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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
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Patient Signature/Consent _____ Date _____

CURRENT SYMPTOMS – PLEASE CHECK ALL THAT APPLY

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