Omega Health Services
Adult Intake (18 yrs and older)

Welcome to our office. We would like to take this opportunity to say thank you for choosing us for your behavioral health needs. We look forward to providing you with personalized, comprehensive care.

Our office hours are generally Monday through Thursday 9:00 am to 5:00 pm and Friday 9:00 am to 3:00 pm. We also are open for our after-hours, walk-in clinic on Mondays and Thursdays from 5:00 pm to 8:00 pm. These hours may vary during the holidays. Any change in the schedule will be posted in advance on our door for each individual holiday.

Our office policy requires payment at the time of service. The following page lists our current fees so that you may plan accordingly. We do accept many insurances; however, ***we advise you to contact your insurance carrier to verify we are in-network with your specific plan prior to your visit and to verify your 'out-patient mental health' benefits, as they are often different than your general medical benefits. Your insurance company may also require authorization to be initiated by the patient and your visit may not be covered if you have not done this prior to your appointment.***

Again, thank you for choosing our office for your behavioral health needs. Please do not hesitate to contact us with any questions that you may have.

5985 W State Street, Boise, ID 83703
Phone: (208) 853-0071 Fax: (208) 853-9422

Omega Health Services

Below is a list of our basic fees. These fees may vary based on the time spent and the type of services required. If you have any questions regarding specific fees, please contact our billing department. If billing insurance, your fees will be based on the insurance companies negotiated rates and will never be more than our basic fees. Please note, we exhaust every effort to verify eligibility and network status prior to your appointments, and while our providers contract with many insurance plans and networks, we may not be contracted with yours. Omega will give you a 'good faith estimate' at each appointment based on the information we obtain while verifying your benefits.

Initial Visit/Psychiatric Evaluation	$330.00 to $550.00
Established Pt Follow-up	$165.00 to $465.00
Initial Visit w/Therapist	$270.00
Individual Therapy w/ Therapist—16-37 mins	$150.00
Individual Therapy w/Therapist—38-52 mins	$185.00
Individual Therapy w/Therapist—53 + mins	$265.00
Family Therapy w/Therapist—with or without pt	$200.00 to $210.00
Injection (each)	$45.00
Urine Drug Screen	$25.00
EKG/ECG	$35.00
Blood Draw (Venipuncture)	$24.50
Court Appearance (**prepayment required)**	$300.00/hr
Report or Letter Preparation	$10.00 to $30.00
After Hours non-urgent calls	$10.00/call
Returned Checks	$25.00/incident
Missed Appts	100% of appt fee
Late Cancelled Appts	50% of appt fee

Please sign below to acknowledge reviewing our fees:

Signature:_____ Date:_____

Patient Information

First Name | Middle Initial | Last Name | Nickname/AKA

Date of Birth | Social Security Number | Gender: ☐ Male ☐ Female | Preferred Pronouns

Marital Status ☐ Single ☐ Married ☐ Divorced ☐ Life Partner ☐ Separated ☐ Widowed ☐ Other

Home Address: | Apt # | City | State | Zip

Home Phone #: | Cell Phone #: | Email:

Preferred Contact? ☐ Home ☐ Cell | Preferred Appt Reminder? ☐ Home ☐ Cell ☐ Email

Name of employer: | Employer Phone:

Responsible Party (Guarantor) Information

Relationship to Patient: ☐ Self (If Self, skip to Insurance Information) ☐ Spouse ☐ Patent ☐ Other

First Name | Middle Initial | Last Name

Date of Birth | Social Security Number

Home Address (if different): | Apt # | City | State | Zip

Home Phone #: | Cell Phone #: | Email:

Insurance Information

Please note that if you do not have your insurance card, you may be responsible for your bill in full.

***Primary Insurance Company name and address:**

Subscriber Name | Date of Birth: | SSN

Relationship to Patient | Policy #: | Group #:

***Secondary Insurance Company name and address:**

Subscriber Name | Date of Birth: | SSN

Relationship to Patient | Policy #: | Group #:

Emergency/Next of Kin Contact Information

Nearest Relative not residing with patient (First and Last Name)

Relationship to Patient | Home Phone #: | Cell Phone #:

Preferred Pharmacy and Location:_____

How Did You Hear About Our Office:

☐ Self-Referred ☐ Internet/Website ☐ Insurance Company

☐ Friend/Family ☐ Other Provider/Facility:_____

Name and Phone

*I hereby consent to treatment by providers at this office. I hereby authorize this office to release to my insurance company any information concerning illness and treatment necessary to expedite insurance payment. I understand that I am ultimately responsible for all charges, regardless of insurance coverage.

Patient/Parent/Guardian Signature: _____ **DATE:** _____

PLEASE UTILIZE
OUR PORTAL FOR:

MANAGING YOUR OWN APPOINTMENTS:

You can schedule, cancel, and verify your own appointment.

MANAGING YOUR MEDICATION AND CARE:

You can request refills, send messages to your provider to clarify directions or ask questions, and access visit summaries.

PLEASE FILL OUT THE FOLLOWING TO ACCESS THE PORTAL:

Do you wish to sign up for our online patient portal? Yes No
*If yes, you will need to give us your e-mail address to receive the invitation. (Circle One)

E-mail:_____

Office and Financial Policy

Please carefully read and initial each statement.

1. Be aware that Omega strictly adheres to the State of Idaho's regulations concerning controlled substances and will not be able to fill these early for any circumstance. Also, be aware that we regularly check the Board of Pharmacy and will be notified if you seek controlled substances elsewhere. We require only 48-72 hour notice on controlled substance prescriptions. We will also require random Urine Drug Screens for any patients receiving controlled substances. **Any requests made prior to a maximum of 3 days early may be cause for termination of care by our office, regardless of the reason for the early request, without exception.** _____

2. I understand that the staff at Omega adheres to the rules and policies of the company and will try their best to help with any situation. I understand that any abusive or aggressive treatment or language directed at staff or providers may be grounds for termination. _____

3. **I understand that if I 'no show' I will be charged 100% of my scheduled appointment time. I understand that if I 'late cancel' (cancel without 24 hr notice), I will be charged 50% of my scheduled appointment time. I understand that this fee is *NOT* covered by insurance. I also understand that if my account receives more than three missed appointments that my services may be terminated, and my care referred elsewhere, without exception.** _____

4. **I understand that arriving late for my appointment may be considered a 'late cancelation', and in some cases a 'no show', depending on when you show. Anything over half of the appointment time, your provider may not be able to see you, and there could be a charge for the missed appointment.** _____

5. I understand that if I request a personal copy of my records that **there is a charge for this service**. _____

6. **I understand that co-payments and patient portions are due at the time of service and are dictated by the insurance companies.** Failing to collect this payment is a violation of our agreement with your insurance company. Additionally, any patient balance that reaches 60 days will be assessed a 1.5% interest rate compounded monthly. Also, any patient balances that reach 60 days or over without contact or payment will be automatically transferred to collections and care will be terminated. _____

7. I understand that I am ultimately responsible for my bill, regardless of insurance status. I understand that it is my responsibility to contact my insurance company to verify benefits, provider contracting status, and authorization for treatment guidelines prior to my appointment. **Although our providers do contract with many insurance plans, they may not be contracted with yours.** _____

8. I understand that if I request forms to be filled out without an appointment, there is a fee for this service, and that fee depends on the length of time it takes my provider to complete the forms. I also understand that **I must follow up as directed and keep my account current or Omega will be unable to complete my forms.** _____

9. I understand that calling the afterhours answering service for **non-urgent issues such as routine prescription refills and scheduling questions** may result in a fee being assessed to my account. I also understand that **excessive calling may result in a charge on my account**, and the charge is at the discretion of my provider. _____

10. **I understand that if the patient is a child or adolescent, I am solely responsible for the account regardless of divorce or custody.** It will be my responsibility to seek reimbursement from any other parties involved. _____

I give my consent to the office of Omega Mental Health to fax labs/medication prescriptions to the pharmacy or lab of my choice. I have read, understood, and agree with all the above-listed consents and disclosures. Please know that **regardless of signature/initials on this page that all office policies will still be enforced**.

For:_____

Print Patient Name DOB

_____

Signature of Patient/Parent/Guardian

OMEGA MENTAL HEALTH

NOTIFICATION AND AUTHORIZATION OF CHARGE

Please carefully read, initial, and sign.

1. I am aware that, per office policy, any appointments that are cancelled late (without 24-hour notice) will incur a fee of 50% of the allotted scheduled time. I am aware that, per office policy, any appointment deemed a 'no show/no call' will incur a fee of 100% of the allotted scheduled time. I am also aware that if I incur a 'late cancellation' or 'no show' charge on my account that the credit card information listed below will be charged for this fee the day of the scheduled appointment. If there is a discrepancy with the charge made, and it is found to be an error, the amount charged will be refunded._____

2. I am aware that my account must be current at all times. If my account is not current and is scheduled for collections, and I have failed to return phone calls or respond to billing statements, I authorize the balance to be charged to the card listed below, in order to safeguard my credit._____

Visa MasterCard Amex Discover (circle one)

Account Number:_____
Expiration Date:_____
Zip Code:_____
Security Code:_____

Signature:_____
Card member/account holder acknowledges terms and conditions and agrees to perform the obligations set forth by this agreement with the issuer.

Patient Controlled Substance Agreement

I, _____, understand and voluntarily agree that (initial each statement after reviewing):

_____I will keep (and be on time for) all my scheduled appointments with my provider.

_____I will keep the medicine safe, secure, and out of the reach of children. If the medicine is lost or stolen, I understand it will not be replaced until my next appointment and may not be replaced at all.

_____I will take my medication as instructed and not change the way I take it without first talking to my provider.

_____I will not call between appointments, or at night, or on the weekends looking for refills. I understand that prescriptions will be filled only during scheduled office visits with my provider.

_____I understand that cannot refill my prescription early, for any reason, no exception. That by requesting a refill early can be cause for my treatment to be terminated.

_____I will make sure I have an appointment for refills. If I am having trouble making an appointment, I will tell a member of the office staff immediately.

_____I will always treat the staff at the office respectfully. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

_____I will not sell this medicine or share it with others and that doing so will result in my treatment being stopped.

_____I will sign a release form to let my provider speak to all other doctors or providers that I see.

_____I will tell my provider all other medicines that I take and let him/her know right away if I have a prescription for a new medicine.

_____I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me.

_____I understand that my prescriptions are tracked by the State of Idaho, and my provider will be monitoring this closely.

_____I understand that I may lose my right to treatment in this office if I break any part of this agreement.

_____I will not get any opioid pain medicines or other medicines that can be addictive such as benzodiazepines (i.e. klonopin, xanax, valium) or stimulants (i.e. Ritalin, Adderall, amphetamine) without telling a member of the treatment team **before I fill that prescription**.

I will use only one pharmacy to get all on my medicines: _____

Pharmacy name/location

_____ _____ _____

Patient signature | Patient name printed | Date

OMEGA HEALTH SERVICES

Authorization for Communication of Protected Health Information to Family Members and Friends

Patient Name:_____

Date of Birth:_____

1. I authorize Omega Mental Health to discuss/share protected health information about me with the following individual(s) who are involved in my care:

THIS IS NOT FOR OTHER PROVIDERS INVOLVED IN YOUR CARE, THIS IS FOR FAMILY/FRIENDS ONLY

Name:	Relationship:	Phone No:
Name:	Relationship:	Phone No:
Name:	Relationship:	Phone No:

2. Type of information to be shared or disclosed:
   - ☐ Appointment Information
   - ☐ Prescription Information
   - ☐ ALL Information

3. I authorize Omega Mental Health to leave detailed phone messages about my medical and health plan information with the following:
   - ☐ Voicemail
   - ☐ Person Answering

This authorization shall remain in effect until revoked in writing by the patient.
Submitting a new form will revoke existing form.

X_____

Signature of patient/authorized individual (minors aged 14 or older must sign this form themselves) Date

DSM-5 Self-Rated Level 1 Cross-Cutting Symptom Measure—Adult

Name: _____ **Age:** _____ **Sex:** _____ **Date:**_____ **MRN #:** _____

If this questionnaire is completed by an informant, **what is your relationship with the individual?** _____
In a typical week, approximately how much time do you spend with the individual? _____ **hours/week**

Instructions: The questions below ask about things that might have bothered you. For each question, select the answer that best describes how much (or how often) you have been bothered by each problem during the **past TWO (2) WEEKS**.

	During the past **TWO (2) WEEKS**, how much (or how often) have you been bothered by the following problems?	**None** Not at all	**Slight** Rare, less than a day or two	**Mild** Several days	**Moderate** More than half the days	**Severe** Nearly every day	**Highest Domain Score** (clinician)
I.	1. Little interest or pleasure in doing things?	○	○	○	○	○	
	2. Feeling down, depressed, or hopeless?	○	○	○	○	○	
II.	3. Feeling more irritated, grouchy, or angry than usual?	○	○	○	○	○	
III.	4. Sleeping less than usual, but still have a lot of energy?	○	○	○	○	○	
	5. Starting lots more projects than usual or doing more risky things than usual?	○	○	○	○	○	
IV.	6. Feeling nervous, anxious, frightened, worried, or on edge?	○	○	○	○	○	
	7. Feeling panic or being frightened?	○	○	○	○	○	
	8. Avoiding situations that make you anxious?	○	○	○	○	○	
V.	9. Unexplained aches and pains (e.g., head, back, joints, abdomen, legs)?	○	○	○	○	○	
	10. Feeling that your illnesses are not being taken seriously enough?	○	○	○	○	○	
VI.	11. Thoughts of actually hurting yourself?	○	○	○	○	○	
VII.	12. Hearing things other people couldn't hear, such as voices even when no one was around?	○	○	○	○	○	
	13. Feeling that someone could hear your thoughts, or that you could hear what another person was thinking?	○	○	○	○	○	
VIII.	14. Problems with sleep that affected your sleep quality over all?	○	○	○	○	○	
IX.	15. Problems with memory (e.g., learning new information) or with location (e.g., finding your way home)?	○	○	○	○	○	
X.	16. Unpleasant thoughts, urges, or images that repeatedly enter your mind?	○	○	○	○	○	
	17. Feeling driven to perform certain behaviors or mental acts over and over again?	○	○	○	○	○	
XI.	18. Feeling detached or distant from yourself, your body, your physical surroundings, or your memories?	○	○	○	○	○	
XII.	19. Not knowing who you really are or what you want out of life?	○	○	○	○	○	
	20. Not feeling close to other people or enjoying your relationships with them?	○	○	○	○	○	
XIII.	21. Drinking at least 4 drinks of any kind of alcohol in a single day?	○	○	○	○	○	
	22. Smoking any cigarettes, a cigar, or pipe, or using snuff or chewing tobacco?	○	○	○	○	○	
	23. Using any of the following medicines ON YOUR OWN, that is, without a doctor's prescription, in greater amounts or longer than prescribed [e.g., painkillers (like Vicodin), stimulants (like Ritalin or Adderall), sedatives or tranquilizers (like sleeping pills or Valium), or drugs like marijuana, cocaine or crack, club drugs (like ecstasy), hallucinogens (like LSD), heroin, inhalants or solvents (like glue), or methamphetamine (like speed)]?	○	○	○	○	○	

Today's Date _____

Health History

Patient Name _____ Age _____ Birth date _____

Occupation _____Last Physical Examination Date _____

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Are you allergic to any medications? If yes, please list them.

Have you or any member of your family been diagnosed with any of the following conditions? List affected family member, if applicable.

	Self	Family	Date
Abnormal Electrocardiogram	_____	_____	_____
Cancer-where and what type	_____	_____	_____
Cataracts/Glaucoma	_____	_____	_____
Colon or Bowel Trouble	_____	_____	_____
Diabetes	_____	_____	_____
Epilepsy	_____	_____	_____
Heart Murmur as Adult	_____	_____	_____
Heart Attack	_____	_____	_____
High Blood Pressure	_____	_____	_____
Kidney Disease	_____	_____	_____
Kidney Stones	_____	_____	_____
Liver disease	_____	_____	_____
Lung disease	_____	_____	_____
Nervous system disorder	_____	_____	_____
Poor Blood Clotting	_____	_____	_____
Skin Condition	_____	_____	_____
Stomach or Duodenal Ulcer	_____	_____	_____
Sexually Transmitted Disease	_____	_____	_____
Thyroid Disorder	_____	_____	_____
MEN			
Prostate Problems	_____	_____	_____
WOMEN			
Menstrual Difficulties	_____	_____	_____
Cystitis	_____	_____	_____
Ovarian Cyst	_____	_____	_____
Other Gynecological Problems	_____	_____	_____
Still Menstruating? Yes/No	_____	NA	_____

Age period started _____ Age period stopped _____ Number of pregnancies _____

Number of children _____ Number of miscarriages _____

Is there any chance you may be pregnant?

Hospitalization's and Dates:

ADULT INTAKE QUESTIONNAIRE

Please be thorough but be ***brief*** with your responses when possible. Please respond to every item for complete accuracy.

Patient Name:_____ DOB:_____Today's Date:_____

Please ***briefly*** describe the reason for your visit or your current problem(s):

PAST PSYCHIATRIC HISTORY:

How old were you when you first encountered mental health services and what compelled your referral or involvement at that time?

Please list what, if any, ***psychiatric medications you have taken in the past:*** None:_____

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Please list your ***current psychiatric medications*** (by name and amount taken each day): None:_____

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Have you been ***hospitalized for psychiatric*** reasons? □Yes □No
How many times: _____

When(age, grade or date is fine) were you first ***psychiatrically hospitalized*** and ***why***?

When most recently and why?

Have you any past suicide attempts? □Yes □No How many times: _____

If yes, ***by what method?***

If you have attempted suicide more than once, ***how old were you when first attempted, and when last?***

SAFETY ISSUES:

Do you have access to any of the following?
_____Large quantities of medications
_____Firearms or other weapons: (list which types)_____

Do you have any other safety issue we should know about? _____

_____

FAMILY HISTORY:

Do any members of your immediate or extended family have psychiatric illness? If so, can you name the diagnoses?

Have there been any completed suicides in your family? If so, who and when?

MEDICAL HISTORY:

List any surgeries you've had:

List any chronic medical illness you know you have (i.e. asthma, arthritis, diabetes, high blood pressure, etc.):

List any ***non-psychiatric*** medications you are currently taking for medical problems:

_____
_____
_____

Have you any known allergies to medications/which?

PSYCHOSOCIAL HISTORY:

Born where (State)? _____Raised by biological parents or otherwise?_____

If raised by your biological parents, are they separated/divorced, approximately how old were you?_____

Childhood: OK?_____ Not OK?_____ If not, briefly state why?

Spiritual/Faith/Religious preference?_____

History of having been physically/emotionally/mentally abused: □Yes □No
If yes, briefly explain over what age period & by whom:

History of having been sexually abused: □Yes □No
If yes, briefly explain over what age period & by whom:

DRUG/ALCOHOL HISTORY:
Drug or Alcohol Use? □Yes □No
Which Substances:

If so, beginning ***approximately*** when (at what age or grade in school)?

Have you ever been in substance abuse treatment? □Yes □No
If yes, outpatient or inpatient and at what age?_____

TOBACCO HISTORY:
Never Smoked:_____

Current Smoker: □Yes □No

If yes, please answer the following:
How often?
_____Some Days
_____Every Day

How much?
_____Less than one pack per day _____One pack per day
_____Two packs per day _____More than two packs per day

Former Smoker: □Yes □No
How long ago did you quit:_____
How often did you smoke?
_____Some Days
_____Every Day

How much did you smoke?
_____Less than one pack per day _____One pack per day
_____Two packs per day _____More than two packs per day

LEGAL HISTORY:
Please describe any legal problems you have or have had:

EDUCATIONAL HISTORY:
High School Graduate: □Yes □No Last Grade Attended: _____
If no, GED: □Yes □No
Special Ed: □Yes □No
College: □Yes □No Degree?_____

EMPLOYMENT HISTORY:
Employed now? □Yes □No
If no, year last employed?_____
Past types of employment/work performed:

ADULT RELATIONSHIPS:
Check all that apply:
□Single □Divorced □Widowed □Significant Other □Married □Remarried

If divorced and remarried, at what age and how many times?

How many children have you?

With whom do you live, and how are you supported at present?

For Office Use Only
Diagnosis:_____

_____

Initial Tx:_____

_____

Omega Health Services

Acknowledgment of receipt of Notice of Privacy Practices:

You may refuse to sign this acknowledgment

I have received a copy of this offices Notice of Privacy Practices.
Please ask receptionist for a brochure if needed

_____
Print Name

_____
Signature

_____
Date

For Office Use Only

We attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained because:

Individual refused to sign.

Communication barriers prohibited obtaining the acknowledgment.

An emergency situation prevented us from obtaining acknowledgment.

Other:_____