



WIREGRASS BEHAVIORAL GROUP LLC

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TODAY'S DATE: _____

NAME: _____

DATE OF BIRTH: _____ SOCIAL SECURITY NUMBER: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

PREFERRED PHONE NUMBER TO RECEIVE APPOINTMENT REMINDER BY **TEXT OR VOICE MAIL**

CELL PHONE: _____

HOME PHONE: _____

EMAIL: _____

POLICY HOLDER/INSURANCE/ INFORMATION

PRIMARY INSURED CARRIER: _____

INSURANCE POLICY/IDENTIFICATION NUMBER: _____

GROUP NUMBER: _____

POLICY HOLDER NAME: _____ **POLICY HOLDER DOB:** _____

INSURED EMPLOYER: _____

SECONDARY INSURANCE (If Applicable):

PRIMARY INSURED CARRIER: _____

INSURANCE POLICY/IDENTIFICATION NUMBER: _____

GROUP NUMBER: _____

POLICY HOLDER NAME: _____ **POLICY HOLDER DOB:** _____

EMERGENCY CONTACT: _____

PARENT / GUARDIAN NAME: _____

(If Patient is a minor)

*Please list anyone you would like to be able to receive information about your care such as appointments, medications (refills), etc. below.

Name	Relationship	Telephone Number

Patient Signature/Consent

Date

CURRENT SYMPTOMS – PLEASE CHECK ALL THAT APPLY

<input type="checkbox"/> Depression	<input type="checkbox"/> Mood swings
<input type="checkbox"/> Loss of interest	<input type="checkbox"/> Anger
<input type="checkbox"/> Crying spells	<input type="checkbox"/> Irritability
<input type="checkbox"/> Appetite or weight increase	<input type="checkbox"/> Easily frustrated
<input type="checkbox"/> Appetite or weight decrease	<input type="checkbox"/> Racing thoughts
<input type="checkbox"/> Appetite or weight unchanged	<input type="checkbox"/> Restlessness or pacing
<input type="checkbox"/> Decreased concentration	<input type="checkbox"/> Inflated or high self esteem
<input type="checkbox"/> Hopelessness	<input type="checkbox"/> Euphoria or happiness
<input type="checkbox"/> Helplessness	<input type="checkbox"/> Increased energy
<input type="checkbox"/> Guilty thoughts	<input type="checkbox"/> Don't need as much sleep
<input type="checkbox"/> Low self esteem	<input type="checkbox"/> Spending sprees
<input type="checkbox"/> Lowered hygiene	<input type="checkbox"/> Sexual promiscuity
<input type="checkbox"/> Isolating yourself	<input type="checkbox"/> Socializing too much
<input type="checkbox"/> Thoughts of death or dying	<input type="checkbox"/> Legal problems
<input type="checkbox"/> Thoughts of suicide or self-harm	<input type="checkbox"/> Traffic problems
<input type="checkbox"/> Symptoms worse during the day	<input type="checkbox"/> Impulsive behaviors
<input type="checkbox"/> Symptoms are worse at night	<input type="checkbox"/> Easily distracted
<input type="checkbox"/> Problems falling asleep	<input type="checkbox"/> Disorganized thinking
<input type="checkbox"/> Problems staying asleep	<input type="checkbox"/> Procrastination
<input type="checkbox"/> Problems waking up too early	<input type="checkbox"/> ADHD
<input type="checkbox"/> Problems sleeping too much	<input type="checkbox"/> Interrupting others
<input type="checkbox"/> Nightmares	<input type="checkbox"/> Rude behavior
<input type="checkbox"/> Sleep talking or other behaviors	<input type="checkbox"/> Road rage
<input type="checkbox"/> Fatigue or easily becoming tired	<input type="checkbox"/> Violence toward others
<input type="checkbox"/> Loss of energy	<input type="checkbox"/> Being a victim of violence
<input type="checkbox"/> Excess worry	<input type="checkbox"/> Bulimia or Anorexia
<input type="checkbox"/> Difficulty relaxing, feeling tense	<input type="checkbox"/> Exercising too much
<input type="checkbox"/> Easily startled	<input type="checkbox"/> Worried about weight & body
<input type="checkbox"/> Anxiety or panic attacks	<input type="checkbox"/> Hearing hallucinations
<input type="checkbox"/> Obsessive thinking	<input type="checkbox"/> Seeing hallucinations
<input type="checkbox"/> Germophobia	<input type="checkbox"/> Feeling hallucinations
<input type="checkbox"/> Perfectionistic tendencies	<input type="checkbox"/> Smelling hallucinations
<input type="checkbox"/> Social anxiety	<input type="checkbox"/> Feeling scared
<input type="checkbox"/> Performance anxiety	<input type="checkbox"/> Feeling someone is after you
<input type="checkbox"/> Compulsive behaviors	
<input type="checkbox"/> Rechecking what you did	
<input type="checkbox"/> Rituals	
<input type="checkbox"/> Other :	

WHO REFERRED YOU: _____

REASON FOR APPOINTMENT: _____

Signature below is acknowledgement that you have received the Notice of Privacy Practices & Office Policies

OUR DUTIES

- **Notice Changes** - We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for PHI we already have about you and any PHI we receive in the future. Current copies of this notice will be available at registration locations. The current Notice will also be posted at our website. The effective date of the notice will be posted on the first page.
- **Cell Phone/Email Mail** - We ask you not to use your cell phone or email in contacting our healthcare providers, personally. Cell Phone and Emails sent to and from you are not secure and could be read by a third-party.
- **Complaints** - If you believe your privacy rights have been violated, then you have the right to submit a complaint to us. Any complaints shall be made in writing or by telephone to Wiregrass Behavioral Group, 256 Honeysuckle Rd. Ste 12 Dothan, AL 36305. We encourage you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against or penalized in any way for filing a complaint. You may also file a written complaint with the secretary of the US Department of Health and Human Services, 200 Independence Ave. S W, Washington DC, 20201, or call toll-free 877-696-6775, by email to OCRCComplaint@hhs.gov or to Region V, Office for Civil Rights, US Department of Health and Human Services, 233 North Michigan Ave, Suite 240, Chicago, IL 60601, voice phone 312-886-2359, fax 312-886-1807, or TDD 312-353-5693.

_____	_____	_____
Client / Legal Guardian Printed Name	Signature	Date
_____	_____	_____
Witness – Printed Name	Signature	Date

Client’s Consent for Communications

Please initial below, with your selection:

_____ I **consent** to my cell phone, home phone or email being used for communications from Wiregrass Behavioral Group, LLC (that are non-clinical and non-urgent only)

_____ I **do NOT consent** to my cell phone, home phone or email being used for communications from Wiregrass Behavioral Group, LLC

Client’s Understanding

- I have read and understood the office policies and agree to abide by the rules listed therein
- I agree to be an active participant in my mental health recovery
- I have received a copy of the Office Policies
- I have received a copy of the Privacy Practices

_____	_____	_____
Client / Legal Guardian Printed Name	Signature	Date
_____	_____	_____
Witness – Printed Name	Signature	Date