Nadeen Medvin, Ph.D., DABPS, DABDA
Licensed Clinical and Industrial/Organizational Psychologist

Client Intake Information

Date: _________________

Please complete all questions and information on this form to facilitate services and insurance authorization.

Demographic and Contact Information:

Name: ____

Address: ____

____

Phone: (Home) ________________________ (Work) ______________________ (Cell) _______________________

Preferred number to receive calls? _______________ May we leave a message on voice mail? _________________

Date of Birth: ______________________________ Social Security Number: _________________________________

E-mail: ____

Marital Status:

___ Never Married ___ Divorced ___ Married (# marriages___) ___ Living w/ Partner ___ Separated

___ Widow/Widower

Family Members:

Name	Age	Sex	Relationship	Living w/ you?

Education:

___ High School ___ Technical School ___ College Field of Study/ Degree ________________________________

School (if attending) / Program of Study: ____

Occupation: ____ Employer: ____________________________________

How Long with Current Employer? ____

Health Concerns or (Physical and/or Emotional) Symptoms You are Experiencing?

____

____

Medications, Supplements? (dose and frequency)

____

____

____

____

____

Substance Use, Alcohol, Other? ____

____

Other Medical Conditions or Treatment? ____

____

____

____

Primary Care Physician: ____

Reason for Visit / Consultation Goals: ____

____

____

____

Referral Source: ____

Insurance Information:

Insurance Company / HMO, PPO: ___________________________ Authorization #:_____________________________

Member ID# ____ Group # ___________________________________

Claims Address ____

Phone: ____

Deductable?__________________________________ Deductible Met? ___________________________________

Other Secondary Insurance? ____

Nadeen Medvin, Ph.D., DABPS, DABDA
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Consent for Treatment

I consent to participate in behavioral health care services provided by Dr. Nadeen Medvin. I understand that I am consenting and agreeing only to those services that the above named provider is qualified to provide within the scope of the provider's license, certification and training. Any treatment recommendations along with advantages and disadvantages will be discussed with me in the course of my treatment.

I consent to the release of all medical information including any psychiatric evaluation, diagnosis and medical record necessary to process insurance claims.

I also authorize Dr. Medvin to release my medical information and records to my primary care physician if pertinent and beneficial to my treatment and health care coordination.

I have been given information regarding my rights and responsibilities as a participant and the limits of the confidentiality of my records.

I have been provided with information concerning the cost of services and understand that I am financially responsible for any copayment or deductible if required by my insurance plan.

I agree to provide a 24hr notice of cancelation if I am unable to keep a scheduled appointment, unless prevented by emergency circumstances. Otherwise, a service charge may be applied.

Patient's Signature: X___________________________________ **Date:** _______________________________

Children and Adolescents:

If the patient is under the age of 18 or unable to consent to treatment, I attest that I have legal custody of this individual and I am authorized to initiate and consent for treatment and/or legally authorized to initiate and consent to treatment on behalf of this individual.

Parent or Guardian's Signature: X______________________________ **Date:** ___________________________

Relationship to Patient (if applicable) ____

Florida HIPAA Notice

Policies and Practices to Protect the Privacy of Your Health Information

Uses and Disclosures for Treatment, Payment, and Health Care Operations:

1. We may use or disclose your protected health care information for treatment, payment, and health care operations with your consent and authorization.

You Have the Right to:

1. Request restriction on certain uses and disclosures of your health information.

2. Request and keep a copy of this notice of privacy practices, and inspect and obtain a copy of your health information.

3. Amend your health record as provided by law.

4. Obtain an accounting of disclosures of your health information as provided by law.

5. Request communication of your health information by alternative means or alternative locations.

6. Revoke your authorization to use of disclose your health information except to the extent that action has already been taken.

Provider Responsibility and Requirement by Law:

1. Maintain the privacy of your health information.

2. Provide you with a notice at to legal duties and privacy practices with respect to information collected and maintained about you.

3. Abide by the names and terms of this notice.

4. Notify you if unable to agree to a requested restriction.

5. Accommodate reasonable request to communicate health information t alternative means or alternative locations.

I have read this notification and understand my rights.

X____

Patient Signature / Date

CIGNA Behavioral Health

Employee Assistance Program (EAP)

STATEMENT OF UNDERSTANDING

Employee Assistance Programs (EAPs) are provided by many employers who wish to offer their employees and family members a professional assessment and referral service. This information is provided to you to help you better utilize available EAP services.

Fees
Sessions within the EAP are offered at no cost to the employee or family members. Your employer has already paid for this service. If an employee or family member needs specialized counseling or treatment services, he or she will be assisted in locating an appropriate resource. While medical benefits may defray some of the costs of the services provided by these resources, the employee or family member assumes financial responsibility for such services.

Privacy
Information concerning the use of the EAP will not be given to anyone outside the EAP without your permission unless required by law. Certain state laws require that the EAP staff assume the responsibility for reporting to appropriate parties instances when a person is a danger to him or herself, to others, or when child or vulnerable adult abuse/neglect is involved.

Self-referrals
If an employee or family member initiates a request for assistance, no one will be notified of the individual's use of the EAP service without that individual's written permission.

Supervisor referrals
If a supervisor initiates the referral of an employee as the result of a performance discussion, or as a result of a positive drug screen, the supervisor will be notified whether or not the employee has kept the appointment with the EAP professional.

Voluntary participation
Use of the EAP is voluntary. It is the client's decision whether to use (or not to use) the services available. In some cases, as noted above, your employer may require participation in the EAP as a condition of employment or as a part of the company's substance abuse policy.

Complaints and grievances
If you have a complaint concerning a person associated with CIGNA's EAP, an EAP service, the quality of services, or any other aspect of the EAP, you may register the complaint with our Customer Service Department by calling 800-926-2273. I have read and received a copy (if requested) of this information.

X____

Participant Signature / Date

COORDINATION OF BENEFITS

Please complete the information below. If you have any questions regarding this form, please contact CIGNA Customer Service at the number on the participant's medical card. Your policy contains a "coordination of benefits" provision that allows CIGNA to share responsibility in covering health care expenses with any other company covering you or your family for medical benefits. When health care expenses are shared between two or more companies, out-of-pocket expenses for the participant may be reduced. In addition to benefiting the individual member, coordination of benefits is beneficial to all participants because it avoids duplication of payments that would result in higher premium rates.

1. Employee___________________________________ Date of Birth________________________
2. Employer Name ______________________________Account Name_______________________
3. Social Security Number_______________________
4. Patient Name________________________________ Participant Date of Birth ______________
5. Patient Address____

If married complete the following:

Name of spouse of employee _____________________Date of Birth ______________________

Spouse's employer & address ____

Is spouse covered under his/her employer's health plan? Yes ___ No ___

If yes, please complete the following:

Employer's health plan name ____

Address for submitting claims ____

Policy # ____Effective Date _____________________

Single Coverage __________ Family Coverage __________

If family coverage, list all covered members____

If you are divorced and/or remarried with dependents, please complete the following:

Dependents:

Person with Physical Custody:

Relationship:

Person Responsible for Dependent Health Care:

Expenses per Divorce Decree:

If you or your family members are covered under any other medical/dental plan in addition to the coverage listed above (i.e., Medicare or Medicaid, other insurance), please complete the following section. (This does not include the employee's current insurance plan.)

____

Health Plan Name Name of Person Covered Policy Number Effective Date

I certify the above information is true and correct. I understand that the purpose of this information is to assure appropriate coordination of benefits of all plans.

X____

Participant Signature / Date

CIGNA, PO Box 188020, Chattanooga, TN 37422