Cal Psychiatric Services

Akindele Kolade, MD
3201 S. Maryland Parkway, Suite 318
Las Vegas, NV 89109
Ph. (702) 629-7490 Fax. (702) 629-7685

Rev: 6/2015

HEALTH CARE INTAKE FORM

Personal Information

Name: ______________________ Date: __________

Address ______________________

Phone: __________ Email: __________

DOB: __________ Sex: __________

Primary Physician: ______________________ Phone: __________

Current Therapist: ______________________ Phone: __________

Complaint

What is your major complaint? ______________________

Start Date: ______ Have you previously suffered from this complaint ? __________

Previous therapist(s) seen complaint? ______________________

Aggravating Factors: ______________________

Relieving Factors: ______________________

☐ Anxiety	☐ Appetite issue	☐ Avoidance	☐ Crying Spells
☐ Depression	☐ Excessive Energy	☐ Fatigue	☐ Guilt
☐ Hallucinations	☐ Impulsivity	☐ Irritability	☐ Libido
☐ Loss of Interest	☐ Panic Attacks	☐ Racing Thoughts	☐ Risky Activity
☐ Sleep Changes	☐ Suspiciousness		

Medical History

Excessive frequency: __________ Exercise Type(s): __________

Allergies: ______________________

What medications are you currently using? ______________________

Previous diagnosis/mental health treatment : ______________________

Previous treated by: ______________________

Previous medications: ______________________

Dates treated: ______________________

Previous medical conditions: ______________________

Previous surgeries: ______________________

Family History

Were you adopted? __________ If yes, at what age? __________

How is your relationship with your mother? ______________________

How is your relationship with your father? ______________________

Siblings and their ages: ______________________

Are your parents married? __________

Did your parents divorce? __________ If yes how old were you? __________

Did your parents remarry? __________ If yes how old were you? __________

Who raised you? __________ Where did you grow up? __________

Family member mental condition(s): ______________________

Family member medical condition(s): ______________________

Treated with medication? ______________________

Medications: ______________________

Early Development

Where did you grow up? ______________________

How often did you move, and where? ______________________

How old were you when you left home? ______________________

Cal Psychiatric Services

Akindele Kolade, MD
2340 Paseo Del Prado, Bldg D. Ste. 301
Las Vegas, NV 89102
Ph. (702) 629-7490 Fax. (702) 629-7685

Rev: 6/2015

Personal Information (cont.)

Have any immediate family members died? ____________ Who? ____________
Have any committed suicide? ____________ Who? ____________
Describe any neglect you suffered, and by whom: ____________
Trauma suffered and by whom: ____________
Abuse suffered and by whom: ____________
Highest education level completed: ____________
Date completed and location ____________
Have you ever served in the military ____________ If yes, where? ____________
Dates of service: ____________ Highest rank achieved: ____________

Present Situation

Work: ☐ Full time ☐ Part time ☐ Student ☐ Unemployed ☐ Disabled ☐ Retired

Are you married ____________ If yes, date of marriage ____________
Are you divorced ____________ If yes, date of divorce ____________
Prior marriages ____________ If yes, how many? ____________
What is your sexual orientation? ____________ Are you sexually active? ____________
How is your relationship with your partner? ____________
Do you have any children? ____________ Dates of birth ____________
How is your relationship with your children? ____________
List anyone else who lives with you: ____________
Are you a member of a religion/spiritual group? ____________
What is your level of involvement? ____________
Have you ever been arrested? ____________ When and why? ____________

Have you ever tried to following (check all that apply)

☐ Alcohol	☐ Tobacco	☐ Marijuana	☐ Hallucinogens (LSD)
☐ Heroin	☐ Methamphetamines	☐ Cocaine	☐ Stimulants (pills)
☐ Ecstasy	☐ Methadone	☐ Tranquilizers	☐ Pain killers

If yes to any, list frequency and dates of use: ____________
____

Have you ever been treated for drunk alcoholic abuse? ____________ If yes when? ____________
For what substances? ____________
Do you smoke cigarettes? ____________ If yes, how many per day? ____________
Do you drink caffeinated beverages? ____________ If yes, how many per day? ____________
Have you ever abused prescription drugs? ____________ If yes, which ones? ____________

Anything else you want the doctor to know

____
____
____
____

Cal Psychiatric Services

Akindele Kolade, MD
3201 S. Maryland Pkwy., Suite 318
Las Vegas, NV 89109
Ph. (702) 629-7490 Fax. (702) 629-7685

Rev: 10/2016

Medical Insurance Request Form

Primary Insurance

Patient Name: ______________________ Date of Birth: ______________

Effective Date: ____________ Insurance Name: ______________

Subscriber's Name: ______________ Date of Birth: ______________

Member ID/Policy ID: ______________ Group No.: ______________

Patient Social Security # :

Who is the Subscriber's Employer? ______________________________

Insurance Claims Address: ______________________________

Please provide the Provider Number (on the backside of your card): ______________

Is the Patient covered by this plan? ☐ YES ☐ NO

What is the Subscriber's relation to the Patient? ______________________

Does the Patient have additional coverage by another plan? ☐ YES ☐ NO

Secondary Insurance

Effective Date: ____________ Insurance Name: ______________

Subscriber's Name: ______________ Date of Birth: ______________

Member ID/Policy ID: ______________ Group No.: ______________

Who is the Subscriber's Employer? ______________________________

Insurance Claims Address: ______________________________

Is the Patient covered by this plan? ☐ YES ☐ NO

What is the Subscriber's relation to the Patient? ______________________

Does the Patient have additional coverage by another plan? ☐ YES NO

If yes, please ask the office staff for an additional form to complete.

If this Document/Form is not filled out and Returned to the Office Staff, ALL APPOINTMENTS will be your RESPONSIBILTY on a CASH PAY BASIS.

NOTICE: If your Insurance requires a Deductible or COPAY/CO-INSURANCE, it must be collected at time of service.

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement. The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.

By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

- Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
- The practice reserves the right to change the privacy policy as allowed by law.
- The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
- The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
- The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

____

____

This consent was signed by: ________________________________

(PRINT NAME PLEASE)

Signature: ________________________________ Date: ____________

Witness: ________________________________ Date: ____________

Cal Psychiatric Services

CONSENT FOR PSYCHOTROPIC MEDICATIONS

1. I have the right to refuse medication.
2. The nature of my mental health condition has been explained to me by the doctor.
3. I have been informed that medication is a helpful form of mental health treatment, that there is a reasonable expectation I may benefit from prescribed medication, but there is no guarantee of improvement.
4. I have been given an explanation of the reasonable alternative treatments available (including other medications and non-medication oriented treatment) and why the physician is recommending this/these medication(s).
5. The name, type of medication(s) that I will be receiving, (brochures available upon my request), the range of dosages, frequency, and amount (including use of PRN orders), the method by which I will take the medication(s) (shots or by mouth), and duration of such treatment(s) have been explained to me by the doctor.
6. The probable side effects commonly known to occur with the drugs being prescribed have been discussed with me, and any particular side effects that may be specific for me. I understand that if I want to know more about my medications I can ask for further information.
7. If the doctor prescribed a major tranquilizer (neuroleptic), he/she discussed with me Tardive Dyskinesia, an additional side effect which may cause involuntary movement of the face, or mouth, hands and feet if the medication is taken beyond 3 months. I have been informed that this side effect may be potentially irreversible and may appear after the medication has been discontinued.
8. I have been informed that the use of alcohol and/or other medications while taking the prescribed medications may cause unexpected reactions and may increase the severity of the side effects described.
9. I understand that this consent may be withdrawn at any time by my stating such intention to any member of the treatment staff.

MEDICATION	INITIAL DOSE AND FREQUENCY	DAILY DOSE UP TO

I acknowledge that I have read and understand the above and agree to accept the medication (s) prescribed to me.

Signature of Patient

Signature of Physician

Parent/Guardian/Conservator

Date

	CONSENT FOR PSYCHOTROPIC MEDICATIONS	Patient Name and ID #

ReviewedLEforms04/04/06

Cal Psychiatric Services

Akindele Kolade, MD
3201 S. Maryland Pkwy., Suite 318
Las Vegas, NV 89109
Ph. (702) 629-7490 Fax. (702) 629-7685

I, ______________________________

Address: ______________________________

City\State: ______________________________

Phone: ______________________

Hereby authorize Cal Psychiatric Services to conduct psychiatric evaluation, diagnosis and treatment of me (or my child). ______________________________

I understand that records concerning my (my child's) treatment will be retained. Such data will be kept confidential. No information about me (my child) will be released without my written consent, except in the case of a medical emergency, or as permitted by law.

Patient Financial Consent Form

Please Initial

________ I have been informed of financial responsibility involved in my (my child's treatment). Unless arrangements have been made in advance, full payment will be required at the time of each visit.

________ Rescheduling/Cancellation/No-Shows policy is 24 hours' notice before the time of the appointment. Rescheduling/Cancella ions/No-Shows with less than 24 hour no ice before the appointment ime will be charged full customary fee of $50.

________ In case of an agreement to bill insurance, deductibles and co-payments will be collected at the time of each visit. **Patients are ultimately responsible for all payment of fees.**

________ In the event that you cancel or miss 3 appointments with less than 24 hours' notice, we will have to refer you to another doctor for treatment.

Signature: ______________________________ Date: ________________

☐ Patient ☐ Parent ☐ Legal Guardian ☐ Witness

Cal Psychiatric Services
Akindele E. Kolade, MD
Board Certified Psychiatrist
Diplomat American Board of Psychiatry and Neurology

Pharmacy Information

Name of your pharmacy: ______________________________

Address: ______________________________

Tel Number: ______________________________

Primary Care Physician:

Name: ______________________________

Tel Number: ______________________________

Address: ______________________________

if the patient is a child, are you the legal guardian? Yes__________ No__________

If the answer is No please be aware we need the legal guardian or a signed letter by legal guardian authorizing you to bring child to their appointments.

If you are not the parent of the patient and you are the legal guardian, we will need paper work from the courts showing the Guardianship. If we do not have that paperwork we will not be able to see the patient or discuss any matter of the patient with you.

3201 S. Maryland Parkway Suite 318 Las Vegas, NV 89109
www.calpsychservices.com
Phone (702) 629-7490 Fax (702) 629-7685

Cal Psychiatric Services
Akindele E. Kolade, MD
Board Certified Psychiatrist
Diplomat American Board of Psychiatry and Neurology

UA / TOXICOLOGY SCREEN

Name ______________________________

____ I give my consent to Cal Psychiatric Services to obtain a drug screen for me via urine or saliva as a diagnostic tool to further aid in my intervention/treatment.

____ I understand that testing will be incorporated as an accountability measure to ensure continued compliance with treatment, prevention of relapse and/or diversion, and to reinforce accountability. Results will be analyzed as expected and consistent with patient history and prescribed medication.

____ I understand that testing will be sent to designated laboratory for analysis. I am aware that results inconsistent with patient history and prescribed medications may result in action which may include increased level of care, termination of services, and if released by consent to my referral source possible legal consequences.

____ Results of collection will be forwarded, provided authorization, for the release has been obtained via consent for release of confidential information to the referring agency/person, i.e.

______________________________ ____________________

Patient Date

______________________________ ____________________

Parent/Guardian Date

3201 S. Maryland Parkway Suite 318 Las Vegas, NV 89109
www.calpsychservices.com

Cal Psychiatric Services

Akindele Kolade, MD
3201 S. Maryland Parkway, Suite 318
Las Vegas, NV 89109
Ph. (702) 629-7490 Fax. (702) 629-7685

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient's Name: ______________________ Date of Birth: ______________

Previous Name: ______________________ Social Security: ______________

I request and authorize ______________________________ to release health care information of the patient named above to:

Name: Akindele Kolade, MD - Cal Psychiatric Services

Address: 3201 S. Maryland Parkway, Suite 318

City: Las Vegas **State:** NV **Zip Code:** 89109

Phone: 702-629-7490 **FAX:** 702-629-7685

This request and authorization applies to:
Healthcare information relating to the following treatment, condition, or dates:

____

____

All healthcare information
Other: ______________________________

Definition: Sexually Transmitted Disease (STD) as defined by law, RCW 70.24 et seq., includes herpes, herpes simplex, human papilloma virus, wart, genital wart, condyloma, chlamydia ,non-specific urethritis, syphilis, VDRL, chancroid, lymphogranuloma venereum, HIV (Human immunodeficiency Virus), AIDS (Acquired immunodeficiency Syndrome), and gonorrhea.

☐ **Yes** ☐ **No** I authorize the release of my STD results, HIV/AIDS testing, whether negative or positive, to the person(s) listed above. I understand that the person(s) listed above will be notified that I must give specific written permission before disclosure of these test results to anyone.

☐ **Yes** ☐ **No** I authorize the release of any records regarding drug, alcohol, or mental health treatment to the person(s) listed above.

Date: ______________

______________________________ ______________________
Signature of Patient Date Signed:

AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED.

HIPAA Privacy Authorization Form

**Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)**

1. Authorization

I authorize ______________________________ (healthcare provider) to use and disclose the protected health information described below to ______________________________ (individual seeking the information).

2. Effective Period

This authorization for release of information covers the period of healthcare from:

a. ☐ ____________ to ____________.

OR

b. ☐ all past, present, and future periods.

3. Extent of Authorization

a. ☐ I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

OR

b. ☐ I authorize the release of my complete health record with the exception of the following information:

☐ Mental health records

☐ Communicable diseases (including HIV and AIDS)

☐ Alcohol/drug abuse treatment

☐ Other (please specify): ______________________________

4. This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effect until _______________ (date or event), at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

8. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

____

Signature of patient or personal representative

____

Printed name of patient or personal representative and his or her relationship to patient

____

Date