Mending Minds, LLC

1311 W 96th Street, Ste 110
Indianapolis, IN 46260
Phone: 317-876-3699
Fax: 317-876-3600

702 W Alto Road
Kokomo, IN 46902
Phone: 765-453-7422
Fax: 765-453-3773

Shannon@mendingminds.info

PATIENT INFORMATION

Are you seeking: ____ Medication Management or ____ Individual Therapy

Who do you want to see at Mending Minds:_____

Patient Email:_____

Last Name:_____ First Name:_____ M.I.___

Address:_____

City:_____ State:_____ Zip Code:_____

SSN:_____ DOB:_____ Marital Status:_____

Sexual orientation:_____ Gender identity:_____

Assigned sex at birth: _____ Pronouns:_____

Home Phone:_____ Cell Phone:_____ Work Phone:_____

Spouse's Phone:_____ Spouse's Name:_____

Name of person filling out this form: :_____

Employer's Name & Address:_____

_____

Jobtitle:_____

In case of an emergency please notify:_____

Phone Number:_____ Relationship:_____

Referring Physician OR therapist :_____

Phone Number:_____ Fax Number:_____

Referring Physician OR PCP :_____

Phone Number:_____ Fax Number:_____

General medical problems:_____

_____

May we contact your Physician/ Therapist: ____ Yes ____No ____I do not have a Physician/ Therapist

Are you court ordered to seek services? Yes_____ No_____

Is Department of Child Services involved? Yes_____ No_____

Current Medications & Dosages

_____ _____mg Times per day:_____

_____ _____mg Times per day:_____

_____ _____mg Times per day:_____

_____ _____mg Times per day:_____

If anymore, please list on another page. Thank you.

Medication allergies:_____

_____

Please specify amount & frequency of the following:

Tobacco usage:_____

Alcohol usage:_____

Drug usage:_____

Are you apart of any state services or wrap around services? Yes:_____ No:_____

Location: ____Indianapolis or ____ Kokomo

Type of Session: ____ In person (If available) or ____ Telehealth

Are you on a Medication Assisted Treatment Program or Suboxone Treatment Program?
Yes:_____ No:_____

Social History

With whom did you live with while growing up?_____

Educational background-include highest grade completed:_____

With whom do you live with currently?_____

Have you ever been physically, verbally, or sexually abused?_____

Religious beliefs (include level of activities):_____

Please describe briefly, your main area of concern for which treatment is being sought at this time:_____

_____

_____

_____

Please describe briefly, all previously psychiatric treatment; including any hospitalizations:_____

_____

_____

_____

List any additional, pertinent information you feel would be beneficial for our provider to know:_____

_____

_____

_____

Name	Age/Age they deceased?	Marital Status (S,M,D,W)	Place of Residence	Drug/Alcohol Problem	Psychiatric Difficulties
Parents					
Siblings					
Spouse(s)					

Did any aunts, uncles, cousins, or grandparents have any psychiatric or drug & alcohol difficulties?
Yes:_____ No:_____ If so, please describe:_____

_____

_____

Medical Insurance Information

Name of insured:_____ DOB:_____

Insurance Company:_____ Insured SSN:_____

Relationship to patient:_____

Policy #:_____ Group/Plan#_____

RxBin #:_____ PCN#_____ RxGroup#:_____

Claims Submission Address:_____

Phone # of Insurance Co. for Pre-Certification:_____

Secondary coverage_____

Policy #:_____ Group/Plan#_____

Claims Submission Address:_____

Phone # of Insurance Co. for Pre-Certification:_____

Are you a part of an EAP Program? Yes:____ No:____ Authorization #:_____

Effective Date:_____ End Date:_____ Number of Sessions:_____

Preferred Pharmacy:_____ Phone Number:_____

Address:_____

Coordination of Care:

It is important for your health care providers to speak to each other so we may work together to help you. Please complete the information below and indicate your approval for us to coordinate your care.

Primary Care Physician:_____Phone:_____

Address:_____

City:_____ State:_____ Zip Code:_____

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Authorization to Release/Obtain MEDICAL RECORDS Consent for Mutual Disclosure(s)

I hereby authorize Mending Minds, LLC to Release/Obtain the following information contained in my records.

Please note: By typing your name in the signature line, you are acknowledging that it is a legally binding signature.

NAME:_____ DOB:_____

ADDRESS:_____

CITY:_____STATE:_____ZIPCODE:_____

HOME/CELL#:_____ WORK #:_____

___Diagnosis & Evaluation ___Lab Results ___Entire Patient Record

___Discharge/Termination Summary ___Alcohol/Drug Related Information

___Other Pertinent Information Explain:_____

A copy of the above-identified information should be furnished by/to:

NAME:_____ PHONE #:_____

ADDRESS:_____ FAX #:_____

NEED BY:_____

This information is being requested for-the following purpose(s):

___Diagnosis & Evaluation ___Formulation of Treatment Plan ___Insurance Claim

___Other:_____

I understand that this request may be revoked by me giving such revocation, in writing, to Mending Minds, and that after such revocation is delivered to Mending Minds, no further information will be furnished pursuant to it.

____If initialed, I request that one hundred eighty (180) days from the date written below, this request will be null, and void and no further information will be furnished pursuant to it. EXPIRES:_____

___If initialed, a copy of authorization shall be as valid as the date on which it was originated.

Signature:_____ **Date**:_____

Witness:_____ **Date**:_____

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These are legal agreements between patient and Mending Minds, LLC that contain important information regarding your care at Mending Minds. Failure to provide this information or return these signed documents will delay in receiving an appointment or could result in closure of your account. Please send these signed forms to Mending Minds via the faxes or secure email listed above. Thank you for entrusting us with your mental health needs. Please note: By typing your name on the signature lines below, you are acknowledging that they are legally binding signatures.

Assignment of Benefits

I authorize payment of medical benefits to the names provider for professional services rendered. The patient will agree, by signing below, to authorize the provider to release information to insurance carrier(s) listed and be paid directly by insurance carrier(s) for services billed. The patient will be responsible for all charges not paid by the insurance companies, including copays, coinsurance, deductibles, insurance plan refusal to pay for failure to obtain authorization, and missed and late cancelations fees. The patient will agree, by signing below, that if it becomes necessary to effect collections of any amount owed, the patient will pay all costs and expenses including any attorney fees.

Signature:_____ Date:_____

Financial Responsibility

I accept **FULL** financial responsibility for all charges incurred for medical services provided. This includes **FULL** responsibility for appointments missed OR canceled within less than a 24-hours' notice. Mending Minds also has the right to legally pursue **ANY & ALL** fees incurred for Non-payment, either through monthly late fees, (if applied), collection fees, and attorney fees. Insurance payments are ordinarily received within 30-60 days from the time of filing. If your insurance company has not made payment within 60 days, we will ask that you contact your insurance company to make sure nothing has changed. If payment is not received or our claim is denied, you will be responsible for paying the full amount at that time. In the event of default in payment. Reasonable collection agency fees equal to (25%) shall be added to the amount on the account, plus any applicable court costs. Possible fees will be charged as follows: FMLA paperwork $50, Disability paperwork $75, No Call No Show or cancellation less than 24 hours before appointment time $80, Record requests $50, Returned check fee $40.

(WE MUST HAVE THIS INFORMATION TO SCHEDULE APPOINTMENTS)

Debit/Credit Card to be electronically secured:

CC Number: _____ Expiration Date:_____ CVC:_____

Name on card:_____

Billing Address for card:_____

Card on file will be used automatically for fees listed above as well as copays, deductibles and self-pay rates.

Signature:_____ Date:_____

Collection Fees

I assume full responsibility for all fees incurred by me or my dependent (s) at Mending Minds. I understand that if my account balance becomes ninety (90) days past due, the remaining balance may be sent to a collection agency. I understand that I will be responsible for any additional fees applied to my account by the collection agency. I understand that I could be subject to pay court costs if legal action is taken against my past due account.

Signature:_____ **Date:**_____

Telephone Consumer Protection Act

I acknowledge under the TCPA, by providing my cell phone or landline phone number, that I am giving my express written consent that Mending Minds and its affiliates, have the authorization to call via auto dialer, pre-recorded voice messages, SMS messages and live calls for any communication that would be associated with my account at this practice.

Signature:_____ **Date:**_____

Written Consent for Emails and Telehealth

I acknowledge by providing my email address, that I am giving my express written consent that Mending Minds and its affiliates, have the authorization to contact me by the email I have provided for any communication that would be associated with my account in this practice. I also give written consent to participate in, a telehealth consultation with my provider through Mending Minds.

Signature:_____ **Date:**_____

Acknowledgement of Awareness

I have read and I am aware of the Notice of Privacy Practices related to the use and disclosure of my health information. I have read and I understand all policies associated with my care at Mending Minds. I give consent for Mending Minds to take over my mental health care; to formulate a treatment plan and revise that plan with me as needed. I also understand that if I am non-compliant with care, I may be discharged as a patient, per my provider's discretion.

Signature:_____ **Date:**_____

FMLA/ Disability Paperwork

Any paperwork needed for FMLA, or Disability will be completed by the provider with assistance from the patient. A 1-hour appointment specifically for paperwork will be needed and a $50.00 fee will be assessed at the time of service. Insurance companies **WILL NOT PAY** for this fee. The charge may be waived if clinically appropriate; this is at the discretion of each individual provider at Mending Minds. I understand that if I need any paperwork to be completed by my provider, there will be a $50.00 fee due at time of service. Patients should allow 7 business days for paperwork to be completed.

Signature:_____ **Date:**_____

Parental Consent for Treatment of a Minor Child

My signature below hereby authorizes Mending Minds to evaluate and treat Minor Child _____ Date of Birth_____.

My signature further attests that I have the legal authority (parental custody or legal guardianship) to authorize such evaluation and treatment. As a parent or legal guardian, I understand that I have the right to request information concerning this evaluation and treatment.

Parent/Legal Guardian Signature:_____ **Date:**_____

Witness:_____ **Date:**_____

Mending Minds, LLC Prescriber Policies Introduction

The following policies are specific for Mending Minds, LLC. These policies are intended to address commonly encountered aspects of treatment, to promote patient safety and satisfaction, and to produce optimal treatment outcomes.

Patient Participation in Care

The patient will be expected to comply with treatment recommendations including prescribed medications, psychotherapy, and routine lab monitoring for efficacy of treatment.

Controlled Substances Policy

As part of the treatment plan, a patient may be prescribed a scheduled, or controlled medication, as defined by the Drug Enforcement Administration (DEA). In accordance with DEA requirements, the provider will access the prescription drug monitoring program database on a regular basis to ensure that prescriptions are being filled appropriately. It is the responsibility of the patient to inform the provider if another provider is prescribing a controlled substance for the patient, as this may affect treatment decisions. Failure to do so may result in discharge from the practice. The patient may be subject to urine drug screens to ensure compliance with scheduled medications, at the discretion of the provider. Failure of a urine drug screen to correlate with appropriate use of a controlled substance may result in discharge from the practice. Scheduled medications may not be refilled early. Any concerning behavior surrounding scheduled medication may result in discharge from the practice, at the discretion of the provider.

Existing Prescriptions for Controlled Substance Policy

At the discretion of the provider, patients may not be provided with prescriptions for any controlled substance if the Indiana prescription drug-monitoring database indicates that they are also being prescribed a controlled substance known to have potentially dangerous interaction. Failure to disclose any prescriptions for controlled substances from an outpatient provider at any time during the course of treatment may result in discharge from the practice, at the discretion of the provider. Patients are not guaranteed that their prescriptions for controlled substances from a previous provider will be continued. This will be at the discretion of the provider, based on clinical assessment and recommendations.

Discharge from Practice Policy

The patient may be discharged from the practice at the discretion of the provider for reasons including, but not limited to, the following: patient-provider conflict, conflict of interest discovered during the course of treatment, lack of patient compliance with treatment, suspected or confirmed misuse/abuse of prescribed medications, failure of patient to remit payment, repeated missed appointments, repeated late cancellations, patient requiring a different level of care. Upon discharge from the practice, the patient will be given a 30-day written notice of discharge and a 30-day supply of medications. The patient will be responsible for finding a new provider.

Your signature below indicates that you have read, understand, and agree to the above policies.

_____ _____

Patient or Legal Guardian Signature **Date**

_____ _____

Patient's Name **Relationship to Patient**