Achieve Whole Recovery
1115 Elkton Drive, Suite 300
Colorado Springs, CO 80907
Office: 719-373-9703 Fax: 877-588-3465

Adult Intake Form:

Name: _____ Birthdate: _____

Address: _____

Email: _____

Insurance Provider: _____

Member ID: _____ Group Number: _____

Relationship to the Insured Subscriber: _____

***The above information is true to the best of my knowledge. I authorize my insurance benefits be paid directly to the provider. I understand I am financially responsible for any balance. I authorize the release of any information required to process claims.**

Signature: _____ Date: _____

Best Phone to Contact you and leave a message: _____

Is it OK to leave a message at this number? Circle YES or NO

Primary Care Name, Address, and Phone Number: _____

_____

Therapist Name, Address, and Phone Number: _____

_____

Emergency Contact: Name: _____ Number: _____

May I share information with this person(s) about your mental health condition?

Circle YES or NO

Please <u>bring all medication bottles</u> including supplements to your first appointment. Also, if you have any lab work from the past 12 months, medical records you would like reviewed, Neuro-Psych Testing Results, ADHD Evaluations, MRI Results, etc. Please bring all of this with you to your intake appointment. Knowing the names and dosages of your current medications is <u>very important</u>.

Adult Intake/ Assessment Interview

Date:

Patient Name: _____ Birthdate: _____

ALLERGIES:

Medications

Please list any medications and dosages you are currently taking (please include over the counter medications, herbals and any nutritional supplements)

1. _____

2. _____

3. _____

4. _____

5. _____

PLEASE USE THE BACK OF THIS PAGE IF YOU NEED MORE ROOM FOR MEDICATIONS

Primary Care Provider: _____

PCP Phone Number: _____

Do you see any specialist: Yes/ No

Specialist Name: _____

Specialty: Phone: _____

What do you consider to be the top three stresses in your life?

1. _____

2. _____

3. _____

Mood *(past 1-2* weeks): Calm Happy Sad Anxious Angry Frustrated Worried Hopeless

Helpless Other: _____

Behavioral Symptoms *(circle problems in the past month):*

Sleep Enjoying Life Motivation Fatigue Guilt Poor Concentration

Appetite Change Impulsiveness Loss of Sex Drive Racing Thoughts

Can't Stop Talking Poor Judgment Strange Thoughts or Behavior

Periods of Very High Energy Periods of Very Low Energy

Mental Health History

1. Have you been in counseling or mental health treatment before?
   (For example: Counselor, Psychiatrist, Psychologist, Marriage/Family Counselor): *Yes / No*
2. Have you ever been hospitalized for mental or emotional problems?
   (For example: nervous breakdown, depression, suicide, mania, schizophrenia, anxiety, drug or alcohol problems, etc): *Yes / No*
3. Has anyone in your family had mental or emotional problems? (For example: nervous breakdown, depression, suicide, mania, drug or alcohol problems, etc): *Yes / No*
4. Have you ever been referred to Social Services? *Yes / No*

RISK ASSESSMENT (Check appropriate boxes):	No	Yes	Recently	Today
1. Been so distressed you seriously wished to end your life?	_____	_____	_____	_____
2. Have you had or do you have:				
a. A specific plan how you would kill yourself?	_____	_____	_____	_____
b. Access to weapons/means of hurting self?	_____	_____	_____	_____
c. Made a serious suicide attempt?	_____	_____	_____	_____
d. Purposely done something to hurt yourself?	_____	_____	_____	_____
e. Heard voices telling you to hurt yourself?	_____	_____	_____	_____
3. Had relatives who attempted or committed suicide?	_____	_____	_____	_____
4. Had thoughts of killing or seriously hurting someone?	_____	_____	_____	_____
5. Heard voices telling you to hurt others?	_____	_____	_____	_____
6. Hurt someone or destroyed property on purpose?	_____	_____	_____	_____
7. Slapped, kicked, punched someone with intent to harm?	_____	_____	_____	_____
8. Been arrested or detained for violent behavior?	_____	_____	_____	_____
9. Been to jail for any reason?	_____	_____	_____	_____
10. Been on probation for any reason?	_____	_____	_____	_____

Physical Symptoms: Circle any that were a problem for you in the last month:

Headaches	*Dizziness*	*Heart Pounding*	*Muscle Spasms*
Muscle Tension	*Sexual Problems*	*Diarrhea*	*Vision Changes*
Numbness	*Tics/Twitches*	*Fatigue*	*Fainting* *Blackouts*
Chest Pains	*Skin Problems*	*Nausea*	*Chills/Hot Flashes*
Sweating	*Rapid Heart Beat*	*Choking Sensations*	*Stomach Aches*
Shortness of Breath	*Trembling/Shaking*	*Mouth Muscle/Joint Pain*	

If Female: Are you on any form of birth control? Yes / No
Are you, or is there a chance you might be, pregnant? Yes / No
When was your last menstrual period? _____

Medical History: Check all that apply:

	Childhood	**Adult**	**Recently**
Serious Illnesses	_____	_____	_____
Serious Injuries	_____	_____	_____
Serious Head trauma	_____	_____	_____

1. Are you allergic to any medications or foods? _____If yes, please list: _____
_____

2. Do you currently have problems with pain? *Yes / No*
   If yes: Where is your pain located? _____
   How long have you had this pain problem? _____
   What things help your pain? _____
   How intense is your pain today? ***(none)*** *0 1 2 3 4 5 6 7 8 9 IO* ***(worst)***
   Do you ever take more pain medication than prescribed? Yes / No
   Are you currently being treated by another doctor for your pain? Yes / No
   If yes, who? _____

Nutrition:
Do you purge, restrict, or overeat? *Yes / No*
Have you had any difficulties or concerns related to food intake? *Yes / No*

Social History
1. Are your parents divorced? *Yes / No* If yes, how old were you? _____
2. Briefly describe your childhood *(happy, chaotic, troubled):* _____
_____
3. Are childhood events contributing to current problems? *Yes / No*
4. Current Marital Status: *Single Married Divorced Widowed Separated*
5. Number of Years Married: _____ Total Number of Marriages: _____
6. Do you have any children? *Yes / No* Ages? _____
7. Have you experienced any abuse (physical, sexual, verbal) *Yes / No*
8. How satisfied are you with your current family life? (circle one)
Very Unsatisfied Unsatisfied Satisfied Very Satisfied

Social Support
How satisfied are you with the support you receive from your family/Friends?
Very Unsatisfied Unsatisfied Satisfied Very Satisfied
Have your current difficulties affected your family/friends/coworkers? *Yes / No*

Quality of Life: Are you satisfied with your quality of life?
Very Unsatisfied Unsatisfied Satisfied Very Satisfied
What do you do for leisure? _____
Are you able to enjoy leisure/recreational activities? *Yes / No*
If no, why? _____

Education History: Years of education completed? _____ Degree(s) _____

Job History

1. How many jobs: Have you held? _____ Been fired from? _____
2. How satisfied are you with your current occupation?

Very Unsatisfied *Unsatisfied* *Satisfied* *Very Satisfied*

3. Do you have performance problems or difficulties with your boss? *Yes / No*

Alcohol Use: Do you or did you:	**In the Past**	**Recently**
1. Regularly use alcohol (more than twice per month)?	*Yes / No*	*Yes / No*
2. Had trouble (legal, work, family) because of alcohol?	*Yes / No*	*Yes / No*
3. Felt you should cut down on your drinking?	*Yes / No*	*Yes / No*
4. Been annoyed by people criticizing your drinking?	*Yes / No*	*Yes / No*
5. Felt bad or guilty about your drinking?	*Yes / No*	*Yes / No*
6. Ever had a drink first thing in the morning?	*Yes / No*	*Yes / No*

Other Substance Use/Abuse Do you or did you?	**In the Past**	**Recently**
1. Use medications (other than over the counter) that were not prescribed to you?	*Yes / No*	*Yes / No*
2. Taken more than the recommended daily dose of an over the counter medication?	*Yes / No*	*Yes / No*
3. Taken more than the prescribed dose of your prescription medication?	*Yes / No*	*Yes / No*
4. Taken or used any illegal substance?	*Yes / No*	*Yes / No*
5. Used any product or other means to get "high"?	*Yes / No*	*Yes / No*

Habits:	**In the Past**	**Recently**
1. Do you smoke or chew tobacco regularly?	*Yes / No*	*Yes / No*

2. How many caffeinated drinks do you have per day (coffee, tea, sodas)? _____

3. How often do you exercise per week? _____

Preferred Exercise: _____

4. Do you have problems with gambling?_____

5. Do you have other potentially harmful habits you want to change? _____

If so, what? _____

Goals for Treatment:

What are your goals for treatment? In other words, what things would you like to see change or be different about yourself? _____

_____

_____

Legal History:

Have you ever been arrested? _____

Do you have any pending legal problems? _____

Spiritual Life:

Do you belong to a particular religion or spiritual group? (Yes) (No)

If yes, what is the level of your involvement? _____

Do you find your involvement helpful during this illness, or does the involvement make things more difficult or stressful for you? ( ) more helpful ( ) stressful

Is there anything else that you would like us to know?

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Signature: _____ Date: _____

Guardian Signature(if under 18):_____ Date: _____

Emergency Contact: _____ Date: _____

Please review the following medications. Circle or check any of the medications you have ever taken, even if only once. I have tried to use the Brand name as well as the generic. I underlined some of the more commonly used mediations. If you do not see a medication you have taken, please write it in the margins. If you remember when you took these medications, the doses you used, and how well they worked, that would be helpful as well. Sometimes you can get a list from your previous provider or from the pharmacy where you filled the prescriptions.

Antipsychotics/neuroleptics/major tranquilizers/anti-Parkinsonians

Thorazine/
Mellaril/thioridazine
Trilafon/perphenazine
Stelazine/trifluoperazine
Prolixin/fluphenazine
Compazine/
Haldol/haloperidol
Orap/pimozide

Navane/thiothixene
Loxitane/loxapine

Newer Antipsychotics
Invega/paliperidone
Risperdal/risperidone
Clozaril/clozapine
Zyprexa/olanzapine

Seroquel/quetiapine
Geodon/ziprasidone
Abilify/aripiprazole
Vraylar/cariprazine

Artane/trihexyphenidyl
Cogentin/benztropine
Symmetrel/amantadine

Antidepressants/mood elevators

Elavil/amitriptyline
Pamelor/nortriptyline
Sinequan/doxepin
Tofranil/imipramine
Norpramin/desipramine
Limbitrol Symbyax
Anafranil/clomipramine
Desyrel/trazodone
Serzone/nefazodone

Newer Antidepressants
Prozac/fluoxetine
Zoloft/sertraline
Paxil/Pexeva/paroxetine
Luvox/fluvoxamine
Celexa/citalopram
Lexapro/escitalopram
Effexor/venlafaxine

Cymbalta/duloxetine
Wellbutrin//bupropion
Remeron/mirtazapine
Trintellix/vortioxetine

MAOIs
Nardil/phenelzine
Parnate/tranylcypromine
Emsam/selegiline

Mood stabilizers and anticonvulsants

Lithium/Eskalith/Lithobid
Depakote/valproic acid
Lamictal/lamotrigine

Tegretol/carbamazepine
Trileptal/oxcarbazepine
Neurontin/gabapentin

Lyrica/pregabalin
Topamax/topiramate

Anxiolytics/minor tranquilizers/sleeping pills

BuSpar/buspirone

Valium/diazepam
Librium/chlordiazepoxide
Tranxene/clorazepate
Serax/oxazepam
Ativan/lorazepam

Xanax/alprazolam
Klonopin/clonazepam
Dalmane/flurazepam
Restoril/temazepam
Halcion/triazolam
ProSom/estazolam

Ambien/zolpidem
Sonata/zaleplon
Lunesta/eszopiclone
Rozerem/ramelteon
Trazodone
Vistaril/hydroxyzine

Please review the following medications. Circle or check any of the medications you have ever taken, even if only once. I have tried to use the Brand name as well as the generic. I underlined some of the more commonly used mediations. If you do not see a medication you have taken, please write it in the margins. If you remember when you took these medications, the doses you used, and how well they worked, that would be helpful as well. Sometimes you can get a list from your previous provider or from the pharmacy where you filled the prescriptions.

Stimulants or medications for ADHD

Adderall/Adderall XR
Vyvanse
Strattera/atomoxetine
Ritalin/Concerta
Daytrana/
Focalin
Provigil/modafinil

Other psychoactive substances – prescription and nonprescription

Tobacco/nicotine products

Alcohol

Marijuana/grass/weed
Ecstasy/MDMA
LSD
Mescaline
Peyote
Psilocybin/mushrooms
DMT
STP
PCP
Amphetamines /speed/diet pills
Glue/other volatile inhalants
Heroin/other opiates
Quaaludes
Barbiturates
Other downers
Suboxone/ buprenorphine
Antabuse/disulfiram
Campral/acamprosate
Revia/Vivitrol/naltrexone

Aricept/donepezil
Exelon/rivastigmine
Namenda/memantine

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems? *(Use "✔" to indicate your answer)*	**Not at all**	**Several days**	**More than half the days**	**Nearly every day**
1. Little interest or pleasure in doing things	0	1	2	3
2. Feeling down, depressed, or hopeless	0	1	2	3
3. Trouble falling or staying asleep, or sleeping too much	0	1	2	3
4. Feeling tired or having little energy	0	1	2	3
5. Poor appetite or overeating	0	1	2	3
6. Feeling bad about yourself — or that you are a failure or have let yourself or your family down	0	1	2	3
7. Trouble concentrating on things, such as reading the newspaper or watching television	0	1	2	3
8. Moving or speaking so slowly that other people could have noticed? Or the opposite — being so fidgety or restless that you have been moving around a lot more than usual	0	1	2	3
9. Thoughts that you would be better off dead or of hurting yourself in some way	0	1	2	3

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	**Somewhat difficult**	**Very difficult**	**Extremely difficult**
☐	☐	☐	☐

Developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke and colleagues, with an educational grant from Pfizer Inc. No permission required to reproduce, translate, display or distribute.

Request for Medical Records
Authorization to Use and Disclose Health Information

Please send records to: Achieve Whole Recovery
FAX: 1-877-588-3465
1115 Elkton Dr, Suite 300, Colorado Springs, CO 80907
Any questions: 719-373-9703

Please fill this out for any offices, therapists, person(s) with whom we can communicate regarding your care and/or for request of records.

I, _____, authorize the following System of Care User Group Agencies,

individuals or programs as listed below to release Medical Records to Achieve Whole Recovery.

Patient's Name:
_____DOB:_____

Patient's Contact phone number:_____

1. **Medical Office/Health Professional Name:**_____

   Phone & Fax #:_____

2. **Medical Office/Health Professional Name:**_____

   Phone & Fax #:_____

3. **Medical Office/Health Professional Name:**_____

   Phone & Fax #:_____

4. **Medical Office/Health Professional Name:**_____

   Phone & Fax #:_____

5. **Person:**_____

   Relationship & Phone #:_____

6. **Person:**_____

   Relationship & Phone #_____

I understand that information disclosed may be written, verbal or electronic form and may include date(s) of contact, locations and reasons for contact, symptoms presented, treatment progress, outcome information, prescriptions, written referrals, educational records, medical records, tests performed, and/or diagnosis.

I understand that disclosure may include: psychological/psychiatric; medical; shelter and case management; and/or alcoholism, drug and/or alcohol abuse information. Information to be released may include information regarding the following.

I understand that the purpose of this information disclosure is to allow the participating entities (identified above) to access and use the information to establish and maintain continuity of care, better assess the effectiveness of the program, and/or to improve their services based on service utilization studies.

I understand that I may refuse to sign this authorization, and no one is conditioning treatment, payment, enrollment or eligibility for benefits on signing this authorization.

I understand that there is potential for information disclosed, as a result of this authorization, to be re-disclosed by the recipient and therefore no longer protected by the HIPAA Privacy Regulations. When applicable, an assessment of the minimum necessary amount of information required has been applied to this authorization.

I understand that I may revoke this authorization, at any time, by giving written notice to the authorized System of Care User Group agencies or programs, except to the extent that action has already been taken to comply with it. Without such revocation this authorization will expire on, or if left blank, one year from my signature date.

I understand that I am entitled to a copy of this authorization.

Patient's Printed Name : _____

Guardian Printed Name: _____

Guardian/Patient Signature (******patient must sign if 12 years of age or older****): __X_____

Guardian Relationship to Patient:_____

Date: _____

ACHIEVE WHOLE RECOVERY INFORMED CONSENT FORM

ACHIEVE WHOLE RECOVERY
1115 Elkton Drive, suite 300
Colorado Springs, CO 80907

Patient Last Name: _____ First: _____ DOB: _____ Date: _____

Fees: All payments for services are due at the time of service.
Cash pay rates are as follows:

- First general psychiatry appointment-$350
- Follow-up Psychiatry Appointment: $125
- **Phone calls**: Brief phone calls (usually less than 5 minutes) to cover issues such as scheduling appointments, reactions to new medications, returning my phone call to you, etc., will not be billed. Extended phone calls or multiple phone calls may be billed an average of $300/hour, and this will be discussed with the patient on a case by case basis.
- **Reports, Consultations, and Other Special Documentation:** In the rare circumstance that my services are needed to prepare specific reports or documentation beyond a routine office appointment, the rate will be $300/hour. These services, if needed, will be fully discussed with the patient prior to the service being provided.
- **Cancelled appointments with less than 24-hour notice and no-shows will be billed to you at the full rate of the scheduled visit. This includes the first appointment and you may be asked to provide credit information to hold your first appointment.**

Cancellation policy: Appointments must be cancelled with at least a 24-hour notice. Cancellations made less than 24 hours or missed appointments without notice ("no-shows") will be billed at the full rate of the scheduled visit. Late arrivals (at least 5 minutes past the time of the scheduled appointment) will be billed at the full rate without extending the scheduled appointment, and another appointment may be required to complete the service.

Past Due Accounts: Payment is due at time of service. Accepted methods of payment include cash, check, credit card, and debit card. There will be a $25 additional charge on all returned checks added to the full-service fee plus any bank charges. Failure to make payment will result in late fees and possible suspension or termination of treatment. Accounts receivable more than 90 days will be assessed a $25 billing fee per month starting with the first month. Past due accounts may be referred to collections and will include the amount owed plus reasonable attorney fees and court costs.

Collaboration of Care with Other Providers: Communication with other care providers, including your family doctor, therapist, or other clinicians is strongly recommended for the best possible treatment outcome. Please provide their contact information and your consent to communicate with them. Only essential and pertinent medical information will be shared with your providers in accordance with privacy laws. Please talk to me about any concerns.

Important health information for females – Pregnancy: All medications pose some danger to the fetus or breast-feeding child. If you are pregnant, feel you may be pregnant, decide to become pregnant, or no longer practice regular birth control, you must notify me as soon as possible so that we can discuss this in advance of a pregnancy. Waiting until you are pregnant may unnecessarily expose the fetus to dangerous medication. Sometimes, the risks of not treating mental illness are greater than the risks of the medication, but treatment will still only be with the consent of the patient, and you will be asked to sign a written consent stating that you understand the risks before treatment is given.

Expectation of Treatment Compliance: Repeated cancelled appointments, at least 2 no-shows/cancellations under 24 hours, or not adhering to the treatment plan such as not taking medication as prescribed or not following through with therapeutic recommendations will disrupt the plan for treatment. If it becomes evident that there is a recurrent pattern of these issues, the first step will be to discuss solutions to see if this is something that can be worked through. If the issues persist after this step, it will be recommended that you seek care with another provider.

Abuse of Prescription Medications: Abuse or misuse of medication prescribed by Achieve Whole Recovery to you will not be tolerated. This not only includes taking more medication than prescribed or recommended, but also selling your medication to others, obtaining duplicate prescriptions for controlled substances without our consent, using Narcotics while taking your prescribed medication with our knowledge, or buying prescription medication "off the street." At a minimum, if this occurs you will be requested to seek care with another provider, but there may also be risk of legal consequences. Controlled substances will be monitored via the Prescription Drug Monitoring Program.

Photo Copies and Electronic Signatures: A photocopy of any signed form will be considered as an original copy. An electronic signature will be considered the same as a signature by hand.

Doctor's Absences and After-Hours Calls: Our administrative assistant will list any upcoming vacations or other absences to help you in planning follow-up appointments or medication refills. Phone calls will be returned within 24 hours except when the office is closed. As noted above, brief telephone calls are not charged, however repeated phone calls and extended calls may result in fees. After-hours calls are managed by a call-service, and messages left by patients forwarded the next business day. Our staff will respond to all messages by phone call within that business day. If your call is of an emergent nature ANYTIME, please go to your nearest emergency room or call emergency services (911). **Please do not delay medical care by waiting for our return call. Delays in response can be beyond our control.**

Medication and Refills: If you are taking medication, you agree to take medication only as prescribed and not to ingest any alcohol or illicit drugs. Medication refills should be called into your pharmacy at least five days before running out. Refill requests made on weekends or holidays might not be accommodated until the office reopens during the normal business week. You are responsible for monitoring your supply. After a prescription has already been written and sent to a pharmacy, it may take up to 24 hours to change the pharmacy location if you request your prescription to be sent to a new site.

Privacy, Confidentiality and Safety: Personal information shared with us during our sessions is confidential and not shared with anyone without a signed release of information, except under specific legal and safety concerns as defined by laws. If there is an indication of child abuse, risk of danger to self, or risk of danger to others, we are legally bound to report the concerns to the appropriate authorities. As noted above, communication with your other care providers including your family doctor, therapist, or other clinicians is strongly recommended for the best possible treatment outcome. Please provide their contact information and your consent to communicate with them. Only essential and pertinent medical information will be shared with your providers in accordance with privacy laws. Your signed consent is necessary for us to be able to communicate with them.

Consent for Treatment

I consent to and authorize the attending physician, physician's assistant, and/or nurse practitioner to perform healthcare examinations, treatment, and diagnostic testing as deemed medically necessary in their professional judgment.

1. I have read and understand my responsibilities as outlined by the policies of Achieve Whole Recovery's office as outlined on www.achievewholerecovery.com.
2. I acknowledge receipt of the HIPAA Notice of Privacy Practices.
3. I have read and understand the above information.
4. I agree to the terms of the office payment and cancellation policies

_____ _____

PATIENT SIGNATURE (if Patient is 12 YEARS OR OLDER) DATE

_____ _____

Parent/Guardian Signature (**if patient is UNDER 18 YEARS OLD, Parent/Guardian MUST also SIGN.) DATE

Client Rights and Responsibilities

At Achieve Whole Recovery we are concerned that each patient entrusted to our care is treated with dignity, respect, and compassion. We recognize that all patients have basic rights, and we are committed to honoring those rights. Likewise, Achieve Whole Recovery has a right to expect reasonable and responsible behavior from patients, their relatives, and friends. The following is a summary of rights and responsibilities that we believe serve as a foundation for a good relationship between patients and staff.

- Patients should be treated courteously, with respect, dignity and regard for your privacy.
- Have personal identifiable data and medical information kept confidential.
- Be given information on treatment options that is easy to understand.
- Take part in decisions made about personal health care, including the right to refuse treatment, except when required by law. When refusal of treatment by you or your legal representative prevents the provision of appropriate care in accordance with professional standards, our relationship with you may be terminated upon reasonable notice.
- Be free from any forms of restraint or seclusion used as a means of coercion, discipline, convenience or retaliation.
- Ask for and receive a copy of personal medical records. Request any necessary changes or corrections.
- Be provided culturally competent services.
- Be supported with interpreter services for the deaf/hard of hearing, when English is not the primary language or for other disabilities requiring assistance.
- Communicate complaints and receive instructions on how to use the complaint process, including the standards for timeliness, to respond to and resolve issues of quality and complaints.
- You have the right to obtain, from the practitioners responsible for your care, complete and current information about diagnosis, treatment, alternatives, risks, and known prognosis. This information should be communicated in terms you understand.
- You are responsible for being considerate of the rights of other patients and clinic staff. You are responsible for being respectful of the property of others and of the clinic. You understand that any abusive or disrespectful behavior could result in your dismissal from Achieve Whole Recovery.
- You are responsible for following rules and regulations that apply to clients at Achieve Whole Recovery.
- You are responsible for following the treatment plan recommended by the practitioner primarily responsible for your care. This may include following the instructions of health staff as they carry out your plan of care.
- You are responsible for keeping appointments and for notifying Achieve Whole Recovery when you are unable to do so. To cancel or reschedule an appointment, call 719-373-9703.
- Achieve Whole Recovery is not responsible for cash, valuables, and personal items you bring to the clinic. This includes eyeglasses, hearing aids, dentures, canes, prostheses, wheelchairs, and other easily misplaced items.

PATIENT NAME: _____ DOB: _____

APPOINTMENT REMINDER AUTHORIZATION FORM

Achieve Whole Recovery

Please indicate below which way(s) you would like to be reminded:

EMAIL: Gives the most information about your appointment and you can confirm. 1 week before

I authorize Achieve Whole Recovery to send Appointment Reminders electronically via Email to the following email address.

EMAIL ADDRESS (please print clearly): _____

TEXT MESSAGE: You can confirm your appointment. 2 days before

I authorize Achieve Whole Recovery to send Appointment Reminders electronically via text message to my mobile phone. I understand that this service is offered free of charge. However, standard text messaging rates from my mobile carrier may apply. Please activate text message reminders for the patient/mobile phone number:

MOBILE #: _____ MOBILE CARRIER: _____

VOICE MESSAGE: You can confirm your appointment. 1 day before

I authorize Achieve Whole Recovery to contact me for Appointment Reminders via voice messaging. If I am unavailable to answer the telephone, I give Achieve Whole Recovery permission to leave a message on my answering machine or with the person answering the telephone.

TELEPHONE #: _____

PLEASE NOTE**: If you miss OR cancel an appointment in LESS THAN 24 hours, you will incur a $350 fee for an INITIAL appointment or $125 fee for a Follow-up appointment.

(Circle One) YES or NO Achieve Whole Recovery may contact me at work to reschedule appointments or confirm existing appointments.

WORK TELEPHONE#_____

Patient Signature: __X_____ Date: _____

OR Parent/Legal Guardian Signature: __X_____ Date: _____

Informed Consent to Photograph

Achieve Whole Recovery
1115 Elkton Drive Suite 300
Colorado Springs, CO 80907
Phone: 719-373-9703

Your signature below indicates that you give Achieve Whole Recovery permission to photograph you and that you understand the following:

1. I may terminate this permission to use my photograph at any time.
2. This picture is confidential and the information will not be shared outside the context of this practice.
3. The picture will be stored on our secure Electronic Health Record.

_____ _____
PATIENT Name DOB

_____ _____
Patient Signature OR Parent/Guardian Signature (if patient is LESS THAN 18 years old) Date

_____
Parent/Guardian PRINTED Name

TELEMED Consent Form

Achieve Whole Recovery

Patient Name: _____ DOB : _____

1. I understand that my health care provider wishes me to engage in a telemedicine consultation.
2. My health care provider has explained to me how the video conferencing technology will be used to affect such a consultation will not be the same as a direct patient/health care provider visit due to the fact that I will not be in the same room as my health care provider.
3. I understand there are potential risks to this technology, including interruptions, unauthorized access and technical difficulties. I understand that my health care provider or I can discontinue the telemedicine consult/visit if it is felt that the videoconferencing connections are not adequate for the situation.
4. I understand that my healthcare information may be shared with other individuals for scheduling and billing purposes. Others may also be present during the consultation other than my health care provider and consulting health care provider in order to operate the video equipment. The above mentioned people will all maintain confidentiality of the information obtained. I further understand that I will be informed of their presence in the consultation and thus will have the right to request the following: (1) omit specific details of my medical history/physical examination that are personally sensitive to me; (2) ask non-medical personnel to leave the telemedicine examination room: and or (3) terminate the consultation at any time.
5. I have had the alternatives to a telemedicine consultation explained to me, and in choosing to participate in a telemedicine consultation. I understand that some parts of the exam involving physical tests may be conducted by individuals at my location at the direction of the consulting health care provider.
6. In an emergent consultation, I understand that the responsibility of the telemedicine consulting specialist is to advise my local practitioner and that the specialist's responsibility will conclude upon the termination of the video conference connection.
7. I understand that billing will occur from both my practitioner and as a facility fee from the site from which I am presented.
8. I have had a direct conversation with my doctor, during which I had the opportunity to ask questions in regard to this procedure. My questions have been answered and the risks, benefits and any practical alternatives have been discussed with me in a language in which I understand.

By signing this form, I certify:

- That I have read or had this form read and/or had this form explained to me
- That I fully understand its contents including the risks and benefits of the procedure(s).
- That I have been given ample opportunity to ask questions and that any questions have been answered to my satisfaction.

X _____ _____

Patient's Signature (if Patient is 15 YEARS OR OLDER) Date

_____ _____

Parent/Gueardian Signature (if patient is UNDER 18 YEARS OLD) Date

_____

Parent/Guardian PRINTED Name

CREDIT CARD AUTHORIZATION

In order to provide you the best possible care, A MINIMUM OF 24 HOURS NOTICE IS REQUIRED TO CANCEL OR RESCHEDULE your appointments. For example, cancel by 2pm 24 hours in advance for a 2pm appointment on the following day. Cancellation must occur via phone call or email.

I, _____, understand the importance of notifying the staff of Achieve Whole Recovery at least 24 hours prior to my scheduled appointment that I am not able to keep my appointment. If I am experiencing an emergency, I will provide as much notice as possible to avoid being charged the LATE CANCELLATION FEE of $350 for an INITIAL appointment or $125 for a Follow-up appointment. I understand that I will be charged a NO SHOW FEE of $350 for an INITIAL appointment or $125 or a follow-up appointment if I fail to call and fail to show for my scheduled appointment. These fees will be charged automatically to my credit card as they occur. This form provides my permission to charge my credit card when a No Show or Late Cancellation occurs.

I will be provided a receipt for all payments upon request. This card may also be used for payment of services upon my request (co-payment, deductibles, and fees). In addition, these fees must be paid before you can schedule a new appointment.

I understand that I may revoke this agreement at any time by providing a request in writing. I am also aware that when psychological services rendered by Achieve Whole Recovery or their associates end, this form shall be considered void.

I am consenting that this card be used for payment of services (co-pay and fees)____Yes

Name on Card_____

Card Number_____

Expiration Date_____

3 digit code_____Street Address_____Zip Code_____

Email address for receipt_____

Patient Name (printed)_____

Patient/Card Holder Signature:

_____ Date_____