Emergency Information

Client's Last Name: _____ First Name: _____ MI: _____

Birthdate: _____ Age: _____ Gender: ☐ F ☐ M Race: _____

Email address: _____

In case of emergency, contact:

Name (1): _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Name (2): _____ Relationship: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

Other Physician: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

READMISSION INTAKE FORM

Oakland Psychological Clinics

Please complete the following information:

Client's Last Name: _____ First Name: _____ M.I.: _____

Birthdate: ___/___/_____ Age: _____

Please list any changes in the following areas that have occurred since your last visit to Oakland Psychological Clinic:

☐ Yes ☐ No Family Relationships / Marital Status (divorce, marriage, etc.): _____

☐ Yes ☐ No Education (graduation, change in grade, etc.): _____

☐ Yes ☐ No Employment (new or lost job, layoff, etc.): _____

☐ Yes ☐ No Health Status (new medical condition, sickness, etc.): _____

☐ Yes ☐ No Financial Status (bankruptcy, etc.): _____

☐ Yes ☐ No Legal Status (arrest, conviction, lawsuit): _____

☐ Yes ☐ No Alcohol and/or Drug Use (starting, stopping, change in amount used): _____

_____

☐ Yes ☐ No Other: _____

Previous Therapist: _____ Current Therapist: _____

Please state the reason you are currently seeking services at Oakland Psychological Clinics:

_____

What areas of your life are being affected by the above?

Social
- ☐ unable to form or maintain friendships
- ☐ withdrawal from family and friends
- ☐ increased conflict with others
- ☐ loss of interest in social activities
- ☐ phobias

Occupational
- ☐ unable to maintain job
- ☐ absenteeism
- ☐ tardiness
- ☐ reduced productivity
- ☐ disciplinary action for poor performance

Academic
- ☐ failing grades
- ☐ truancy
- ☐ tardiness
- ☐ detention
- ☐ reduced productivity at school

Physical
- ☐ decreased energy/fatigue
- ☐ difficulty getting out of bed
- ☐ decreased appetite
- ☐ substantial weight gain or loss
- ☐ stress related illness (headaches, etc.)

Affective Distress
- ☐ crying spells
- ☐ anger/rage
- ☐ disorganized thoughts
- ☐ feeling overwhelmed with emotions

Risk Assessment
- ☐ suicidality
- ☐ homicidality
- ☐ drug/alcohol use
- ☐ unprotected sex
- ☐ cutting/self-mutilation

Have you received any other therapy, counseling or psychiatric services since you last attended Oakland Psychological Clinics? ☐ Yes ☐ No
If yes, please provide information pertaining to the type of services, when, where and with whom: _____

Please list any past or current medications, dosages, and the prescribing physician:

_____ _____
Client Signature Date

_____ _____
Parent/Guardian Signature Date

_____ _____
Therapist Signature Date

_____ _____
Medical Staff Signature & Credentials Date

MEDICATION LIST and RECONCILIATION

Must be reviewed and updated at least every 3 months according to review by the patient

Patient Name: _____ DOB: _____

Medical Marijuana Card: ☐ Yes ☐ No Reason for using medical marijuana:

Name and address of physician:

Medication Name Include: Prescriptions, OTC, Supplements/Herbal	**Strength**	**Frequency** ex: 3x's/day; 1@bed; 2 in am; etc.	**Prescribing Physician**	**Start Date**	**Reason for Use**	**Discontd Date**	**Date Reconciled / Staff Initials**

In order to coordinate your care and avoid medication interactions, it is important that you list the names/addresses of all prescribing physicians and their specialties (e.g., neurologist, cardiologist, etc.)

Name of Physician	Address & Phone Number	Type of Specialty

Notice to Patients:

In an effort to improve our customer service to you, we have automated our appointment reminder calls. We will call and/or text the phone number listed in your account. We identify ourselves as "OPC" in that message and on caller ID.

If you do not want to receive reminder calls, please advise us.

Please select the method you prefer and include the phone number to receive your appointment reminders

☐ Voice/Text: _____
(1 day/2 days prior)

☐ E-mail: _____
(3 days prior)

☐ Do not confirm my appointments.

NOTE: Please be sure to respond to your reminder message. If you do not respond, a second and possibly third message will be generated. Thanks.

Please speak with the manager if you have any concerns.

Patient Printed Name: _____

_____ _____

Signature Date

Dear Client/Guarantor:

Oakland Psychological Clinics, like many other healthcare offices, implemented a credit card on file policy. You will be asked for a credit card number at the time of your first appointment. It can only be a credit card, NOT A DEBIT CARD that requires a PIN. Cards must be run as credit. The information will be held securely to be used to pay balances on your account, such as deductibles, copays, insurance rejections and no show/late cancellation fees. Payment is due at the time services are rendered.

This will be an advantage to you, since you will no longer have to remember to bring your payment with you at each session. It will be an advantage to us as well, since it will greatly decrease the number of statements that we have to generate and mail. This will be a benefit to everyone in helping to keep the cost of healthcare down.

This in no way will compromise your ability to dispute a charge or question your insurance company regarding how they processed your claim.

If you choose not to participate, you must maintain a zero account balance. If you make a payment with cash, debit or check on the day of your appointment your credit card will not be charged. All insurance rejections and no show/late cancellation fees will be charged to your credit card within 30 days if you have an unpaid balance on the account.

If you have any questions, please do not hesitate to speak with clinic management. We are working diligently to be stewards of all resources and attempting to keep your costs to a minimum.

Sincerely,

OAKLAND PSYCHOLOGICAL CLINICS

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Client Name: _____ Date: _____

Date of Birth: _____ Case Number: _____
(for office use only)

Name of the Person who is Responsible for Payment: _____

Relationship to Client: _____

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☐ I AUTHORIZE Oakland Psychological Clinics to charge outstanding balances on my account to the following credit card:

☐ VISA ☐ MASTERCARD ☐ AMEX

Account Number: _____ Exp Date: _____ Security Code: _____

Name on Card (please print): _____

Billing Address: _____

Signature: _____ Date: _____

Witness: _____ Date: _____

☐ Please send me a credit card receipt when my credit card has been charged.

☐ I DO NOT authorize Oakland Psychological Clinics to charge my credit card. I understand that payment must be made in full at each session and that I must maintain a zero balance on the account.

Oakland Psychological Clinic **Orientation Checklist**

Identifying Information

Name: _____ Case Number: _____

Clinician: _____ Admit Date: ___/___/___

Program: □ Adult □ Child/Adolescent □ Family □ Marital □ Substance Abuse

Support Staff

□ Program Description

□ Code of Ethics

□ Insurance/Payment Responsibilities

□ Recipient Rights

□ Child Immunization Record (Clients under 18 years of age)

□ Copy of Consent to Treatment form Offered

Clinical Staff

□ Overview of Individual Plan Development (including transition/discharge criteria)

□ Reviewed Consent to Treatment form including:

- □ Program Rule/Regulations
- □ Non-Voluntary Discharge
  - □ Appeal Process
  - □ Readmission Policies
- □ Cancellation/Returned Check Policies
- □ Client must contact insurance regarding Referrals made for services not provided Clinic (MD, lab, etc.)

My signature indicates orientation to my individual program

Signed: _____ Date: ___/___/___

Witness: _____ Date: ___/___/___

Parents are expected to wait for their minor children in the waiting room.