SunDance Behavioral Resources, LLC

Adult Registration & History Form

Name: _____ Sex: M / F Date of Birth ___/___/___ Age: _____

Address: _____ Social Security #: _____

_____ Occupation: _____

City State Zip Employer: _____

Cell Phone _____ Select all that apply:

Home Phone _____ □ Single □ Married □ Separated □ Divorced □ Widowed

Email: _____ Employed □ Full-time □ Part-time □ Homemaker

Preferred Mode of Appointment Reminder: Student □ Full-time □ Part-time

□ Phone call □ Email □ Text

Emergency Contact: _____ Phone & Type: _____

Relationship to Patient: _____

Children's names and ages: _____

_____

Additional members of household (please include relationship & ages): _____

_____

If You Are ***NOT* The Main Insurance Holder:**

Name of Policy Holder: _____ Sex: M / F Date of Birth ___/___/___

Address ***if*** Different: _____

City State Zip

Insurance Plan: _____

Patient's Relationship to Insured: □ Self □ Spouse □ Child □ Other

*****If your insurance changes, it is your responsibility to let SunDance know. *****

Release of Information

By signing this form where indicated on page 5, I authorize SunDance Behavioral Resources, LLC to release information to and /or receive information from the following individual(s) as indicated:

1. Name: _____ Relationship: _____ Phone Number: _____

□ make appointments □ cancel appointments □ discuss treatment □ refill prescriptions □ other _____

2. Name: _____ Relationship: _____ Phone Number: _____

□ make appointments □ cancel appointments □ discuss treatment □ refill prescriptions □ other _____

Medical History

Please list all current medications (indicate if it is an injectable medication): _____
_____
_____
_____

Please list any past medications: _____
_____
_____
_____
Who is/was the prescriber for these medications? _____

Please list any medication allergies: _____

What is the approximate date of your last physical exam? _____

Please list any doctors or therapists that you are currently seeing outside of SunDance: _____
_____
_____

Please describe any additional current medical problems: _____
_____
_____
_____

Do you use tobacco products? Yes / No How frequently_____

What products do you use? _____

Do you drink alcohol? Yes / No How frequently? _____

Please list any illegal substances you have you used in the past year: _____

Please list any previous mental health diagnosis: _____

Please list any history of mental health hospitalizations: _____
_____
_____

Please list any history of self-harm or suicide attempts: _____
_____

Please indicate if you have/had any of the following conditions:

□ Asthma	□ Allergies	□ Jaundice
□ Chronic Bronchitis	□ Head Injury	□ Liver Disease
□ Emphysema	□ Cancer	□ Anemia
□ Pneumonia	□ Epilepsy	□ Diabetes
□ Tuberculosis	□ Glaucoma	□ Heart Disease
□ Rheumatic Fever	□ Stomach Ulcer	□ High Blood Pressure
□ Hepatitis	□ Thyroid Disorder	□ Stroke
□ Venereal Disease	□ Kidney Disorder	□ Other:

Have you recently experienced any of the following symptoms?

□ Blurred Vision	□ Chest pain	□ Feelings of Guilt
□ Frequent Headaches	□ Heart Murmur	□ Feeling Overwhelmed
□ Trembling/Shaking	□ Heart Palpitations	□ Feelings of Unreality
□ Flashbacks	□ Other Heart Problem	□ Feelings of Worthlessness
□ Easy Bleeding/Bruising	□ Recurrent Stomach Pain	□ Loss of Interest
□ Balance Problems	□ Changes in Bowels	□ Poor Concentration
□ Dizziness	□ Excessive Perspiration	□ Sadness/Crying
□ Loss of Hearing	□ Black Stools	□ Wishing to Run Away
□ Ringing in the Ears	□ Rectal Bleeding	□ Suicidal Thoughts
□ Chronic Cough	□ Pain/Difficulty Urinating	□ Compulsiveness
□ Blood with Cough	□ Blood in Urine	□ Easily Distracted
□ Difficulty Swallowing	□ Change in Appetite	□ Irritability
□ Shortness of Breath	□ Excessive Fatigue	□ Obsessions
□ Swollen/Sore Glands	□ Excessive Sleep	□ Restlessness
□ Wheezing	□ Low Energy	□ Atypical Vaginal Bleeding
□ Abnormal Chest X-ray	□ Sleep Difficulty	□ Infertility/Impotence
□ Numbness of Tingling	□ Weight Change	□ Sexual Difficulties
□ Swelling in Limbs	□ Avoiding Situations	□ Sexual Pain

Are you court ordered to have mental health or substance abuse treatment? If yes, please explain: _____

_____

_____

Are you seeking disability benefits? _____

What is/are the main reason(s) you are seeking mental health treatment at this time? _____

_____

_____

Patient Consent To Treatment/Agreements

Please initial beside each section to indicate that you have read and understand each policy:

____ **Payment is due at time of service whether it's a co-pay, coinsurance, or deductible.**

____ **Cancellations and Missed Appointments**

Missed appointments cancelled with less than 24 hours notice prior to the appointment must be paid in full by the patient or guardian. **Charges are $75.00 for each appointment missed with each provider.** Insurance companies do not pay for these. Missing three (3) unexcused appointments may result in a termination of treatment at SunDance. If you are under the care of a psychiatrist, a transition prescription will be provided.

____ **Late Arrival**

Please be advised if you are here for a psychiatrist appointment and you are more than 10 minutes late, most doctors will not be able to see you and there will be a $75.00 charge for a missed appointment.

____ **Prescription Refills**

Insurance companies do not reimburse for prescriptions researched and filled between appointments. **You will be charged $15 for any prescriptions filled outside of an appointment and only up to your next appointment.** Some schedule II prescriptions are required by law to be written every thirty (30) days, and are excluded.

____ **Paperwork and Letters**

SunDance providers will not complete Disability, FMLA, or Insurance paperwork unless you are an existing patient of one (1) full year. Letters requested from therapists and/or doctors outside of an appointment will include a $25.00 charge.

____ **Collections and Legal Fees**

A $50 fee will be incurred for each returned check. Should collection become necessary, your signature on this document indicates your agreement to pay an additional 40% of the amount overdue as a collection fee in addition to all legal fees connected to the collection, with or without suit, including attorney fees and court costs.

____ **Binding Arbitration Agreement**

This agreement requires that you submit all future claims to arbitration instead of having the claim heard in court by a judge or jury. This agreement is included to minimize the cost of any disputes that may arise from your contact with SunDance. You have the right to have all of your questions about arbitration answered. You may decline to sign the arbitration agreement and still receive health care at SunDance. Simply write: "*I decline the binding arbitration agreement*" above your signature on the next page.

____ **Costs of Services Not Covered by Insurance and other Third Party Payers.**

On occasion there is need for SunDance to provide services that are not covered by insurance or other third party payers. These may include, but are not limited to; letters, reports, conversations, or other communication to attorneys, government agencies, school, or employment entities, etc. This also includes any required response(s) to subpoenas, court orders, etc. SunDance will always make a good faith effort to notify the patient or responsible party and will release records only as required by law. In such an event, any costs incurred will be billed to the patient or responsible party.

____There are no Prescribing Doctors or APRNs in the office on Fridays or Major Holidays.

Primary Care Physician

In order to offer the best care possible, we would like to notify your primary care physician of your care at SunDance. **This is recommended, but not required.** Please Initial One:

_____ I decline authorization to notify to my doctor.

_____ I authorize SunDance Behavioral Resources to release important information about my mental and physical treatment to my doctor.

_____
Doctor's Name

_____ _____
Address Phone Number

<u>You must present Photo ID at the time of your first visit or we are unable to see you.</u>

By signing below, I acknowledge I have received and understand all parts of this Registration form, including the Consent to Treatment, and that I agree to the terms herein. I also acknowledge I have received the HIPAA Notice form. I give SunDance Behavioral Resources, LLC all rights to payments from my insurance company or other third party payer(s).

Signed this _____day of _____, 20_____

_____
Name (PLEASE PRINT)

_____
Signature

We encourage you to use our website www.sundancebehavioral.com **to contact us regarding: appointments, medication refills, and any communication with our providers.**

Email us at: office@sundancebehavioral.com