

**Adult Information Form**

Full name: \_\_\_\_\_ Date of birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Preferred nickname: \_\_\_\_\_ Gender at birth: \_\_\_\_\_ Gender identity: \_\_\_\_\_

Mailing address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Email: \_\_\_\_\_ Phone number: \_\_\_\_\_

Religion/spiritual connection: \_\_\_\_\_ Race/ethnicity: \_\_\_\_\_ Language: \_\_\_\_\_

**Emergency Contacts:**

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Relation: \_\_\_\_\_ Phone: \_\_\_\_\_

Primary Care Physician (name, address, and phone):  
\_\_\_\_\_  
\_\_\_\_\_

Would you sign a release to allow contact with your primary physician? Yes No

**Referral Info:**How did you hear about us? This helps us to understand how to reach out to and help more of our community.  
\_\_\_\_\_  
\_\_\_\_\_Current concerns/symptoms to be addressed:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_How long have you experienced these concerns/symptoms?  
\_\_\_\_\_  
\_\_\_\_\_Please list any past psychological treatments, medications, tests, or hospitalizations:  
\_\_\_\_\_  
\_\_\_\_\_

**Employment History:**

Please list your three most recent:

Company Name

Dates of Employment

Reason for Leaving

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Highest school grade completed: \_\_\_\_\_

Degrees or Certifications: \_\_\_\_\_

What activities do you enjoy doing? \_\_\_\_\_

Are you involved with any clubs, sports, or other hobbies? \_\_\_\_\_

Personal strengths and talents: \_\_\_\_\_

**Family Information:**

Marital status:    Single       Married       Widowed       Partnership       Legally Separated       Divorced

If Separated or Divorced, when did this occur? \_\_\_\_\_

If remarried, when did this occur? \_\_\_\_\_

Who is the person you feel most comfortable with sharing your secrets, worries, or feelings? \_\_\_\_\_

**Please list the members of your immediate family (include children/stepchildren):**

Name	Relationship	Age	Medical & Psychological History (Please include difficulties with attention span, learning, emotion regulation, and substance abuse.)	Age of Diagnoses	Living? Y    N	Residing Together? Y    N
					Y    N	Y    N
					Y    N	Y    N
					Y    N	Y    N
					Y    N	Y    N
					Y    N	Y    N

**Please check any of the following stressful events that apply to you or your family:**

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Relocations                   | <input type="checkbox"/> Deaths                      | <input type="checkbox"/> Illnesses                           |
| <input type="checkbox"/> Marital Problems              | <input type="checkbox"/> Job Changes                 | <input type="checkbox"/> Legal Issues                        |
| <input type="checkbox"/> Experienced a traumatic event | <input type="checkbox"/> Witnessed a traumatic event | <input type="checkbox"/> Physical or sexual abuse or neglect |
| <input type="checkbox"/> Social Services involvement   | <input type="checkbox"/> Other: _____                |  |

**Your Medical History:**

	<b>Circle One</b>	<b>Ages</b>	<b>Describe</b>
Allergies	Y N		
Appetite/eating problems	Y N		
Asthma	Y N		
Clumsiness/poor motor skills	Y N		
Chronic constipation	Y N		
Chronic ear infections	Y N		
Headaches	Y N		
Hearing/ear problems	Y N		
Head injury	Y N		
Nightmares	Y N		
Persistent high fevers	Y N		
Physical disabilities	Y N		
Seizures	Y N		
Sleep apnea/snoring	Y N		
Surgeries	Y N		
Tics/twitching	Y N		
Vision/eye problems	Y N		
Alcohol use/abuse	Y N		
Illicit drug use/abuse	Y N		
Risky behaviors	Y N		

Additional medical and hospitalization history information: (please include age)

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Are you currently being treated for anything? (describe) Yes No

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**Current Prescribed and Over-the-Counter Medications:**

Name of Medication Dosage Name of Prescribing Physician

<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
<hr/>	<hr/>	<hr/>
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Difficulties following doctor's advice for medication or other treatments? (describe) Yes No

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**Please list past, or current, counselors, psychologists, psychotherapists, and psychiatrists:**

<u>Age</u>	<u>Provider Name</u>	<u>Service (testing, treatment, medication)</u>	<u>Helpful?</u>	
<hr/>	<hr/>	<hr/>	Yes	No
<hr/>	<hr/>	<hr/>	Yes	No
<hr/>	<hr/>	<hr/>	Yes	No
<hr/>	<hr/>	<hr/>	Yes	No

Would you sign a release to allow contact with these providers?                      Yes                      No

Please write any additional remarks you would like to review with us and how we may be able to help.

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Thank you for taking the time to complete this information form. Please make sure to drop it off at the reception desk when it is completed.



Mental Health Clinic and Emily M. Young  
Assessment Center

UE Mental Health and Wellness Clinic  
& Emily M. Young Assessment Center  
University of Evansville  
1931 Lincoln Ave. Suite A  
Evansville, IN 47722  
812-488-5640

NPI: 1265211288  
Tax ID: 35-0868074

## Clinician Good Faith Estimate

Client Name: \_\_\_\_\_ Date of Notice: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

<u>Description of Services</u>	<u>Price</u>
Initial Diagnostic Examination	\$20
Individual Counseling Session	\$20
Psychological Screening* *Requires Recommendation from Your Clinician	\$40
Family w/ Client Counseling Session	\$20
Family w/o Client Session	\$20
Testing* *Requires Initial Diagnostic Examination	\$250 *(+\$20)

Diagnosis Code: TBD

Location: On-site or Telehealth

I understand the following information as it pertains to the Clinician Good Faith Estimate:

1. This estimate is not a contract and does not require you to obtain the items or services listed above.
2. There may be additional items or services that are recommended as part of the course of care that must be scheduled or requested separately and are not reflected in the good faith estimate.
3. Information provided in the good faith estimate is only an estimate regarding items or services reasonably expected to be furnished at the time the good faith estimate is issued to the individual and that actual items, services, or charges may differ from the good faith estimate.
4. The client has the right to initiate the patient-provider dispute resolution process if the actual billed charges are substantially in excess of the expected charges included in the good faith estimate, as specified in **§ 149.620**. Instructions for how to initiate a patient-provider dispute resolution process will be provided by request at any time to the patient. Initiation of the patient-provider dispute resolution process will not adversely affect the quality of health care services furnished to the individual.

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

\_\_\_\_\_  
Client, Parent/Guardian, Representative

\_\_\_\_\_  
Date



**Mental Health Clinic and Emily M. Young  
Assessment Center**

**Departmental Members**

Kevin Jordan, PhD, HSPP  
Jennifer Braun, PhD, HSPP  
Matt Powless, PhD, HSPP  
Juliet Aura, PhD

**Student Clinician Consent Form**

The UE Mental Health and Wellness Center & Emily M. Young Assessment Center is a training site for clinical psychology in addition to providing clinical services for our community. Our student clinician providers are in training and are supervised by our full-time psychology faculty members listed above. As a client of our doctoral students, the supervising psychologist(s) will review all of your communications and records. We ask for your consent in using audio and video equipment for the purposes of student training. The student will view tapes periodically and discuss your case with his or her supervisor and our other faculty. As these videos are used for purposes of critiquing clinician procedures only, they will not be considered a part of your medical record. All such recordings will be erased as soon as possible once they have been used for supervisory and educational purposes. The only exception is if you otherwise grant permission to maintain these recordings to a faculty supervisor by a separate written consent. All reports and any other written communications will be co-signed by one of the supervising psychology faculty members.

If you have any questions or concerns during your time in the UE Mental Health and Wellness Center & Emily M. Young Assessment Center, we ask that you first bring these concerns to the student clinician who is working with you. However, if you do not feel can be answered or addressed by our student clinician, you are encouraged to bring those concerns directly to Dr. Jennifer Braun, clinic director, who will either address this concern directly or immediately pass this to the supervising faculty member or program director. Please note that at certain times, multiple trainees or supervisors may be involved in your care or that of your child. The departmental phone number is 812-488-5640, and we will work to get back with you as soon as possible. Also, we will bill for your services through insurance when possible; however, in certain instances this is not possible given the educational status of the trainee (s). Thus, a self-pay arrangement should have been made prior to these services occurring; when this occurs, a bill will not be submitted to insurance and you will be responsible for full payment. If you have questions about this, please contact our psychology support staff at the phone number above.

Thank you again for giving us the privilege of serving you and/or your child. We seek to provide the utmost expertise and compassion in what we do, both in collaborating with you around important issues and also while training the professionals of the next generation.

Client's Name: \_\_\_\_\_ Parent/Guardian Name \_\_\_\_\_

Client/Parent/Guardian Signature: \_\_\_\_\_ Date: \_\_\_\_\_

**CONSENT FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS**

Client Name: \_\_\_\_\_ Client DOB: \_\_\_\_\_

**CONSENT FOR TREATMENT**

I consent to and authorize any healthcare professional who may be involved in my care at the UE Mental Health and Wellness Clinic and Emily M. Young Assessment Center to perform any evaluation procedures and/or therapy. I understand and acknowledge that within any of the treatment spaces that my care will be video, and audio recorded. I understand that the recording will be used for internal educational purposes only, and that only those directly involved in training will have access to any identifying information about me. Additionally, I acknowledge that due to UE's payment system integration, UE's Accounting and Audit department, as well as the Student Financial Services department, may have access to my name in relation to billing and financial processing.

**FINANCIAL RESPONSIBILITY**

Thank you for choosing the UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center. Your understanding of our financial policy is important to our professional relationship. If you need assistance at any time, please contact us at 812-488-5640. We accept Cash, Check, and all major credit cards

**ALL ACCOUNTS**

I agree to be responsible for payment on the account. Payment is expected to be paid at time of service unless other arrangements are made in advance.

**COMMUNICATIONS**

I authorize the UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center and any of its agents to contact me by telephone, at any of the numbers provided, including any wireless number for me and/or my spouse, which could result in charges to me/us. I acknowledge that my spouse or I may also be contacted by sending text messages, and/or emails, using any email address provided.

**INSURANCE**

UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center will file all insurance claims when applicable. **It is my responsibility to verify coverage with my insurance company. I understand that a quote of benefits from my insurance company is not a guarantee of payment.** It is my responsibility to understand my insurance coverage. Payment of deductibles, non-covered/denied services and co-payments are my responsibility. I also understand it is my responsibility to provide the insurance company with all requested information. If charges are denied due to my lack of response, the charges will become my sole responsibility. I will notify the UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center immediately of any change in my insurance. Failure to notify of any changes will result in my responsibility for all charges that may occur.

**ASSIGNMENT OF INSURANCE BENEFITS**

I authorize my signature on all insurance claim forms and assign insurance payments to be made directly to the UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center for services rendered.

**RELEASE OF INFORMATION**

I hereby authorize the release of information necessary to file claims with my insurance company. I also authorize one or all the designated parties below to request and receive the release of any protected health information regarding my treatment. UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center cannot prevent re-disclosure of your information by the person or facility who receives your records under this authorization and the information may not be covered by state and federal privacy protections after it is released. By signing this authorization, you release the UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center from any and all liability resulting from a re-disclosure by the recipient. The authorization to release medical records will expire 180 days from close of file.

**NOTICE OF PRIVACY PRACTICES ACKNOWLEDGMENT**

**I have read, understand, and agree to the terms listed above. (Consent for treatment, Financial Responsibility and Release of Information) My signature also indicates that I have received a Notice of Privacy Practices from UE Mental Health and Wellness Clinic & Emily M. Young Assessment Center.**

Signature: \_\_\_\_\_

Printed Name: \_\_\_\_\_

\_\_\_\_\_  
Client, Parent/Guardian, Representative\_\_\_\_\_  
Date



Mental Health Clinic and Emily M. Young  
Assessment Center

## ATTENDANCE POLICY

Client Name: \_\_\_\_\_ DOB: \_\_\_\_ / \_\_\_\_ / \_\_\_\_

We are looking forward to working with you. Consistent attendance is required in order for clients to achieve maximal benefit from these services. Failure to maintain regular attendance can result in a reduction in frequency of sessions or discharge from therapy altogether.

Clients are expected to attend all scheduled sessions. These sessions can be distinguished by the following:

### Psychological Evaluations

Due to the demand and time of psychological testing, we may not reschedule if this appointment is a no show.

### Ongoing Therapy

3 no shows within 6 months may result in termination of services.

**If you are unable to keep your scheduled appointment, please contact our department as soon as possible. Another client may be able to utilize this spot.**

- 812-488-5640 (Main Office)
- After hours- you can leave a message on our answering machine
- A late cancel is defined as cancelling within 4 hours of your scheduled appointment. Late cancels will be monitored and can result in a reduction in therapy sessions.

### Arrival Policy

Please note that if 15 minutes have passed after your scheduled appointment start time and you have not arrived for check-in, we may need to reschedule your appointment. We recommend contacting the clinic as soon as possible if you anticipate being late.

### SUPERVISION OF YOUTH DURING VISIT (AGES 0-17)

Parents, guardians, or other adult designees bringing children (ages 0-17) to the clinic MUST remain on the property for the entire duration of the child's visit(s). If you would like to leave the lobby (while staying on the premises), you must check in at the reception window or with your provider and ensure we have updated contact information for you, should we need to get in touch with you during your visit. Please return to the lobby prior to the end of your child's visit. Your provider may require your presence in treatment at any time.

By signing below, I agree to maintain consistent attendance. I understand that therapy will be discontinued if I am unable to meet the above-listed requirements.

X \_\_\_\_\_  
Client (or Parent/Guardian/Representative) Signature

\_\_\_\_\_  
Date