Insights

Colorado Assessment and Therapy, PC

P: 303-935-5307 F: 303-935-5085
899 Logan St. Suite 406
Denver, CO 80203
www.insightsdenver.com

Adult
Diagnostic Assessment-Intake Information

Patient's Full Name: _____ Date of Birth: _____

Address: _____

City:_____State:_____Zip:_____

Primary Phone: _____ Email: _____

Cell Phone: _____ Occupation: _____

Insurance Information:

Company Name: _____ Phone: _____

Claims Mailing Address: _____

City:_____State:_____Zip:_____

Member ID#: _____ Group#: _____

Primary Insured

(if different from patient)

Full Name: _____ Gender/Sex: _____

Address: _____

City:_____State:_____Zip:_____

Date of Birth: _____ SS#: _____

Referral Source

Name: _____ Phone: _____

Authorizations

I understand that it is my responsibility to know my insurance benefits including information regarding my deductible, co-insurance, and copays. I hereby authorize payment directly to Insights, PC and hereby authorize Insights, PC to release any information required in the processing of my insurance claims.

Signature (Insured Person): _____ Date: _____

Reason for Referral

(why are you seeking an evaluation?)

Reason 1: _____

Reason 2: _____

Reason 3: _____

Spouse/Partner Information

Single _____ Married _____ Divorced _____ Widowed _____

Full Name: _____

Home Address: _____

City: _____ State: _____ Zip: _____

Primary Phone: _____ Email: _____

Occupation Phone: _____ Work Phone: _____

Children

Name:_____ Gender: M F Age: _____

Name:_____ Gender: M F Age: _____

Name:_____ Gender: M F Age: _____

Parent's Information

Parents are: ☐ In a relationship ☐ Married ☐ Separated ☐ Divorced

Parent #1 Full Name: _____

Home Address: _____

City: _____State: _____ Zip: _____

Primary Phone: _____ Email: _____

Occupation: _____ Work Phone: _____

Parent #2 Full Name: _____

Home Address: _____

City: _____State: _____ Zip: _____

Primary Phone: _____ Email: _____

Occupation: _____ Work Phone: _____

Siblings

Name:_____ Gender: M F Age: _____

Name:_____ Gender: M F Age: _____

Name:_____ Gender: M F Age: _____

Educational Background & Participation

High School:

Name: _____ Dates Attended: _____

Special Education Services Received: _____

Transition Program:

Name: _____ Dates Attended: _____

Special Education Services Received: _____

University/College/Professional/Vocational School:

Name: _____ Dates Attended: _____

Special Education Services Received: _____

Other:

Name: _____ Dates Attended: _____

Special Education Services Received: _____

Employment History

Please list all jobs in order of employment beginning with most recent:

_____

_____

_____

_____

_____

_____

_____

Medical History

Medications

Please list any medication or supplements (including medical marijuana) and prescribing doctor:

Medication 1:_____ Reason Prescribed: _____
Medication 2:_____ Reason Prescribed: _____
Medication 3:_____ Reason Prescribed: _____
Medication 4:_____ Reason Prescribed: _____
Medication 5:_____ Reason Prescribed: _____

Family History

	Relationship to yourself
Autism, Asperger's	
Hyperactivity/ADHD	
Motor delays	
Speech delays	
Learning disability	
Behavioral Disorder	
Seizure Disorder	
Cognitive Impairment	
Tic Disorder	
OCD	
Genetic Disorder	
Mood Disorder	
Depression	
Anxiety	
Phobias	
Psychotic Disorder	
Suicidal Behavior	
Alcohol Abuse	
Drug Abuse	
Serious Medical Issues	
Other	

Does you have a history of any of the following? (Please check all that that apply)

_____Hospitalization _____Eating problems _____ Hearing problems

_____ Head Injury _____ Special diet _____ Weight issues

_____ Seizure _____Problems with ADLs (dressing,hygiene) _____ Speech issues

_____Many ear infections _____ Motor Problems _____ Stomach problems

_____ Vision problems _____ Dental issues _____ Toileting problems

_____ Sleep disturbance _____ Food Allergies _____ Seasonal Allergies

_____ Sensory Issues _____ Asthma _____ Poor coordination

_____ Anxiety _____ Depression _____ Aggression

Evaluation History

Please note all testing previously conducted, including professional or organization that conducted the testing, date, and results.

☐ Head Injury: _____

Provider/Date(s):_____

☐ Seizures**:** _____

Provider/Date(s):_____

☐ Sensory/Motor:_____

Provider/Date (s):_____

☐ Speech/Language: _____

Provider/Date(s):_____

☐ Allergy: _____

Provider/Date (s):_____

☐ Hearing: _____

Provider/Date (s):_____

☐ Vision: _____

Provider/Date (s):_____

☐ Genetic Testing: _____

Provider/Date (s):_____

☐ Immunological: _____

Provider/Date (s):_____

☐ Hospitalization(s)/Surgery: _____

Provider/Date (s):_____

☐ Other: _____

Provider/Date (s):_____

Your Strengths

Learning: _____

_____

Personality: _____

_____

Interests: _____

_____

Other: _____

_____

Your Struggles

Social: _____

_____

Communication: _____

_____

Behavioral: _____

_____

Self-Care: _____

_____

Other: _____

_____

PATIENT NAME: _____ DATE: _____

CONSENT TO TREATMENT

The information on this page is made available so that you will be fully aware of some important matters concerning the psychologist-patient relationship and Insights policies. A "psychologist-patient" or "treatment" relationship does not exist until after an initial assessment is completed and we have decided to move ahead as evidenced by your signature on this form. It is important that we agree that we will be able to successfully work together to accomplish your goals. We will discuss this during the first visit and decide whether or not to proceed, and whether we need to continue the assessment for one or more subsequent visits.

CONFIDENTIALITY AND HIPAA

Generally speaking, the information provided by and to the patient during the assessment and any subsequent treatment, is legally confidential and cannot be released without the patient's consent. There are exceptions to this confidentiality, some of which are listed in section 12-43-218 and the Notice of Privacy Rights that can be provided to you in full upon your request as well as other exceptions to Colorado and Federal Law. For example, mental health professional are required to report child abuse to authorities. If a legal exception to psychologist-patient arises, if feasible, you will be informed accordingly.

Any person who alleges that a mental professional has violated the licensing laws related to the maintenance of records of a client eighteen years of age or older, must file a complaint or other notice with the licensing board within seven years after the person discovered or reasonably should have discovered this. Pursuant to law, this practice will maintain records for a period of seven years commencing on the date of termination of services or on the date of last contact with the client, whichever is later.

DIAGNOSTIC ASSESSMENT

Diagnostic Assessment is a process that requires involvement from the patient, family, and, at times, other caregivers, such as teachers or therapists. These services require face-to-face contact for interviewing and testing. They also include the psychologists' time required for the reading of records, consultations with other professionals, scoring of tests, interpreting of results, report writing, and any activities to support these services.

INSURANCE

We will be glad to provide invoices to help in filing insurance claims. However, you will be responsible for the full fee at the time of service unless we make other arrangements. If you are insured by a carrier with whom we contract with part of your evaluation may be covered by insurance. In these cases, you are still responsible at the time of service for any co-payment. co-insurance, and deductible depending on your plan. Additionally, if your insurance carrier will be reimbursing us, you will still be responsible in the event that the insurance company denies a claim or you have additional co-insurance or have not met your deductible. In the event that your insurance company does not pay, for whatever reason, it is your responsibility to pay the balance due. It is also your responsibility to then seek reimbursement from your insurance; Insights does not pursue denied claims on your behalf. As the insured, you are ultimately responsible for determining which services are covered by your insurance company. While we are providers for certain insurance companies, it is not the responsibility of Insights to know what your plan does and does not cover; plan coverage varies greatly. It is also your responsibility to alert us that you will be going through your insurance for services rendered at the outset of therapy. We are not able to back date claims or reimburse for sessions already paid for. If you have questions, about the payment process, please ask.

Initials: ____

AGREEMENT FOR FINANCIAL RESPONSIBILITY

The estimated cost of the evaluation will be discussed before the initial appointment. Half of the total cost of the evaluation must be received with your intake paperwork at the initial appointment. At the time of your final appointment and before receipt of the diagnostic report, the remainder of your balance is due in full. Cash, money order, check, MasterCard, or Visa are accepted. Insights will provide an itemized receipt of your payment, upon request, at the final meeting.

OTHER FEES

In the event that it is determined that Insights owes you a refund (example: insurance covered more than anticipated), Insights will issue you reimbursement. Please note that if a payment was made by credit card, there will be a 5% fee deducted from the refund. This fee can be avoided by paying with check or cash.

Insights will not agree to court appearances or other legal involvements unless the matter has been discussed and it is agreed that such involvement is within our range of competence and will not interfere with the treatment relationship. Professional fees for court appearances, depositions and attorney consultations are $300.00 per hour (two hour minimum) plus travel and waiting time, are non-discountable, and are payable in advance only.

CANCELLATIONS

Insights asks that you provide at least 24 hours notice prior to canceling an appointment. There is a $150.00 charge for no-shows and late cancellations that must be paid immediately and is not eligible for reimbursement by insurance, and will not be applied to rescheduled evaluations. Please contact Insights regarding cancellations.

EMERGENCIES

Insights does not provide formal emergency services. Please visit our website for current office hours, If you are unable to reach anyone during office hours, please leave a message and your call will be returned as quickly as possible. Nighttime and weekend calls will typically be returned during business hours. If you find yourself in an urgent situation, please dial 911 or go to the nearest emergency room.

I understand that I am fully responsible for all fees incurred through Insights. I agree to pay all fees in full, including those that are not covered by my insurance company (unless otherwise agreed upon). I understand that my account may be turned over to a collection agency for non-payment after 30 days.

Please sign below indicating that you have read, understand, and agree to the information and terms of this document.

_____
Patient's name

_____ _____
Signature of responsible person Date

_____ _____
Insights Staff Date