Comprehensive Health Care PA

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Phone (713) 984-4546 Phone: (321) 355-7377 Fax (800) 930-4957

Patient Intake Form

Please provide the following information and answer the questions below. Please note that all information you provide here is protected as confidential information.

Patient Name:		**Parent Name: (in case under 18)**	
DOB		**Age**	
Gender		**Marital Status**	
Home Phone		**Cell Phone**	
Referred By		**Email**	
Home Address Full (as per insurance)			
Emergency Contact Name, phone number and Relationship			

Coordination Of Benefits					
Insurance Name					
Full Name		**Member ID**			
Does the patient have any secondary coverage?			**YES**		**NO**
Insurance Name		**Member ID**			

Pharmacy Information	
Name Of Pharmacy	
Address	
Phone Number	

Have you previously received any type of mental health services?	**YES**		**NO**	
If Yes, What is name of Therapist/Practitioner?				

Are you currently employed:	**YES**		**NO**	
If Yes, what is the current Employment situation?				

Are you currently experiencing anxiety, panic attacks, or any phobias?	**YES**		**NO**	
If yes, when did you begin Experiencing this?				

Are you currently experiencing any chronic pain?	YES		NO	
If yes, please describe				

Are you currently taking any prescription medication?	YES		NO	
If yes, Please Enlist.				

Have you ever been prescribed psychiatric medication?	YES		NO	
If yes, Please list and provide dates:				

What significant life changes or stressful events have you experienced recently?

- **GENERAL HEALTH AND MENTAL HEALTH INFORMATION:**

How would you rate your current physical health? Please check ✓the relevant box.									
Poor		Unsatisfactory		Satisfactory		Good		Very Good	
Please list any specific health problems you are currently experiencing.									

How would you rate your current sleeping habits? Please check ✓the relevant box.									
Poor		Unsatisfactory		Satisfactory		Good		Very Good	
Please list any specific sleep problems you are currently experiencing.									

Please list any difficulties you experience with your appetite or eating patterns:

Have You Ever Suffered From The Following? Please check ✓the relevant box.									
Diabetes		Arrhythmia		Fainting		Head Trauma		Seizures	

Have you ever suffered from drug use?	YES		NO	
	Current		Past	
If yes, Please list them				

Do you use any tobacco products?	YES		NO	
	Current		Past	
If yes, Please list them				

Patient Healthcare Questionnaire (PHQ-9)	Not at all	Several Days	More than half day	Nearly everyda
Little interest or pleasure in doing things				
Feeling down, depressed, or hopeless				
Trouble falling or staying asleep, or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as newspaper reading or watching TV.				
Moving or speaking so slowly that other people could have noticed. Or being so fidgety or restless that you have been moving around a lot more than usual.				
Thoughts that you would be better off dead. Or of hurting yourself				

Cancellation Policy

If you fail to cancel a scheduled appointment, we cannot use this time for another client and you will be billed for the entire cost of your missed appointment.

A full session fee is charged for missed appointments or cancellations with less than 24---hour notice unless it is due to illness or emergency. A bill will be mailed directly to all clients who do not show up for, or cancel an appointment.

Thank you for your consideration regarding this important matter.

Client Signature (Client's Parent/Guardian if under 18)		**Today's Date**

Notice of Privacy Practices Acknowledgement

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan, and direct my treatment and follow---up among the multiple Healthcare providers who may be involved in that treatment directly.
- Obtain payment from third---party payers.
- Conduct normal healthcare operations such as quality assessments and physician certification.

I have received, read, and understand your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at the address above to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or healthcare operations. I also understand that you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

Client Name	
Relationship To Client	
Signature	
Date	

AGREEMENT FOR PSYCHOTHERAPY/EVALUATION SERVICES

Consent To Treatment Or Evaluation: By signing below, you hereby give full consent for your child or yourself/yourselves to receive and treatment services of Comprehensive Health Care until we determine that services are no longer appropriate or will no longer be provided. You also certify that you have the legal authority to authorize and consent to this evaluation and/or treatment as parent(s), managing conservator, or guardian(s) of this child. You further certify that you have the legal authority to authorize and consent to this evaluation and/or treatment as parent(s), managing conservator, or guardian(s) of this child.

In case of a divorced or divorcing family, please indicate whether the child is subject to a court order (e.g., divorce decree):

Child is subject to a court order	
Child is NOT subject to a court order	

If the child is subject to a court order, I will need to see a full, true, and correct copy of that court order before meeting and working with the child.

Client's Parent/Guardian Printed Name	Client's Parent/Guardian Signature	Today's Date

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

The Health Insurance Portability & Accountability Act of 1996 ("HIPAA") is a federal program that requires that all medical records and other individually identifiable health information used or disclosed by us in any form, whether electronically, on paper, or orally, are kept properly confidential. This Act gives you, the client, significant new rights to understand and control how your health information is used. "HIPAA" provides penalties for covered entities that misuse personal information.

As required by "HIPAA", we have prepared this explanation of how we are required to maintain the privacy of your health information and how we may use and disclose your health information. We may use and disclose your medical records only for each of the following purposes: treatment, payment, and health care operations.

- Treatment means providing, coordinating, or managing health care and related services by one or more health care providers. An example of this would include a physical examination.
- Payment means such activities as obtaining reimbursement for services, confirming coverage, billing or collection activities, and utilization review. An example of this would be sending a bill for your visit to your insurance company for payment
- Health care operations include the business aspects of running our practice, such as conducting quality assessment and improvement of activities, auditing functions, cost---management analysis, and customer service. An example would be an internal quality assessment review.

We may also create and distribute de---identified health information by removing all references to individually identifiable information.

We may contact you to provide appointment reminders or information about treatment alternatives or other health---related benefits and services that may be of interest to you.

Any other uses and disclosures will be made only with your written authorization. You may revoke such authorization in writing and we are required to honor and abide by that written request, except to the extent that we have already taken actions relying on your authorization.

You have the following rights with respect to your protected health information, which you can exercise by presenting a written request to the Privacy Officer:

- The right to request restrictions on certain uses and disclosures of protected health information, including those related to disclosures to family members, other relatives, close personal friends, or any other person identified by you. We are, however, not required to agree to a requested restriction. If we do agree to a restriction, we must abide by it unless you agree in writing to remove it.
- The right to reasonable requests to receive confidential communications of protected health information from us by alternative means or at alternative locations.
- The right to inspect and copy your protected health information.
- The right to amend your protected health information.
- The right to receive an accounting of disclosures of protected health information.
- The right to obtain a paper copy of this notice from us upon request.

You have recourse if you feel that your privacy protections have been violated. You have the right to file a written complaint with our office, or with the Department of Health & Human Services, Office of Civil Rights, about violations of the provisions of this notice or the policies and procedures of our office. We will not retaliate against you for filing a complaint.

Please contact us for more information:
Dr. Riaz Rahman MD
Comprehensive Health Care
Phone: (713) 984-4546
Fax: (800) 930-4957

Scheduling Department .
David S **Phone: (281) 573-0369**