Date_____

ELAINE S. BERMAN Ed.D.
CLIENT INTAKE INFORMATION FORM

CLIENT INFORMATION

Name Last_____First_____Mi___

ADDRESS_____City_____ST_____Zip_____

PHONE Home (____) ____-_____ Work(____) ___-_____

Marital Status ___ (S-single M-married W-widowed D-divorced SP-separated)

Sex___ SSN____-____-_____ Date of Birth ____/____/_____

Employer_____ Occupation_____ Ph(____)____-___

Address_____ City_____ ST_____ Zip____

SPOUSE'S NAME Last_____First_____Mi_____

Birth Date_____ Occupation_____

RESPONSIBLE PARTY INFORMATION

NAME Last_____First_____Mi____

Address_____City_____ST_____Zip____

Phone(____)_____-_____

CLIENT'S RELATIONSHIP TO THE RESPONSIBLE PARTY____ (S-self P-spouse C-child O-other)

REFERRAL INFORMATION

NAME Last_____First_____Mi____

Business Name_____ Phone(____)_____-_____

Address_____City_____ST_____Zip____

TYPE: __Educator __Clergy __Legal __Medical __Business
__Presentation __Friend Cincinnati Yellow Pages
__Hamilton Yellow Pages. If yellow pages, which heading?_____ Other_____

Please sign and date to grant permission for me to thank your referral source for referring you.

_____
Signature DATE

 (please complete other side)

OTHER INFORMATION

All Present & Previous Marriage(s)/Divorce(s) and/or Significant Relationships Dates

Patient's _____

_____

_____

Spouse(s)/Significant Other _____

_____

_____

CHILDREN'S NAMES ¦ SEX ¦ SCHOOL OR WHEREABOUTS ¦ BIRTHDATE ¦ ETC.

_____

_____

_____

_____

_____

HEALTH HISTORY (Physical and Psychological)

Illness ¦ Physician ¦ Medication & Dose ¦ Dates

_____

_____

_____

_____

_____

Present Medications: _____ _____

Present Handicaps : _____ _____

Emergency Person to Contact _____ Phone(____)____-_____

Education Grade Completed- Man's _____ Woman's _____

Present Problem _____

UNITED
BEHAVIORAL HEALTH

EXCHANGE OF INFORMATION FORM

UBH requires contracted behavioral health practitioners/providers to coordinate treatment with other behavioral health practitioners/ providers, primary care practitioners (PCPs), and other appropriate medical practitioners involved in a member's care. This is an optional form that can be used to facilitate coordination of care. Please send it to the appropriate care provider(s) treating the member.

PATIENT NAME: _____

A. Treating Behavioral Health Practitioner/Provider Information:

Name: _____ Phone: _____

Name: _____ Phone: _____

B. PCP/Medical Practitioner or Other Behavioral Health Practitioner/Provider/ Information:

Name: _____ Phone: _____

Address: _____

Name: _____ Phone: _____

Address: _____

C. Patient Clinical Information:

1. **The patient is being treated for the following behavioral health problem(s):**

☐ ADHD/ Behavior D/O ☐ Substance Abuse ☐ Psychotic Disorder ☐ Bipolar D/O
☐ Depressive D/O ☐ Anxiety D/O ☐ Eating Disorder ☐ Adjustment D/O
☐ Personality D/O ☐ OTHER: _____

2. **The patient is taking the following prescribed psychotropic medication/s:**

☐ Antidepressant ☐ Anxiolytic ☐ Clozaril
☐ Anticonvulsant ☐ Antipsychotic ☐ Mood Stabilizer

☐ Other(s): _____

3. **Expected length of treatment:** ☐ <3 months ☐ 3-6 months ☐ 6-12 months ☐ >1 year

4. **Coordination of Care Issues/Other Significant Information impacting medical or behavioral healthcare:**

_____

_____

DATE FORM MAILED OR FAXED TO OTHER PRACTITIONER/PROVIDER: _____
(PLACE A COMPLETED COPY OF THIS FORM ON THE PATIENT'S MEDICAL RECORD)

I hereby freely, voluntarily and without coercion, authorize the behavioral health practitioner listed above in Section A to release the information contained on this form to the practitioner/provider listed in section B above. The reason for disclosure is to facilitate continuity and coordination of treatment. This consent will last _____ days from the date signed. I understand that I may revoke my consent at any time.

I do not wish to have information shared with:

☐ my PCP/medical practitioner ☐ my other behavioral health practitioner(s)/provider(s).
☐ I am not currently receiving services from a PCP
☐ I am not currently receiving services from any other behavioral health practitioner/provider.

_____
Patient Signature **Date**

_____
Behavioral Health Practitioner Signature **Date**

[THIS IS NOT A REQUEST FOR MEDICAL RECORDS]

Approved by UBH St. Louis Network Clinician Advisory Council Committee 6/28/04

Elaine S. Berman Ed.D.
Florida Licensed Psychologist

1712 Lago Vista Blvd.
Palm Harbor, FL 34685

CONSENT TO TREAT

I HEREBY GIVE WRITTEN CONSENT FOR _____
(Patient(s)
BORN _____/_____/_____, TO BE PROVIDED PSYCHOLOGICAL SERVICES

BY ELAINE S. BERMAN, Ed.D., PSYCHOLOGIST.

_____ _____
Signature of Patient (Parent or Guardian if patient is a minor) Date

_____ _____
Signature of Witness Date

ALERT®

Wellness Assessment - Adult

Completing this brief questionnaire will help us provide services that meet your needs. Answer each question as best you can and then review your responses with your clinician. Please shade circles like this ●

Client Last Name | First Name | Date of Birth: (mm/dd/yy)

Subscriber ID | Authorization #

Clinician Last Name | First Name | Today's Date: (mm/dd/yy)

Clinician ID/Tax ID | Clinician Phone | State | MRef ○

Visit #: ○ 1 or 2 ○ 3 to 5 ○ Other

For questions 1-16, please think about your experience in the past week.

How much did the following problems bother you?	*Not at All*	*A Little*	*Somewhat*	*A Lot*
1. Nervousness or shakiness	○	○	○	○
2. Feeling sad or blue	○	○	○	○
3. Feeling hopeless about the future	○	○	○	○
4. Feeling everything is an effort	○	○	○	○
5. Feeling no interest in things	○	○	○	○
6. Your heart pounding or racing	○	○	○	○
7. Trouble sleeping	○	○	○	○
8. Feeling fearful or afraid	○	○	○	○
9. Difficulty at home	○	○	○	○
10. Difficulty socially	○	○	○	○
11. Difficulty at work or school	○	○	○	○

How much do you agree with the following?	*Strongly Agree*	*Agree*	*Disagree*	*Strongly Disagree*
12. I feel good about myself	○	○	○	○
13. I can deal with my problems	○	○	○	○
14. I am able to accomplish the things I want	○	○	○	○
15. I have friends or family that I can count on for help	○	○	○	○

16. In the past week, approximately how many drinks of alcohol did you have? ☐☐ Drinks

Please answer the following questions only if this is your first time completing this questionnaire.

17. In general, would you say your health is: ○ Excellent ○ Very Good ○ Good ○ Fair ○ Poor
18. Please indicate if you have a serious or chronic medical condition:
    ○ Asthma ○ Diabetes ○ Heart Disease ○ Back Pain or Other Chronic Pain ○ Other Condition
19. In the past 6 months, how many times did you visit a medical doctor? ○ None ○ 1 ○ 2-3 ○ 4-5 ○ 6+
20. In the past month, how many days were you unable to work because of your physical or mental health? *(answer only if employed)* ☐☐ Days
21. In the past month, how many days were you able to work but had to cut back on how much you got done because of your physical or mental health? *(answer only if employed)* ☐☐ Days
22. In the past month have you ever felt you ought to cut down on your drinking or drug use? ○ Yes ○ No
23. In the past month have you ever felt annoyed by people criticizing your drinking or drug use? ○ Yes ○ No
24. In the past month have you felt bad or guilty about your drinking or drug use? ○ Yes ○ No

9626

Clinician: Please fax to (800) 985-6894

Rev. 2007

ELAINE S. BERMAN, Ed.D.

PSYCHOLOGIST

1712 Lago Vista Blvd.

Palm Harbor, FL 34685

YOUR SIGNATURE BELOW INDICATES THAT YOU HAVE READ THIS AGREEMENT AND AGREE TO ITS TERMS AND ALSO SERVES AS AN ACKNOWLEDGEMENT THAT YOU HAVE RECEIVED THE HIPAA NOTICE FORM DESCRIBED ABOVE.

_____ _____

Signature Date

Assignment of Benefits

I authorize payment of medical benefits to Elaine S. Berman, Ed.D., licensed psychologist, for professional services rendered.

_____ _____

Signed (Subscriber) Date

Release of Information

I authorize release of any medical information necessary to process this claim and to obtain preauthorization for any services which are provided by Elaine S. Berman, Ed.D. licensed psychologist.

_____ _____

Signed Patient(s) or (Parent if a Minor) Date

Rev 5/2/2008