Serenity Now Psychiatric & Counseling Services

(A Division of Hoosier Uplands Economic Development Corporation)
2125 16th St. • Bedford, IN 47421
(812) 275-4053 • Fax (812) 275-5494

Enclosed you will find our new client information packet. Please complete all forms and return them to Serenity Now. Once we receive your completed packet with a copy of your insurance card, your information will be reviewed by our Clinical team to determine if we can appropriately serve your needs. Serenity Now is an independent psychiatric and counseling clinic which provides specialized services. When our ongoing clients are interested in psychiatric medication management, we work on a team philosophy in which clients receiving medications are also actively engaged in therapy with our staff at Serenity Now. At this time we are unable to see children under the age of 12 for medication management.

FIRST APPOINTMENT: Coming in for treatment for the first time to a new location can be intimidating for some. You will be meeting with one of our therapists on your first appointment to complete your initial evaluation. If appropriate, the therapist will make arrangements for you to be scheduled with one of our prescribers for medications at a later date. *You will not be prescribed medication on your initial evaluation at Serenity Now.*

If the client is a minor (under the age of 18) the legal guardian (parent, case worker or state appointed guardian) **MUST BE PRESENT FOR THE INITIAL APPOINTMENT** and at every medication appointment with Dr. Eckard or Carrie Long, PMHNP. If there is a custody arrangement, make sure to bring a copy of the custody papers.

If you have any mental health records, school records or psychological testing within the last five years, please obtain a copy and have them sent to our office. In order to provide the best mental health services it is crucial to obtain as much background information as possible. Please complete any needed Releases of Information so we may contact your referring resource.

ATTENDANCE: We have a strict policy in place on attendance. It is the policy of Serenity Now that failure to attend a scheduled appointment or failure to cancel a scheduled appointment more than 24 hours in advance, may result in a $25 fee. This fee will need to be paid prior to your next appointment. Three no-shows or late cancellations within a 6 month period will result in termination of services. If you miss your initial appointment we will not reschedule.

Thank you for considering us for your mental health needs.

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HOOSIER UPLANDS

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IMPORTANT INFORMATION REGARDING INSURANCE

It is your responsibility to check with your insurance carrier to ensure that our providers are within your network.

Please check with your insurance prior to your first appointment.

When sending in your intake packet, please provide us with a copy of the front and back of your insurance card. We will be happy to copy it for you when you drop off your intake packet, if you don't have access to a copier.

Our providers are as follows:

Dr. John Eckard- Psychiatrist

Carrie Long, PMHNP

Tom Trent, LCSW- Staff Therapist

Paralee Daggy, LCSW- Staff Therapist

Michael Dockery, LMFT- Staff Therapist

Charles "Randy" Bugh, LMHC, LCAC- Chemical Addictions Counselor and Staff Therapist

Cara Williams, LCSW- Staff Therapist

Kaitlin Pickett, LMHCA- Staff Therapist

Mary Miller, LMHCA- Staff Therapist

Haley Maranda, LMHCA- Staff Therapist

Brandy Terrell, LCSW- Staff Therapist

Serenity Now Patient Demographic Sheet

Name: _____ Date of Birth: _____
First Middle Last

Address: _____ Social Security Number: _____

City/State/Zip: _____ Primary Phone: _____

Sex: Male / Female Status: Single / Married / Widowed / Divorced

Email address: _____

Is this visit covered by your Employee Assistance Program (EAP): Y / N Authorization Number: _____

Emergency Contact

Name: _____ Phone: _____

Relationship: _____

Primary Insurance

Company: _____ Policy Number: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Policy Holder Address: _____ Policy Holder SS#: _____

City/State/Zip: _____ Relationship to Patient: _____

Secondary Insurance

Company: _____ Policy Number: _____

Policy Holder Name: _____ Policy Holder Date of Birth: _____

Policy Holder Address: _____ Policy Holder SS#: _____

City/State/Zip: _____ Relationship to Patient: _____

Financial Responsibility

Name: _____ Relationship: _____

Address: _____ Phone Number: _____

City/State/Zip: _____ Employer: _____

Coordination of Benefits

Primary Care Doctor: _____ Phone Number: _____

I give permission to Serenity Now Psychiatric and Counseling Services to contact my primary care provider to inform them that I am seeking treatment. This information will be limited to the Coordination of Benefits guidelines and will not include personal information disclosed during treatment without a Release of Information signed by myself/guardian/representative.

Signature: _____ Date: _____

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I understand the policies listed below and agree to them as a condition of receiving treatment at Serenity Now Psychiatric & Counseling Services:

- Failure to attend a scheduled appointment, or failure to cancel a scheduled appointment more than 24 hours in advance, may result in a **$25 fee.**
- This fee **must** be paid prior to the next scheduled appointment.
- **Three** no-shows or late cancellations within a 6 month period, may result in termination of services.
- In addition, more than **6** cancellations, reschedules, no-shows, and/or late cancellations within a 1 year time period, may result in termination of services.
- A late cancellation or now show with your therapist may also result in the cancellation of all future scheduled appointments at Serenity Now until you are seen by your therapist again.

- As a courtesy, Serenity Now will make reminder calls **1 Day** before the scheduled appointment. This call is only a courtesy to our clients. If you do not receive a reminder call, you are still responsible for attending your appointment or rescheduling no later than 24 hours before your appointment to avoid the no show or late cancelation fee.

- If you no show or late cancel an appointment, Serenity Now holds the right to **not** refill your prescription medication until your next appointment with your medication provider.

_____ _____

Client Signature Date

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CLIENT SELF-ASSESSMENT

The following questions will help us to know you and help in the planning of your care. Please answer all questions to the best of your ability. All information received is confidential.

Name_____ Age_____ Date of Birth___/___/___

If Child: Parents' Names: _____
Phone Numbers: _____

Custody_____ (please provide us with a copy of the custody papers)

I have contacted my insurance and my policy will cover the following providers:

☐ Dr. John Eckard	☐ Paralee Daggy, LCSW	☐ Tom Trent, LCSW
☐ Carrie Long, PMHNP	☐ Cara Williams, LCSW	☐ Michael Dockery, LMFT
☐ Kaitlin Pickett, LMHCA	☐ Mary Miller, LMHCA	☐ Haley Maranda, LMHCA
☐ Charles "Randy" Bugh, LMHC, LCAC		☐ Brandy Terrell, LCSW

Who referred you here?_____Today's Date ___/___/___

Presenting Problem and History of Present Illness:
Please tell us about the events that brought you here today:

_____

_____

_____

_____

When did the problem / symptoms start?: _____

_____

Was there anything that happened to bring on the problem or make it worse?:_____

_____

Have you tried anything to help the problem?:_____

What have you tried?: _____

Are you currently in treatment?: ☐Yes ☐No With whom?_____

What services are you seeking?:

☐ Individual Therapy ☐ Medication ☐ Family Therapy ☐ Group Therapy
☐ Couples Counseling (Please be aware that it is a requirement of treatment to be in therapy)

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If currently in treatment elsewhere, why are you wanting to seek services with us?:_____

Please check if you are having problems with any of these:

☐ Anger	☐ Appetite	☐Concentration	☐ Energy
☐ Hallucinations	☐ Mood	☐ Relationships	☐ Sleep
☐ Thinking	☐ Thoughts of hurting Self		☐ Thoughts of hurting others

Past Psychiatric Treatment:
Have you had counseling for this problem? If yes, when, with whom, and was it helpful?:

_____

_____

Have you taken medication for this problem? If yes, what, when, who prescribed it, and was it helpful?:

_____

_____

Medical History:
Illnesses: Please check any of the following that you have, or have had in the past.

Respiratory problems: ☐ Asthma ☐ Infectious Disease
Cardiovascular problems: ☐ Heart Murmur ☐ High Blood Pressure ☐ Low Blood Pressure ☐ Anemia ☐ Heart Attack ☐ Bypass Surgery
Neurological problems: ☐ Seizures ☐ Stroke ☐ Headaches ☐ Blackouts ☐ Head Injury With Loss of Consciousness ☐ Head Injury Without Loss of Consciousness ☐ Neuropathy
Endocrine problems: ☐ Diabetes ☐ Thyroid
Gastrointestinal problems: ☐ Reflux ☐ Gastritis/Ulcers ☐ Hepatitis
Weight change: ☐ Loss ☐ Gain Amount:_____ Length of time:_____
Musculoskeletal problems: ☐ Arthritis ☐ Fractures ☐ Sprains ☐ Back Pain ☐ Physical Limitations ☐ Degenerative Disk
Skin problems: ☐ Skin Problems ☐ Rash ☐ New Tattoo ☐ Burns ☐ Cuts ☐ Scars
Sleep problems: ☐ Sleep Apnea ☐ Restless Legs ☐ Snoring ☐ Daytime Fatigue ☐ Insomnia ☐ Problem Falling Asleep ☐ Interrupted Sleep

Hospitalizations: _____

Surgeries: _____

_____

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Are you experiencing any type of current or chronic pain?: ☐ Yes ☐ No

If Yes, Location?_____
How often does it occur?:_____ How long does it last?: _____
What relieves your pain?:_____
What makes your pain worse?: _____

Are you under pain management?: ☐ Yes ☐No
If yes, with whom?: _____

Allergies:_____

Reactions:_____

Who are your **Primary and/or Treating Doctor(s):** _____
_____

Current Medications: (include over the counter medications and nutritional supplements):

NAME	DOSAGE	HOW OFTEN	HOW LONG HAVE YOU TAKEN	PRESCRIBED BY

Language (optional- leave blank if you do not wish to answer)
My preferred language is: ☐ English ☐ Other (please specify) _____

Substance Use:

Substance Type	Current Use	Past Use
	Check All That Apply:	Check All That Apply:
Caffeine		
Tobacco/Cigarettes		
Over-the-Counter		
Alcohol		
Marijuana		
Heroin/Opiates		
Methamphetamine		
Sedatives		
Cocaine/Crack		
Hallucinogens		
Other_____		

Family History:
Please check if anyone in your family has had any of the following problems:

PROBLEMS:	WHO HAD PROBLEM:	PROBLEMS:	WHO HAD PROBLEM:
Anxiety		Blood Pressure	
Bipolar Disorder		Cancer	
Criminal Behavior		Diabetes	
Depression		Heart Attack	
Mental Illness Unknown		Seizure	
Schizophrenia		Stroke	
Substance Abuse		Thyroid troubles	
Suicide		Other	

Social History:
I was told I had the following problems in early growth or development:
☐ None ☐ Learning to walk ☐ Learning to talk ☐ Major childhood illness
☐ Problems in relationships with others ☐ Other (please explain)_____

I have been a victim of violence and/or abuse:
☐ None ☐ Childhood physical abuse ☐Childhood sexual abuse ☐ Childhood emotional abuse
☐ Rape ☐ Spouse abuse ☐ Other (please explain)

_____

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Education:
☐I did not finish high school ☐I graduated high school ☐I have a G.E.D.
☐I completed some college ☐I have a college/graduate degree in_____

Relationship Status:
I am: ☐ Single ☐ Married ☐ Separated from my spouse ☐ Widowed ☐ Divorced
☐ Currently in a relationship

My sexual orientation is: ☐ Heterosexual ☐ Homosexual ☐ Bisexual
☐ I have concern about my gender identity

I am currently living: ☐ Alone ☐ With spouse ☐ With parents ☐ With children ☐ With partner
☐ With friends/roommates ☐Other (please specify)_____

Race (optional- leave blank if you do not wish to answer)
I am: ☐ white ☐ black or African American ☐ Asian ☐ Native American or Native Alaskan
☐ Native Hawaiian or Pacific Islander ☐ multi-racial

Ethnicity (optional- leave blank if you do not wish to answer)
I am: ☐ not Hispanic/Latino ☐ Hispanic/Latino

Military Status:
☐None ☐Veteran ☐Presently in the military
Number of years/months served:_____ Type of discharge:_____
☐ Service connected disability (please explain)_____

Employment Status:
I am currently: ☐ Working as a _____
☐ Home maker ☐ Unemployed ☐ Disabled ☐ Student ☐ Retired

I have been fired or asked to resign from my job(s) in the past ☐Yes ☐No

Please explain:_____

I have/had legal problems in the past or present (criminal or civil) ☐Yes ☐No

Please explain: _____

I have contact with a Social Agency (Welfare, Social Security, Community Services) to get help for my family or myself: ☐Yes ☐No

Please explain:_____

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Client Rights and Responsibilities

As a client of Serenity Now Psychiatric and Counseling Services, you have certain rights while receiving services. It is important that you are knowledgeable and understanding of the services you will receive. This consent acknowledges your voluntary participation and your understanding of these client rights. As treatment begins, you will be asked to participate in the development of your treatment goals.

Client Rights

- To receive quality treatment from trained clinical professionals and to be treated with respect.
- To be free from abuse, neglect, financial or other exploitation, retaliation, or humiliation.
- To be provided with information about treatment options and their effectiveness
- To be given information about consent, refusal or expression of choice regarding services, release of information, service providers, and involvement in research projects if applicable.
- To receive services without regard to your race, color, spiritual belief, gender, sexual orientation, age, language, social and economic standing, or ethnic background.
- To refuse treatment.
- To be provided with information concerning side effects of medication that may be prescribed.
- To look at your medical record, upon approval of your treatment team, and a written request for copies.
- To your constitutional, statutory, and civil rights, except as denied or limited by a legal proceeding.
- To be treated in a setting that is most beneficial for your treatment.
- To tell staff or others if you have a complaint about a staff member or services without having to worry about the complaint affecting your treatment.
- To be involved in your treatment plan.
- To privacy during your appointment.
- To have information about you and the services you receive kept confidential, unless you give us permission or the law states we must share information with others.
- To obtain the names, qualifications and titles of the professionals providing your care.
- To be referred to legal entities and private practitioners of your choice at your own expense if requested.
- To be provided with information and/or referred to self-help and advocacy services.
- To be assured of adherence to research guidelines and ethics, if applicable.
- To be assured that alleged infringement of rights will be investigated and resolved in a timely manner.

Client Responsibilities

• To respectfully treat staff the same way you want them to treat you. • To come to your scheduled appointments on time, or call 24 hours before your appointment to cancel and reschedule. • To inform the staff of all information that will assist them in helping you.	• To follow your treatment plan and take your medications if they apply to your treatment plan. • If you attend group counseling or education sessions, keep any information others in the group share with you confidential. • To pay your share of the costs of your treatment and have your insurance billed.

Client Complaint Process

If you ever have a concern about your treatment, it is important that the concern be addressed as soon as possible. The following process will assure that your concerns are heard:

• Discuss the concern with your therapist and try to work it out with that person. • If you are still unsatisfied, contact the Director of Operations.	• The Director of Operations will hear your concerns and work to find a solution within 7 business days. • If you believe your concern has still not been addressed, a member of the Serenity Now leadership team will become involved and will help to reach a satisfactory resolution.

I acknowledge that I have received and reviewed these Client Rights and Responsibilities.

Client Signature _____ **Date** _____

Serenity Now Psychiatric & Counseling Services **CONDITION OF SERVICES**

A Division of Hoosier Uplands Economic Development Corporation

1. I, the undersigned, hereby consent to and authorize the administration and performance of all treatment and healthcare operations that, in the judgment of my physician/healthcare providers, may be considered necessary or advisable.

   I further consent to and authorize Serenity Now Psychiatric & Counseling Services, a Division of Hoosier Uplands Economic Development Corporation (hereinafter referred to as Serenity Now) to furnish or release to any insurance company, worker's compensation board, self-insured organization, mutual hospital associations and/or other covered entity and/or their representative, information from or copies of medical records pertaining to me, providing such company or entity is directly concerned in the payment or authorization of cost of my medical treatment.

2. **Medicare/Medicaid Claims:** Client's Certification, Authorization to Release Information and Payment Request: I certify that the information given by me applying for payment under Title XVIII or Title XIX of the Social Security Act is correct. I request that payment of authorized Medicare benefit be made either to me or on my behalf for any services furnished by Serenity Now including physician services. I authorize any holder of medical and/or other information about me to release to Center for Medicare and Medicaid Services and its agent any information needed to determine these benefits or benefits for related services.

3. **Assignment of Insurance Benefits:** I agree that any benefits of any type arising out of any policy of insurance for me, or any other party liable to me, are hereby assigned to Serenity Now or treating health care provider that renders services for which an assignment if applicable. I understand that I am financially responsible to Serenity Now or treating health care provider for charges not covered by this authorization.

4. **Financial Agreement:** The undersigned agrees, whether he/she signs as agent or as a client that in consideration of the services to be rendered to the client he/she hereby individually obligates himself/herself to pay the account of Serenity Now and treating health care provider in accordance with the regular rates and terms of said providers. Should the account be referred for collection, the undersigned shall pay reasonable attorney's fees and collection expenses. All delinquent accounts bear interest at the rate of eight percent (8%).

5. **Co-pays and Co-insurance:** The undersigned understands that all copays are due at the time of service. If the client has co-insurance, where the client is responsible for a percentage of the allowable charges, the undersigned agrees to make a payment at the time of service based on the estimated co-insurance for which the client will be responsible. If this estimate results in overpayment, the account balance will be credited for future visits. A refund will be applied upon request.

6. **HIPAA Notice of Privacy Practice:** The undersigned hereby acknowledges being advised of the HIPAA Notice of Privacy Practice of Serenity Now and has been offered a written copy of that document. If the undersigned does not accept a copy of the same at this point in time, he/she understands that he/she is bound by the terms of said Notice of Privacy Practice of Serenity Now and may request a copy at any time.

7. **Appointments:** That the undersigned understands that it is necessary for a treatment plan to be followed and a lack of compliance with the treatment plan or failure to attend, or, in the alternative to cancel more than 24 hours in advance 3 appointments within a 6-month period may result in termination of services. I further understand that I will be charged a fee of $25.00 for any missed appointments that are not cancelled more than 24 hours in advance. This charge will have to be paid in full prior to any future appointments being scheduled.

   As part of the treatment plan to be followed, drug screens may be required. If any drug screen is ordered, it shall take place within forty-eight (48) hours of the request, excluding Saturdays, Sundays and legal holidays.

   Serenity Now will notify the undersigned in the event there is termination of services and will provide names of other local providers.

8. **Current Information:** The undersigned agrees to provide current address and telephone number(s) and in the event these change, it shall be the responsibility of the undersigned to present that information to Serenity Now.

9. **Permission to Call:** That the undersigned further agrees that Serenity Now shall have the authority to call me at the telephone number(s) provided to remind me of appointments.

THE UNDERSIGNED CERTIFIES THAT HE/SHE HAS RAD THE FOREGOING, RECEIVING A COPYOR OFFERED A COPY THEREOF, AND IS THE PATIENT, OR IS DULY AUTHORIZED BY THE PATIENT AS PATIENT'S GENERAL AGENT TO EXCUTE THE ABOVE AND ACCEPTS ITS TERMS.

Client Signature:_____
(if client is a minor or unable to sign, the person who is taking the responsibility must sign below)
Responsible party:_____
Relationship:_____
Date:_____

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Consent for Release of Prescription History

I authorize Serenity Now to access my prescription history from unaffiliated medical providers, insurance companies, pharmacy benefit managers and the SureScripts database, to help keep my medical record as complete as possible. I understand that my prescription history from other sources may be viewable by the providers and staff within Serenity Now, and may include prescriptions dating back several years.

MY SIGNATURE CERTIFIES THAT I READ AND UNDERSTOOD THE SCOPE OF MY CONSENT AND THAT I AUTHORIZE THE ACCESS.

_____ _____

Printed Patient Name Date

_____

Signature

My preferred pharmacy is _____

Location:_____

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Information Release Form

Only for patients 18 yrs and older

(HIPAA Release Form)

Patient Name: _____ Date of Birth: ____/____/____

[ ] I give authorization for Serenity Now to release the specified protected health information to the following individual(s):

[ ] Spouse_____ Date of Birth____/____/____
- [ ] Appointment Information / Prescription Pick-Up
- [ ] Lab and Test Results
- [ ] Diagnosis and Treatment Information
- [ ] All Protected Health Information

[ ] Child_____ Date of Birth____/____/____
- [ ] Appointment Information / Prescription Pick-Up
- [ ] Lab and Test Results
- [ ] Diagnosis and Treatment Information
- [ ] All Protected Health Information

[ ] Other_____ Date of Birth____/____/____
- [ ] Appointment Information / Prescription Pick-Up
- [ ] Lab and Test Results
- [ ] Diagnosis and Treatment Information
- [ ] All Protected Health Information

_____ _____
Printed Patient Name Date

_____
Signature

Revised 1/18

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Controlled substance medications (i.e. Benzodiazepines, stimulants) are very useful, but have a high potential for misuse and are, therefore, closely controlled by local, state, and federal governments. In the event that I am prescribed a controlled substance medication, I agree to the following:

_____1. I am responsible for the controlled substance medications prescribed to me. If my prescription is misplaced, stolen, or if I increase the use of my medication without prior approval from the office, I understand that this medication may not be replaced regardless of the circumstances

_____2. I understand that many of these medications are intended for short term use as needed.

_____3. I agree to sign a release of information for my primary care physician and other pertinent prescribers.

_____3. I agree to report all medications being prescribed to me by other providers. I understand that failure to do so could result in discontinuation of controlled substance medication prescribing by Serenity Now and potential discharge from services.

_____4. I am solely responsible for taking the medication as prescribed and for keeping track of the remaining pills.

_____5. I understand that if I need refills, I must call ahead within 72 hours to schedule an appointment.

_____ 6. I agree to comply with random urine or oral drug testing and pill counts, thereby, documenting the proper use of any medications.

_____7. I understand that I may be called into the office at any time for a random drug test or random pill count as ordered by my prescribing medical provider.

_____8. I understand that if I violate any of the above conditions, my prescriptions for controlled medications may be terminated immediately. If the violation involves obtaining these medications from or for another individual, overdosing on the medication or in combination with the use of non-prescription illicit (illegal) drugs, I may also be reported to my primary care physician and other pertinent prescribers.

_____9. Understanding of the long term advantages and disadvantages of chronic benzodiazepine and stimulant use may change as a result of ongoing research. As a result, I understand that my treatment

may change at any time. I understand, accept, and agree that there may be unknown risks associated with the long term use of controlled substances.

_____10. I further understand that if I violate this controlled substance contract due to non-compliance of medical directions, including but not limited to, failure in taking medications as prescribed, utilizing other illicit drugs, or abuse of controlled medications, I may be subject to dismissal from this facility.

I understand that some individuals may develop a physical dependence and/or addiction to these medications. Stopping these medications too quickly can result in adverse reactions that could be potentially life threatening. Therefore, I agree to seek medical supervision before stopping any prescribed medications.

Patient Signature: _____Date:_____

Prescriber Signature: _____Date:_____

While on a controlled substance, patients are typically seen in the office every 1-3 months. The frequency will be determined at the discretion of the prescriber. Failure to attend scheduled appointments may result in discontinuation of the medication.

We do accept that these policies may produce some hardships for a few people. We ask only that you understand that it is our intention to practice evidence-based medicine in the safest and most efficacious manner possible while complying with all local, state, and federal regulations.

Patient Signature _____ Date _____

Prescribers Signature _____Date_____