

**Patient Demographic Sheet**

Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
          First                    Middle                    Last

Address: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Sex M/F Status: Single/Married/Widowed/Divorced Cell Phone: \_\_\_\_\_

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

**Emergency Contact**

Name: \_\_\_\_\_ Home Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

**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: \_\_\_\_\_ Date of Birth: \_\_\_\_\_  
          Write "Self" if same as Patient

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: \_\_\_\_\_



## Serenity Now Psychiatric & Counseling Services

(A Division of Hoosier Uplands Economic Development Corporation)

2125 16th St. Bedford IN. 47421

(812) 275-4053

The undersigned understands that it is the policy of Serenity Now Psychiatric & Counseling Services, 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 **must** be paid prior to the next scheduled appointment. More than three no-shows or late cancellations within a 6 month period, may result in termination of services.

As a courtesy, Serenity Now will make reminder calls 2 Days 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.

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Client Signature

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Date



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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

<ul style="list-style-type: none"><li>• To receive quality treatment from trained clinical professionals and to be treated with respect.</li><li>• To be free from abuse, neglect, financial or other exploitation, retaliation, or humiliation.</li><li>• To be provided with information about treatment options and their effectiveness</li><li>• 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.</li><li>• To receive services without regard to your race, color, spiritual belief, gender, sexual orientation, age, language, social and economic standing, or ethnic background.</li><li>• To refuse treatment.</li><li>• To be provided with information concerning side effects of medication that may be prescribed.</li><li>• To look at your medical record, upon approval of your treatment team, and a written request for copies.</li><li>• To your constitutional, statutory, and civil rights, except as denied or limited by a legal proceeding.</li></ul>	<ul style="list-style-type: none"><li>• To be treated in a setting that is most beneficial for your treatment.</li><li>• 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.</li><li>• To be involved in your treatment plan.</li><li>• To privacy during your appointment.</li><li>• 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.</li><li>• To obtain the names, qualifications and titles of the professionals providing your care.</li><li>• To be referred to legal entities and private practitioners of your choice at your own expense if requested.</li><li>• To be provided with information and/or referred to self-help and advocacy services.</li><li>• To be assured of adherence to research guidelines and ethics, if applicable.</li><li>• To be assured that alleged infringement of rights will be investigated and resolved in a timely manner.</li></ul>
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### Client Responsibilities



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- 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.

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**Client Signature**

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**Date**

**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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## 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:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Dr. John Eckard                  | <input type="checkbox"/> Cara Williams, LCSW    | <input type="checkbox"/> Tom Trent, LCSW       |
| <input type="checkbox"/> Paralee Daggy, LCSW              | <input type="checkbox"/> Kaitlin Pickett, LMHCA | <input type="checkbox"/> Michael Dockery, LMFT |
| <input type="checkbox"/> Charles "Randy" Bugh, LMHC, LCAC | <input type="checkbox"/> Carrie Long, PMHNP     |  |

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:

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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)

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



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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?:

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

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### **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





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## 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		Seizure	
Unknown			
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) \_\_\_\_\_

### 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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## **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-A- Staff Therapist

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

Cara Williams, LCSW- Staff Therapist

Kaitlin Pickett, LMHCA- Staff Therapist



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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.** 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.

Serenity Now Psychiatric and Counseling Services