems?☐Y ☐N
Kidney Problems?☐Y ☐N
Genitalia Problems?☐Y ☐N
Stomach or Intestinal Problems?☐Y ☐N
Bone Problems?☐Y ☐N
Liver Problems?☐Y ☐N
Cancer ☐Y ☐N Type __________
If yes, what age __________
Family member ever diagnosed with cancer? ☐Y ☐N
Who? ______________
Immunization for the flu? ☐Y ☐N
TB test within the past year? ☐Y ☐N If yes when? ________
Do you exercise on a regular basis? __________
Any changes in your appetite over the last month? ☐Y ☐N

Additional Comments:

____
____
____
____

By signing, I acknowledge that I have read and understood and that the information provided isaccurate:

______________________ Signature

______________________ Date

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Symptoms Checklist:

Difficulties with Behavior Management in past four weeks (check all that apply)

_____ Impulsive
_____ Hyperactive
_____ Oppositional
_____ Violence/Aggression
_____ Runs off/ runs away

Difficulties with Activities of Daily living in past four weeks (check all the early)

_____ Appetite problem
_____ Difficulty with sleep
_____ Decreased energy
_____ Anhedonia
_____ Not able to work/ attend school
_____ Not able to maintain personal hygiene
_____ Social withdrawal
_____ Panic attacks
_____ Other (please specify)

Other symptoms present in past four weeks (check all that apply)

_____ Depressed Mood
_____ Elevated Mood
_____ Grief
_____ Hopelessness
_____ Worthlessness
_____ Guilt
_____ Anxiety
_____ Obsessions/ Compulsions
_____ Irritability
_____ Disruption of thought process/ content
_____ Somatic complaints
_____ Other (please specify)

Risk Factors present present in past four weeks (check all that apply)

_____ Suicidal ideation
_____ Homicidal Ideation
_____ Violence/ aggression
_____ Substance abuse
_____ Delusions
_____ Hallucinations
_____ Paranoia
_____ Dissociative states
_____ Emotional/physical/sexual trauma victim