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.

Name _____ Date of Birth _____

Address _____ Legal 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? _____

Primary Care Physician_____

Phone _____

Preferred Pharmacy _____

Pharmacy Phone _____

Please check according to your preference

- ☐ I would rather communicate with office staff and my clinician over telephone only.
- ☐ 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 (complete) _____

Phone Number _____

1. Briefly describe why you are seeking help

_____

_____

How long have you had this problem? _____

2. Have you had previous psychiatric treatment? Yes _____ No _____

If yes, physicians name _____

Diagnosis (if known) _____

Previous psychiatric meds prescribed _____

_____

Any previous psychiatric hospitalizations? Yes _____ No _____

If yes, where and when _____

_____

3. Please list medications you are currently taking, both psychiatric and those for other medical conditions

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

Are these medications working for you? Yes _____ No _____

4. Do you have any allergies to medications? _____

_____

5. Family history of psychiatric illness, depression, schizophrenia, suicide, bipolar, etc?

_____

_____

_____

_____

6. Previous surgeries and/or hospitalizations and the approximate date

_____

_____

_____

7. What medications, if any, have you tried and failed. Please tell us why you failed the medication.

_____

8. Have you EVER had any of the following

Asthma / Breathing Problems	Heart Disease
Arthritis	Hypertension (High Blood Pressure)
Bleeding / Clotting d/o	Liver or Lung Disease
Bowel / Stomach Problems	Neurological d/o, Chronic Headaches
Cancer	Pulmonary Embolism / DVT
Diabetes	Stroke
Eye Problems (Glaucoma, Cataract)	Seizure / Epilepsy
Thyroid d/o	Urinary / Kidney d/o

Please list any other medical illnesses/problems and provide details for any of the above conditions

_____

_____

9. Family history of any of the above illnesses. If yes, who and which type of illness?

_____

_____

10. Do you smoke? Yes _____ No _____ If yes, how much? _____
    Do you drink alcohol? Yes _____ No _____ If yes, how often? _____
    Do you use illicit drugs? Yes _____ No _____ If yes, what? _____
    Former smoker,previously drank alcohol or used illicit drugs? _____
11. **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 _____

12. Do any of the following items apply to you

Thoughts of Suicide	Thoughts of Harming Others	Phobias	Anxiety or Panic Attacks
Trouble getting to sleep or staying asleep	History of Suicide Attempts	Excessive Guilt	Forgetfulness
Impulsive Decision Making	Cutting and/or Self-Harm	Increased Energy	Feeling Lost or Hopeless
Financial Problems	Inability to Make Decisions	Mood Swings	Family Problems
Health Problems	Loss of Appetite or Increased Appetite	Trouble Controlling Temper	Hearing Voices
Decreased need or sleeping too much	Problems at Work	Seeing Things others Don't	Violence towards Others
Talking Excessively or Trouble Concentrating	Worrying a lot	Racing Thoughts	Legal Problems

The following questions apply to patients under the age of 18. We ask that parents allow your child to PLEASE complete the information in their own words.

1. Please describe any behaviors that are particularly concerning you

_____

_____

_____

_____

2. Please list any unusual, traumatic, or possibly stressful events in your life that you feel may have had an impact on your development and/or current level of functioning.

_____

_____

3. Current grade in school _____

4. How do you feel you are as a student? _____

5. Are you on an IEP or 504 plan? Yes _____ No _____ If yes, for what reason

_____

Welcome to Mokscare Psychiatry and Family Medicine! We are pleased that you have chosen us for your mental health evaluation and treatment. 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 psychiatric 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 therapeutic 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 spenddown 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.

Informed Consent for use of AI
NABLA, for example, is an application powered by an AI language model. It assists in data collection and note-taking, which in turn aids in patient care. The application records the conversation between a patient and healthcare professional then dictates the information into your HIPAA compliant EHR. No data is shared with a third party. All information is reviewed prior to saving of the documentation within the Mokscare note.

Medication Refills
Medication refills need to be sent electronically from your pharmacy. Please have your pharmacy send this request 72-hours prior to you needing a refill. If a request is received earlier than this, the request will be denied. Examples of these medication refills include Alprazolam, Lorazepam, Risperidone, Escitalopram, Vybrid, or Prozac. If you are prescribed stimulant medications such as Adderall or Vyvanse, 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.

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: _____