Affective Mental Wellness,
LLC Mental Health Intake

Dr. Sara L. Koenig, DNP, APRN, PMHNP-BC
Dallas Henson, MSN, PMHNP-BC
Michelle Murray, MSN, PMHNP-BC

This form must be filled out in its entirety. Incomplete forms will lead to the appointment being rescheduled. There are no exceptions.

Name_____ Date of Birth _____
Address_____
Phone Number_____ Email Address _____
Primary Insurance Provider and Member ID _____
Secondary Insurance Provider and Member ID _____

Do you give permission for ongoing/regular communication with your primary care/ counselor? Yes [ ] No [ ]
Primary Care Provider _____ Phone Number _____
Current Counselor _____ Phone Number _____

Who currently prescribes your psychiatric medication? _____
Why do you want to get medication from us instead?

_____
_____

1. What is the number one problem you are seeing the Nurse Practitioner for today, or your chief complaint?

_____
_____

2. What symptoms are you currently having?

__ Depressed mood	__ Racing Thoughts	__ Anxiety Attacks
__ Unable to enjoy activities	__ Impulsivity	__ Avoidance
__ Sleep disturbances	__ Increased Risky Behavior	__ Hallucinations
__ Loss of interest	__ Increased Libido	__ Suspiciousness
__ Concentration/Forgetfulness	__ Decreased need for sleep	__ Excessive worry
__ Excessive energy	__ Decreased Libido	__ Fatigue
__ Excessive guilt	__ Increased Irritability	__ Crying spells

3. Have you ever had feelings or thoughts that you didn't want to live? Yes [ ] No [ ]
If YES, please answer the following. If NO, skip and answer number 4.

Do you currently feel that you don't want to live? Yes [ ] No [ ]
Do you have a plan to kill yourself? Yes [ ] No [ ]
If YES, what is the plan?

_____
Have you ever tried to kill yourself before? Yes [ ] No [ ]
Have you ever harmed yourself without wanting to die? Yes [ ] No [ ]

4. Do you have access to guns? Yes [ ] No [ ]

5. Do you have any allergies to drugs/medication? Yes [ ] No [ ]
If YES, list here: _____

6. What is your current height? _____ What is your current weight: _____

7. Have you ever had an EKG, and if so, when? Yes [ ] No [ ] Date: _____
IF YES, was it: Normal [ ] Abnormal [ ]

8. Sexual Health History
Are you currently Sexually Active: Yes [ ] No [ ]
Do you have a history of STI/STD: Yes [ ] No [ ]
Do you have a history of HIV/AIDS: Yes [ ] No [ ]
In the past month, has your appetite been: __ Normal __Increase __ Decrease

In the past month, has your sleep been: __ Normal __Increase __ Decrease

For Men Only:
Date of last prostate exam: ___
Able to get and keep an erection: __ Yes __ No

For Females Only:
When was your last period? _____ What Birth Control do you use?: _____

Have you had a pap smear in the past year? Yes [ ] No [ ]
Have you had a mammogram? Yes [ ] No [ ]
Have you had a bone density test? Yes [ ] No [ ]
How many times have you been pregnant? ___
How many live children do you have? ___
How many abortions/miscarriages have you had? ___

9. Please list All medications currently being taken:

_____
_____
_____
_____
_____

10. Please list all current over the counter supplements currently being taken:

_____

11. What mental health diagnoses have you been informed of in the past?

_____
_____

11. Medical/Developmental/Family/Psychiatric/Social/Substance/Legal History

Do YOU have a history of:

[ ] Thyroid disease	[ ] Anemia	[ ] Anemia
[ ] Liver disease	[ ] Kidney disease	[ ] Diabetes
[ ] Asthma/Breathing problems	[ ] Stomach problems	[ ] Cancer
[ ] Heart disease	[ ] Epilepsy or seizures	[ ] Chronic pain
[ ] High cholesterol	[ ] High blood pressure	[ ] Head Trauma

[ ] Other _____
[ ] Surgeries _____

Does anyone in your FAMILY have a history of (list who):

[ ] Thyroid disease _____	[ ] Bipolar disorder_____
[ ] Liver disease_____	[ ] Depression_____
[ ] Diabetes_____	[ ] Anxiety_____
[ ] Schizophrenia_____	[ ] Cancer_____
[ ] Heart disease_____	[ ] Epilepsy or seizures_____
[ ] Chronic pain_____	[ ] High cholesterol_____
[ ] High blood pressure_____	[ ] Head Trauma_____

12. Have you ever spent time in jail or prison? Yes [ ] No [ ] Explain _____
Are you currently on probation/parole? Yes [ ] No [ ] Explain _____
Do you currently have an open CPS or APS case? Yes [ ] No [ ] Explain _____
Do you have any legal concerns? Yes [ ] No [ ] Explain _____

13. What is you current living situation (boarding home, group home, assisted living, independent…)

_____

Are you currently married or dating? Yes [ ] No [ ]
How many children do you have? _____

What is the highest grade in school you completed?

14. Have you previously been hospitalized for psychiatric illness? Yes [ ] No [ ]
Please list dates and reasons:

_____
_____
_____

15. Have you received outpatient treatment for psychiatric illness? Yes [ ] No [ ]
Please list dates and reasons:

_____
_____
_____

16. Please list ANY of the psychiatric medication you have tried in the past that have NOT worked for you, and how they made you feel:

_____
_____
_____
_____

17. Substance Use History:
In the past, have you received treatment for drug or alcohol use or abuse? Yes [ ] No [ ]
Please list dates and reasons:

_____
_____
_____

Do you currently use illicit/street drugs? Yes [ ] No [ ]
Yes [ ] No [ ]
Please list what, how much, and last use:

_____
_____
_____

Are you a current or past tobacco user? Yes [ ] No [ ]

Have you ever felt you should cut down on your drinking? Yes [ ] No [ ]
Have people annoyed you by criticizing your drinking? Yes [ ] No [ ]
Have you ever felt bad or guilty about your drinking? Yes [ ] No [ ]
Have you ever had a drink first thing in the morning to steady your nerves or get rid of a hangover (eye-opener)? Yes [ ] No [ ]

18. Trauma history
Were you adopted? Yes [ ] No [ ]
Do you have a history or being emotionally abused? Yes [ ] No [ ]
Do you have a history of being sexually abused? Yes [ ] No [ ]
Do you have a history of being physically abused? Yes [ ] No [ ]
Do you have a history of being neglected? Yes [ ] No [ ]

Please list dates and by whom:

_____
_____
_____

19. Is there anything you want the nurse practitioner to know today?

_____
_____
_____
_____

Informed Consent

Psychiatric health care, either in perrons or through telemedicine can involve the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include primary care practitioners, specialists, and/or subspecialists. The information may be used for diagnosis, therapy, follow/up and/or education, and may include any of the following: Patient medical records, medical images, Live two/way audio and video, Output data from medical devices and sound and video files.
Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

EXPECTED BENEFITS
Improved access to medical care by enabling a patient to remain in his/her office (or at a remote site) while the physician obtains test results and consults from healthcare practitioners at distant/other sites. More efficient medical evaluation and management. Obtaining expertise of a distant specialist.

POSSIBLE RISKS
As with any medical procedure, there are potential risks associated with the use of telemedicine. These risks include, but may not be limited to: In rare cases, information transmitted may not be sufficient (e.g. poor resolution of images) to allow for appropriate medical decision making by the physician and consultant(s); Delays in medical evaluation and treatment could occur due to deficiencies or failures of the equipment; In very rare instances, security protocols could fail, causing a breach of privacy of personal medical information; In rare cases, a lack of access to complete medical records may result in adverse drug interactions or allergic reaction or other judgment error.

BY SIGNING THIS FORM, I ATTEST TO AND UNDERSTAND THE FOLLOWING:

1. I understand that the laws that protect privacy and the confidentiality of medical information also apply to telemedicine, and that no information obtained in the use of telemedicine which identifies me will be disclosed to researchers or other entities without my consent,
2. I understand that I have the right to withhold or withdraw my consent to the use of telemedicine in the course of my care at any time, without affecting my right to future care or treatment,
3. I understand that I have the right to inspect all information obtained and recorded in the course of telemedicine interaction, and may receive copies of this information for a reasonable fee,
4. I understand that a variety of alternative methods of medical care may be available to me, and that I may choose one or more of these at any time. A representative Affective Metal Wellness, LLC has explained the alternatives to my satisfaction,
5. I understand that telemedicine may involve electronic communication of my personal medical information to other medical practitioners who may be located in other areas, including out of state.
6. I understand that it is my duty to inform Affective Mental Wellness, LLC of electronic interactions regarding my care that I may have with other healthcare providers.

7. I understand that I may expect the anticipated benefits from the use of telemedicine in my care, but that no results can be guaranteed or assured.
8. I attest that I am located in the state of Texas and will be present in the state of Texas during all telehealth encounters with Affective Mental Wellness, LLC.

PATIENT CONSENT TO THE USE OF TELEMEDICINE
I have read and understand the information provided above regarding telemedicine, have discussed it with my physician or such assistants as may be designated, and all of my questions have been answered to my satisfaction. I hereby give my informed consent for the use of telemedicine in my medical care.

I understand a copy of this form will be available for me to print.

Consent to Bill Insurance

I, the undersigned, hereby certify and attest that I have sought evaluation, treatment, or medical advice from the staff at the clinic named above. I therefore authorize the medical staff and personnel to release my or my minor child's medical information to the insurance company listed above for the purpose of determining and receiving benefits for medical bills. I understand and acknowledge that the medical staff will submit my claim to the insurance company on my behalf. I further understand that I will be held responsible for any amount of my medical bills not covered by my insurance policy or claims, and that I will be responsible for paying all deductibles, fees, co-payments, and co-insurance payments required. I understand that any portion of my medical bills not covered by insurance will be billed to me at the address I have provided above. Non-compliance or defaulting on payments may result in denial of service and/or a legal claim against me for non-payment.

Indemnification Clause
I agree to indemnify, defend, protect, and hold harmless the medical providers employed by Affective Mental Wellness, LLC and their respective officers, directors, employees, stockholders, assigns, successors and affiliates
(Indemnified Parties) from, against and in respect of all liabilities, losses, claims, damages, judgments, settlement payments, deficiencies, penalties, fines, interest and costs, expenses suffered, sustained, incurred or paid by the indemnified parties, in connection with, results from or arising out of, directly or indirectly, the medical providers employed by Affective Mental Wellness, LLC rendering medical care, services, advice, and/or treatment, my failure to disclose all relevant information regarding my medical and physical condition, acts or omissions, the medical providers employed by Affective Mental Wellness, LLC harm or injury resulting from medical care or pharmaceuticals provided directly or indirectly by the medical providers employed by Affective Mental Wellness, LLC;. I am aware of the potential side effects associated with ketamine therapy, accept all the risks involved in going through ketamine therapy, and will not seek indemnification or damages from the indemnified parties.

Privacy Policy

OUR LEGAL RESPONSIBILITIES

We are required by law to give you this notice. It provides you on how we may use and disclose protected health information about you and describes your rights and our obligations regarding the use and disclosure of that information. We shall maintain the privacy of protected health information and provide you with notice of our legal duties and privacy practices with respect to your protected health information.

We have the right to change these policies at any time. If we change our privacy policies, we will notify you of these changes immediately. This current policy is in effect unless stated otherwise. If the policy is changed, it will apply to all your current and past health information.

You may request a copy of our notice any time. You may contact Affective Mental Wellness, LLC at 705 Landa St. Suite E, New Braunfels, TX 78130 at any time to request a copy of this privacy policy.

HOW WE MAY USE OR DISCLOSE YOUR PROTECTED HEALTH INFORMATION

The following examples describe ways that we may use your protected health information for your treatment, payments, healthcare operations etc. but please be advised that not every use or disclosure in a particular category will be listed.

Treatment: We may use and disclose your protected health information to provide you treatment. This includes disclosing your protected health information to other medical providers, trainees, therapists, medical staff, and office staff that are involved in your health care.

For example, your medical provider might need to consult with another provider to coordinate your care. Also, the office staff may need to use and disclose your protected health information to other individuals outside of our office such as the pharmacy when a prescription is called in.

Payment: Your protected health information may also be used to obtain payment from an insurance company or another third party. This may include providing an insurance company your protected health information for a pre-authorization for a medication we prescribed.

Health Care Operations: We may use or disclose your protected health information in order to operate this medical practice. These activities include training students, reviewing cases with employees, utilizing your information to improve the quality of care, and contacting you by telephone, email, or text to remind you of your appointments.

If we have to share your protected health information to third party “business associates” such as a billing service, if so, we will have a written contract that contains terms that will protect the privacy of your protected health information. We may also use and disclose your protected health information for marketing activities. For example, we might send you a thank you card in the mail with a coupon for specialized services or products. We may also send you information about products or services that might be of interest to you. You can contact us at any point to stop receiving this information.

We will not use or disclose your protected health information for any purpose other than those identified in this policy without your specific, written Authorization. You may give us written authorization to use your protected health information or to disclose it to anyone for any purpose. You can revoke this authorization at any time but will not affect the protected health information that was shared while the authorization was in effect.

Appointment reminders: We may contact you as a reminder that you have an appointment for your initial visit, follow up visit, or lab work via text, phone or email.

Others Involved in Your Health Care: We may disclose protected health information about you to your family members or friends if we obtain your verbal agreement to do so, or if we give you an opportunity to object to such a disclosure and you do not raise an objection. For example, we may assume that if your spouse or friend is present during your evaluation, that we can disclose protected professional information to this person. If you are unable to agree or object to such a disclosure, we may disclose such information as necessary if we determine that it is in your best interest based on our professional judgment if there is an urgent or emergent need. In addition, we are a teaching facility. You may be seen or observed by a student during your session. You have the right to object to their presence during your session by verbal or written means at any time during your course of treatment.

Research: We will not use or disclose your health information for research purposes unless you give us authorization to do so.

Organ Donation: If you are an organ donor, we may release protected health information to organizations that handle organ procurement or organ, eye or tissue transplantation if it is necessary to facilitate this process.

Public Health Risks: We may disclose your protected health information, if necessary, in order to prevent or control disease, report adverse events from medications or products, prevent injury, disability or death. This information may be disclosed to healthcare systems, government agencies, or public health authorities. We may have to disclose your protected health information to the Food and Drug Administration to report adverse events, defects, problems, enable recalls etc. if required by FDA regulation.

Health Oversight Activities: We may disclose protected health information to health oversight agencies for audits, investigations, inspections or licensing purposes. These disclosures might be necessary for state and federal agencies to monitor healthcare systems and compliance with civil law.

Required by Law: We will disclose protected health information about you when required to do so by federal, state and/or local law.

Workman’s compensation: We may disclose your protected health information to workman’s comp or similar programs.

Lawsuits: We may disclose your protected health information in response to a court action, administrative action or a subpoena.

Law Enforcement: We may release protected health information to a law enforcement official in response to a court order, subpoena, warrant, subject to all applicable legal requirements.

YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION

Access to medical records: You have the right to access and receive copies of your protected health information that we use to make decisions about your care. You must submit a written request to obtain your protected health information to the individual listed at the end of this privacy policy. We reserve the right to charge you a fee for the time it takes to obtain and copy the protected health information and provide it to you.

Amendment: If you believe the protected health information, we have about you is incorrect or incomplete, you may ask us to amend the information You will need to submit a written request on why you feel the health information should be amended. We may deny your request to amend if you did not send a written request or give a reason on why it should be amended. If we deny your request, we will provide you a written explanation. We may deny your request if we believe the protected health information is accurate and complete.

Accounting of Disclosures: You have the right to receive a list of instances in which we disclosed your personal health information unless the disclosure was used for treatment, payment, healthcare operations, was pursuant to a valid authorization and as otherwise provided in applicable federal and state laws and regulations. You must submit a written request to obtain this "accounting of disclosures" to the individual listed at the bottom of this policy. After your request has been approved, we will provide you the dates of the disclosure, the name of the individual or entity we disclosed the information to, a description of the information that was disclosed, the reason why it was disclosed, and any additional pertinent information. This information may not be longer than the statue of limitations in the state of Texas prior to the date the accounting is requested. We reserve the right to charge a reasonable fee for this process.

Restriction Requests: You have the right to request a restriction or limitation on the protected health information we use or disclose about you for treatment, payment, or healthcare operations. We shall accommodate your request except where the disclosure is required by law. We require this be a written request submitted to the individual at the end of this policy.

Confidential Communication: You have the right to request that we communicate with you about healthcare matters in a certain way and at a certain location. We must accommodate your request if it is reasonable and allows us to continue to collect payments and bill you.

Paper copy of this notice: You may request a hard copy of this practice policy if you reviewed and signed it via electronic means. To obtain this copy, contact the individual at the end of this privacy policy.

Complaints: If you believe your privacy rights have been violated, you may file a complaint with our office. You also file a complaint with the U.S. Department of Health and Human Services. We will provide you with the address to file your complaint with the U.S. Department of Health and Human Services upon request.

Please sign and date indicating you have read and understand you're Patient Rights:

Patient signature: _____ Date: _____

Patient printed name:_____

Signature / printed name of legal representative (if patient is a minor child or has a legal guardian:_