MOKSCARE

Date _____

Thank you for setting up an appointment with Mokscare Psychiatry and Family Medicine. Please complete the following intake form so your clinician will be more prepared for your upcoming visit. Should you have any questions when completing this form, please feel free to call the office.

Legal Name _____ Date of Birth _____

Preferred Name _____

Address _____ Birth Gender_____

City, St, Zip _____

Phone _____ Home Cell

Email address _____

Social Security # _____

Insurance Name _____

Ins Claim Address (complete) _____

Provider Phone Number _____

Member ID Number _____ Member Group Number _____

Employer/Occupation _____

Alternate/Emergency Contact _____

Relationship and Phone # _____

Who referred you to our office? _____

Preferred Pharmacy _____

Pharmacy Phone _____

Please check according to your preference

- ☐ I would rather communicate with office staff and my clinician over telephone only and it is ok to leave a voicemail.
- ☐ I give permission for Mokscare staff and my clinician to contact me via email and I accept the limitation of privacy with email (my email may not be secure).
- ☐ I give permission for Mokscare staff and my clinician to contact me via text and I accept the limitation of privacy with texts (someone may look at my texts).

If someone other than yourself is responsible for your account (**under age 18 and/or guardianship forms**), please supply their information.

Name _____ Relationship _____

Address _____

City, St, Zip _____

Phone Number _____

Briefly describe why you are seeking help _____

_____

_____

How long have you had this problem? _____

Please list medications you are currently taking (use the back side, if needed)

Medication Name	Strength	Directions
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you have any allergies to medications? _____

_____

Health History

Vaccinations (date of last injection)

Tetanus/Tdap _____ Flu _____

Pneumonia _____ HPV _____

Shingles _____ COVID _____

Other

If applicable, when was your last mammogram? _____

If applicable, when was your last pap smear (female only)? _____

If applicable, when was your last rectal exam? _____

If applicable, when was your last colonoscopy? _____

Last set of labs performed, when and where? _____

Do you have a Durable Power of Attorney? Yes _____ No _____ Medical _____ Financial _____

Do you have an Advance Directive? Yes _____ No _____

Do you have a DNR? Yes _____ No _____

Social History

Do you smoke? Yes _____ No _____ If yes, how many packs p/day and how long have you smoked? If not but previously smoked, when did you quit? _____

Do you drink alcohol? Yes _____ No _____ If yes, how often/much and drink of choice? If you previously drank, when did you stop? _____ _____

Do you use illicit drugs? Yes _____ No _____ If yes, what? _____

Do you exercise? Yes _____ No _____ If yes, how much? _____

Female patients only, is there any chance you could be pregnant? Yes _____ No _____

Number of past pregnancies _____ How many live deliveries _____

Age of first menstrual cycle _____ Perimenopausal? Post Menopausal? (circle one)

Past Medical History (please check mark the box if any are a yes)

Alcoholism		Bypass Surgery		Kidney Disease	
Allergies (seasonal/environmental)		Cancer (any type)		Osteoporosis	
Appendectomy		Cholecystectomy (gallbladder removal)		Respiratory Disease (COPD)	
Asthma		Depression		Seizure disorder	
Anxiety		Diabetes		STD	
Arthritis		Heart Attack		Stomach Ulcer	
Birth Defects		High Blood Pressure		Stroke	
Blood Transfusion		High Cholesterol		Thyroid Disorder	

If cancer or if more information you want to share, please do so _____

_____

_____

Family History (please indicate the relationship of the family member in the box)

	Mother or Father	Alive or Deceased
Blood Clots		
Cancer		
Depression		
Diabetes		
Heart Disease		
Osteoporosis		
Stroke		
Thyroid Disorder		

If cancer or if more information you want to share, please do so _____

_____

_____

Review of Symptoms (please mark if you have had any of the following symptoms in the past 3-months)

General		Eyes		Respiratory	
Appetite Loss		Blurred Vision		Cough	
Chills		Discharge		Coughing up Blood	
Excessive Sweating		Double Vision		Shortness of Breath	
Fever		Pain		Sleep Disturbances due to breathing	
Generalized Weakness		Sensitivity to Light		Snoring	
Fatigue		Redness		Sputum Production	
Night Sweats		Vision Loss - Left		Wheezing	
Weight Gain or Loss		Vision Loss - Right		**Endocrine**	
Head / ENT		Visual Disturbance		Cold Intolerance	
Congestion		Visual Halos		Excessive Thirst	
Ear Discharge		**Cardiovascular**		Excessive Urination Volume	
Ear Pain		Blue Skin or Nails		Heat Intolerance	
Headaches		Chest Pain		Increased Appetite	
Hearing Loss		Irregular Heartbeat		**Hematologic**	
Hoarseness		Leg Swelling		Enlarged Lymph Node	
Nose Bleeds		Near-Fainting or Fainting		Bleeding	
Painful Swallowing		Pain in Legs with Walking		Bruises / Bleeds Easily	
Sore Throat		Palpitations		**Neurological**	
Inhale Wheeze		Shortness of Breath Lying Flat		Brief Paralysis	
Ringing in Ear		Shortness of Breath on Exertion		Concentration Difficulty	
Gastrointestinal		Waking at Night Short of Breath		Coordination Disturbances	
Abdominal Bleeding		**Genitourinary**		Daytime Sleepiness	
Abdominal Pain		Bladder Incontinence		Dizziness	
Anorexia		Blood in Urine		Focal Weakness	
Black Tarry Stools		Decreased Libido		Light-Headedness	
Bloating		Flank Pain		Loss of Balance	
Bowel Habits change		Frequency of Urination		Loss of Voice	
Bowel Incontinence		Genital Sores		Numbness	
Constipation		Heavy Periods		Prickling or Tingling Sensation	

Gastrointestinal cont		Genitourinary cont		Neurological cont	
Diarrhea		Hesitancy		Seizures	
Excessive Appetite		Incomplete Bladder Emptying		Sensory Change	
Fresh Blood in Stools		Missed Periods		Tremors	
Gas		Night-time Urination		Vertigo	
Heartburn		Painful Urination		**Allergy / Immunology**	
Hemorrhoids		Pelvic Pain		Environmental Allergies	
Nausea Vomiting		Urgency of Urination		HIV Exposure	
Throwing up Blood		Vaginal Bleeding (non-menstrual)		Hives	
Trouble Swallowing		**Musculoskeletal**		Persistent Infections	
Yellowing of Eyes or Skin		Arthritis		**Psychiatric**	
Skin		Back Pain		Abnormal State of Awareness	
Changes in Nail Beds		Falls		Altered Mental Status	
Discoloration		Gout		Depression	
Dryness		Joint Pain		Hallucinations	
Flushing		Joint Swelling		Memory Loss	
Itching		Muscle Cramps		Nervous / Anxious	
Poor Wound Healing		Muscle Pain		Substance Abuse	
Rash		Muscle Weakness		Suicidal Thoughts	
Unusual Hair Distribution		Neck Pain		Thoughts of Violence	
Suspicious Lesions		Stiffness		Trouble Sleeping	

Consent

Welcome to Mokscare Psychiatry and Family Medicine! We are pleased that you have chosen us for your primary care healthcare needs. In order to proceed, we want to make sure you understand the nature of our services, your rights, and the financial aspects involved. Please read this document carefully and let us know if you have any questions or concerns. Your signature at the end of this document indicates your informed consent and agreement.

I consent to primary care services to be provided by Mokscare Psychiatry and Family Medicine. If I reside in a facility and the only way to see a provider is via telemedicine, I continue to consent to services. I understand that Mokscare only provides professional services to clients, and will not engage in any personal relationship with clients and their families outside of the professional relationship. My evaluations and treatment plans are confidential, but I understand there are limits to this confidentiality.

Confidential information may be disclosed under the following conditions:

1. I have been evaluated to be a danger to myself or others
2. My treating clinician believes I am a victim of abuse or if I divulge information about such abuse
3. I give written consent to disclose information

Assignment of Insurance Benefits/Release of Information

The providers may disclose patient information, as necessary to my insurance plan. I hereby authorize my insurance company to pay benefits for this exam and any future follow-up appointments. Furthermore, I understand I am responsible for any amount not paid or covered by the insurance.

I understand Mokscare to consult with and discuss the results of my examination or any progress notes with the medical, nursing, or therapeutic staff in order to facilitate the highest level of medical restoration and quality of life. I authorize Mokscare to furnish only pertinent information to my insurance carrier in relation to payment of my claims. I assign to Mokscare all payments for professional services rendered.

If I don't have insurance coverage and/or agree to a self-pay option, *I understand that in order to receive any type of discount, payment must be received at the time of service*. If services aren't paid for at the time of service, I will be responsible for the full charge amount. I understand that a Good Faith Estimate will be provided to me where the costs of my visits will be outlined as per the No Surprises Act.

As a courtesy to patients, Mokscare will bill my insurance (s) for services received. I acknowledge that Mokscare accepts Medicare and Medicaid. If I have both Medicare and Medicaid, or Medicaid only, I am aware I am not obligated to pay additional coinsurance amounts and will not be personally billed for these services. However, if I have a Medicaid spend down and my visits are applied to this, I will be responsible.

I understand Medicare deductibles and coinsurance amounts will be billed to any secondary insurance I provide. I am aware that not all secondary insurance companies cover these amounts, as there are plans that have a copay due or where deductibles aren't covered.
If my insurance plan changes, I will notify and provide my provider with a copy of the insurance card immediately. I am aware my provider MUST file claims within a certain amount of time and if I fail to provide said information outside of these parameters, I will be held responsible for the fees associated with services received. Example … Blue Cross Blue Shield of Kansas City has a timely file limit of 90-days. Services were provided to you on January 2 and we aren't given the insurance information until April 15th, then this would be outside of our timely file limits and you would be responsible.

If my insurance company inadvertently pays me directly, I will sign the payment check over to Mokscare within 1 week of receiving. I am aware that my provider does receive an explanation of benefits, so they will be aware of any payment I receive. Failure to do sure may result in a termination of services.

I understand that my balance with Mokscare must be kept current. Any outstanding balances over 90-days may result in collection placement and termination of services. Copays and outstanding balances will be collected at your scheduled visit. Should financial issues arise, please reach out to the Office Manager at Mokscare to set up a payment arrangement.

Late Cancellation/No-Show Policy

We understand that circumstances may require you to cancel or reschedule appointments. However, we ask that you provide us with at least a 24 hours' notice. Failure to do so will result in a late cancellation fee of $75 which I am responsible for paying *prior to* rescheduling my appointment and receiving medication refills.

Telehealth Services

I hereby provide my informed consent for receiving mental health evaluations and treatment services through telehealth from Mokscare Psychiatry and Family Medicine. I understand that telehealth involves the use of technology to facilitate communication between me and my provider, allowing me to receive care without being present in his/her office. I understand that telehealth services may include but are not limited to video conferencing or phone calls.

I am aware of the pros of telehealth such as increased flexibility and reduced travel times; there are cons to this service such as a disruption of service, privacy concerns, or the feeling of not receiving the same quality of care. I understand my provider will take all reasonable steps to ensure privacy of our conversations and/or televideo sessions. I am also being held accountable for the private and secure location to which I am receiving the call or televideo session.

In the case of an emergency, telehealth services may not be the best option. I understand that my provider may determine that my current level of care doesn't validate telehealth and feels that an in person appointment is necessary or another level of care is needed. If I feel I am in immediate crisis, I agree to call 911 or seek help at my nearest emergency room.

Medication Refills

Medication refills need to be sent electronically from your pharmacy. Please have your pharmacy send this request 3 to 5 days prior to you needing a refill. If a request is received earlier than this, the request will be denied.

If you are prescribed controlled medications, please call the office for a refill 72-hours prior to you needing a refill. These types of medications will NOT be filled earlier than 24-hours prior to them being due for refills.

If you lose a medication, there will be a charge for a replacement script. If your medication is stolen, a police report is required and there will be a charge for a replacement script. There may be times when you will be asked to bring in prescription bottles for controlled substances for review prior to refills. Providers have the right to decline refills if medication count is not correct.

HIPAA

Mokscare does not share any information about you or the treatment you are receiving with anyone without your consent. It would be a violation of the Health Insurance Privacy and Accountability Act to do so. The only exceptions to this were mentioned on page 1.

- ☐ Yes, I would like a printout of the HIPAA guidelines
- ☐ No, I don't need a copy of the HIPAA guidelines

Consent for release of confidential information (please check appropriate box)

- ☐ I consent to the release of all information regarding my care to the responsible party of my account and/or family members involved in my care.
- ☐ Exceptions to consent - I do not wish to release information to the following person (s) _____

By signing below, you acknowledge that you have read and understood the information provided in this document. You agree to comply with the terms outlined, including financial responsibilities.

Patient Name: _____

Patient Signature: _____ Date: _____

<u>If the patient is a minor</u>, please print the patient name above, and sign below.

Guarantor Name: _____

Guarantor Signature: _____ Date: _____