WELCOME!

This is to confirm your appointment at our MK Plus office on

_____, _____ at_____ with
Day Date Time

_____.
Provider Name

Our office is located at:
31 Cambridge Lane
Suite A
Newtown, Pennsylvania 18940
(local landmarks include Citizen's Bank. We are located on the 2nd Floor)

Please do not hesitate to call us at **215-968-5151** should you require directions to our office. If you prefer, you can print directions from our website www.mkplusnewtown.com

Prior to your visit, please review and complete the enclosed information and bring it with you to your appointment. Feel free to call our office at 215-968-5151 should you have any questions on completion of the packet prior to your visit.

If for any reason you need to cancel or reschedule your intake appointment, we ask that you provide our staff with as much notice as possible. Please call our office 215-968-5151 and leave a message in our general mailbox and we will take care of notifying the provider.

We look forward to meeting you!

Name: _____ **Date**: _____

Address: _____ **Birthdate**: _____

_____ **Home phone #**: _____

Cell phone #: _____

PRESENTING CONCERN:

Please describe the main difficulty that has brought you to see me:

_____

_____

REFERRAL SOURCE:

Who referred you to our office? _____

Can we have your permission to thank them for the referral? _____

TREATMENT:

Have you ever received psychological, psychiatric, drug or alcohol treatment, or counseling services before?

(__) No (__) Yes If yes, please indicate:

When?	From whom?	For what?	With what results?

Have you ever taken medications for psychiatric or emotional problems?

(__) No (__) Yes If yes, please indicate:

When?	From whom?	Which medications?	For what?	With what results?

EDUCATIONAL TRAINING

Where? [School]	From when?	To When?	Accomplishments [Degrees, Special Classes]

EMPLOYMENT/MILITARY EXPERIENCE

Where?	From when?	To When?	Comments about the experience

RELATIONSHIPS IN YOUR FAMILY OF ORIGIN. Please describe the following:

Your parents' relationship with each other:

_____

_____

_____

Your relationship with each parent and with other adults present:

_____

_____

_____

Your parents' physical health problems, drug or alcohol use, and mental or emotional difficulties:

_____

_____

_____

Your relationship with your brothers and sisters, in the past and present:

_____

_____

_____

ABUSE HISTORY

(__) I was not abused in any way. (__) I was abused. If you were abused, please describe below:

Your age	Kind of Abuse	By whom?	Effects on you?	Whom did you tell?	Consequences of telling?

PRESENT RELATIONSHIPS

How do you get along with your present spouse or partner?_____ How do you get along with your children?_____ Your important friends, past and present:

Names	Good parts of relationship	Bad parts of relationship

CHEMICAL USE

Have you ever felt the need to cut down on your drinking? (__) No (__) Yes

Have you ever felt annoyed by criticism of your drinking? (__) No (__) Yes

Have you ever felt guilty about your drinking? (__) No (__) Yes

Have you ever taken a morning “eye-opener”? (__) No (__) Yes

How much beer, wine, or hard liquor do you consume each week, on the average? _____

Are there times when you drink to unconsciousness, or run out of money as a result of drinking? _____

How much tobacco do you smoke or chew each week? _____

Have you ever used inhalants (“huffing”), such as glue, gasoline, or paint thinner? (__) No (__) Yes If yes, which and when?

_____

Which drugs (not medications prescribed for you) have you used in the last 10 years? _____

_____

Please provide details about your use of these drugs or other chemicals, such as amounts, how often you used them, their effects and so forth _____

_____

Have you ever injected drugs? _____ Yes _____No

Ever shared needles? _____ Yes _____No

Have you had HIV testing in the last 6 months? _____ Yes _____No

If yes, results:

_____

At the present time, are there any other medical or physical problems you are concerned about?

_____

PAST MEDICAL HISTORY

Starting with your childhood up to the present, list all diseases, illnesses, important accidents and injuries, surgeries, hospitalization, periods of loss of consciousness, convulsions/seizures, and any other medical conditions you have had.

Age	Illness/diagnosis	Treatment Received	Treated by	Result

Describe any allergies you have.

To what?	Reaction you have	Allergy medications you take

List all medications, drugs or other substances you take or have taken in the last year—prescribed, over-the-counter vitamins, herbs and other

Medication/drug	Dose (how much)?	Taken for	Prescribed and supervised by

MEDICAL CAREGIVERS

Your current family or personal physician or medical agency:

Name	Specialty	Address	Phone #	Date of last visit

Other physicians treating you at present or in last five years:

Name	Specialty	Address	Phone #	Date of last visit

HEALTH HABITS

What kinds of physical exercise do you get?

How much coffee, cola, tea or other sources of caffeine do you consume each day?

Do you try to restrict your eating in any way? How? Why?

Do you have any problems getting enough sleep?

FOR WOMEN ONLY

At what age did you start to menstruate (get your period):

_____

Menstrual period experiences:

How regular are they? _____

How long do they last? _____

How much pain do you have? _____

How heavy are your periods? _____

Other experiences during periods? _____

Please list all of your pregnancies:

Your age	What happened with this pregnancy			Problems?
	Miscarriage	Abortion	Child born	

Is there anything else that is important for me as your therapist to know about, and that you have not written about on any of these forms? If yes, please tell me about it here or on another sheet of paper:_____

_____

PAYMENT POLICY

Two copies of this policy are being provided to you. Please review it carefully and sign one copy where indicated. Return the signed copy to our office at the time of your next appointment. The second copy is for you to retain for your reference.

Thank you for your cooperation.

MK Plus Behavioral Health Providers **do not** currently participate with any insurance plans.

MK Plus Behavioral Health services are provided on a payment-for-service basis.

All fees will be discussed and agreed to by you prior to the initiation of treatment.

Full payment is due at each visit and will be collected upon check-in for the appointment. Our office does not *bill* for any services rendered. The fee for these sessions with _____are _____.

For the convenience of our clients, our office accepts the following credit cards: Master Card, Visa, American Express and Discover.

For your convenience, our office will retain your credit card information in a locked and secure file for the duration of the treatment and charge for visits as they occur.

Upon payment, each client will be provided with a receipt. This receipt will be appropriate for submission to your insurance company should you be entitled to any reimbursement for services provided.

Our office requires 24 hours advance notification of any appointment that you wish to cancel and/or reschedule. If for any reason you need to cancel, please call our office at 215-968-5151 and leave us a message in our general mailbox. We will take care of notifying the provider. Out of courtesy to other clients waiting for appointments, please note that you will be charged for any appointment where you do not show up or you cancel the appointment less than 24 hours in advance.

Your signature below acknowledges receipt and understanding of the above payment policies.

_____ _____

Client Name (Please Print) Client Signature

_____

Date

(OFFICE COPY)

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_____ _____

Client Name (Please Print) Client Signature

_____

Date

(CLIENT COPY)

CREDIT CARD AUTHORIZATION

MKPlus requires that you provide your credit card to be retained on file in our secure electronic medical system. Please complete the information below and bring it with you to the next session. ***NOTE: No charges will be made to the credit card unless you request to use this card for payment of services, or in the event of the non-payment of services, missed session, or cancellations within 24 hours.***

This authorization will be good for a period of twelve (12) months. -You authorize these charges to your credit card and understand that you will be provided a receipt for anything charged to your card. A receipt for each payment will be mailed to you and the charge will appear on your statement as "MKPlus." MKPlus accepts Visa, MasterCard, American Express, and Discover cards for payment of fees.

PATIENT'S INFORMATION			
Patient's Last Name:	First Name:	Middle:	OP ID:

PAYMENT METHOD INFORMATON		
Name as it appears on the card:		
Street Address:		
City:	State:	ZIP:
Maximum Charge Amount: (Charges up to the Patient's individual annual deductible will be charged unless other amount is listed.)		
Please charge to the following:	**Credit card:** ☐ Visa ☐ MasterCard ☐ American Express ☐ Discover	**Other:** ☐ Health Savings Account ☐ Flexible Spending Account
Expiration Date: _____ / _____	Last 4 Digits of Card Number: (Must have card on hand in office to store securely) X X X X - X X X X - X X X X -	
Card holder's signature:		
Date:	Phone number:	

HIPAA Privacy Practices Acknowledgement Form

I have received the Notice of Privacy Practices for MK Plus and I have been provided an opportunity to review it.

Patient name: _____

Name of person reviewing the information (if someone other than patient)

_____ Relationship to patient: _____

Patient Date of Birth: _____

Signature: _____ _____

Patient or Patient Representative Date

Disclosure of My Personal Health Information

I request the following allowance for the disclosure of my health information:
(In addition to patient/patient representative please list any person(s) with which we may disclose/discuss patient information)

Name of Individual	Relationship to Patient (parent, sibling, relative, friend etc)

Messages on Answering Machine/Cell Phone/Email

Can we leave detailed messages on answering machine?	On your cell phone including text messages?
( ) Yes phone number ( )	( ) Yes phone number ( )
( ) No	( ) No

Can we email you appointment reminders? ( ) Yes ( ) No

Confirm correct Email address:_____

Authorization for Consent to Treat a Minor

I, _____, hereby authorize
Name of parent or legal guardian

_____ to bring my child _____

Name of person authorized to bring child to appointment Name of Child

to his/her appointments at MK Plus. The authorization shall be limited to the following time period: _____. If no time period is designated, this authorization shall terminate one year from today's date. I accept responsibility for all charges related to any medical treatment or hospitalization rendered by reason of this authorization.

Signature _____ Date _____