The Illuminated Mind, PLLC
4121 Okemos Rd, Ste 15
Okemos, MI 48864

Patient Information

Last Name_____ First_____MI_____

Street Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Email Address_____

Communication Preferences: **Ok to leave phone message?** Yes ☐ No ☐ **Ok to text message?** Yes ☐ No ☐ **Ok to email** Yes☐ No ☐

Gender as enrolled with insurance company _____Female _____ Male Language Preference _____

Date of Birth_____Age_____ Preferred Pronouns _____

Guarantor Information

LEGAL GUARDIAN MUST COMPLETE THIS SECTION
(IF PATIENT IS A MINOR OR INCAPACITATED ADULT)

Last Name_____ First_____MI_____

Street Address_____City_____State_____Zip_____

Home Phone_____ Cell Phone_____ Email Address_____

Communication Preferences: **Ok to leave phone message?** Yes ☐ No ☐ **Ok to text message?** Yes ☐ No ☐ **Ok to email** Yes ☐ No ☐

Date of Birth _____ Age _____ Language Preference _____

Release of Information to Third Party Payors/Agents & Authorization and Assignment of Benefits Agreement for Payment of Services:

I authorize my provider to disclose portions for the clinical record on the client named below to my insurance company and/or its contracted managed care/utilization review company for the purpose of reimbursement of services rendered at this facility. Such disclosure may include review and release of copies of psychiatric/psychological and/or substance abuse diagnosis, history & physical examinations, intake assessment, treatment plan, progress notes, testing results, discharge summary and any other information or records necessary for the discharge of the legal contractual obligations of the insurance company.

I hereby release my provider and its' officers, agents, employee and any clinician associated with my case from all liability that may arise as a result of the disclosure of information to the insurance company and/or its contracted managed care/utilization review company.

By signing this release, I acknowledge the following:

1. I am aware that I may revoke this authorization at any time except to the extent that action has been taken in reliance hereon.
2. I agree that this authorization will be valid during the pendency of the claim.
3. I further authorize that payment be made to my provider of service on my behalf.
4. I understand that I am financially responsible for all charges not covered by insurance and/or those stated to be patient responsibility by the third party payor.
5. I understand that any expense that is incurred by my provider associated with collecting the balance on my account, such as collection fees and/or attorney's fee will be my responsibility to pay.

Patient OR Guarantor Signature (if patient is a minor or incapacitated adult)_____Date_____

Medicare Authorization and Assignment of Benefits: (MEDICARE PATIENTS ONLY)

I request that payment of authorized Medicare Benefits be made either to me or on my behalf for any services furnished by or in the office of my provider of service. I authorize any holder of medical or other information about me to release to the Centers of Medicare and Medicaid Services (CMS) and its agents any information needed to determine these benefits or benefit of related services.

Signature_____ Date_____

PERSONAL HISTORY

Name: _____ Date: _____

Address: _____
Street

_____
City State Zip

Home No. : _____ Work No. : _____ Cell No. : _____

Please indicate the best number to contact you: ☐ Home ☐ Work ☐ Cell

DOB: _____ Age: _____ Place of Birth: _____

Occupation: _____ Place of Employment: _____

Marital Status: ☐ Never Married ☐ Domestic Partnership ☐ Married

☐ Separated ☐ Divorced ☐ Widowed

Names and ages of any children: _____

_____

_____

Highest level of education: _____ Vocational training: _____

Referred by (if applicable): _____

Emergency Contact: _____ Relationship: _____

Address: _____ Phone No.: _____

Medical Information

Primary Care Physician: _____ Phone number: _____

Psychiatrist: _____ Phone number: _____

Date of last physical exam: _____ Findings within normal limits? ☐ Yes ☐No

If no, please specify: _____

_____

Please list any allergies or sensitivities you have: _____

_____

Please list all medications you are currently taking:

Medication	Dosage	Reason for Taking	For How Long

Do you smoke? ☐Yes ☐No If so, how much? _____

Do you drink? ☐Yes ☐No If so, how much? _____

Do you exercise? ☐Yes ☐No If so, how much? _____

Caffeine consumption? ☐Yes ☐No If so, how much? _____

Other illicit substances? ☐Yes ☐No If so, how much? _____

On average, how many hours of sleep do you get each night: _____

Mental Health History

Have you received therapy services in the past? ☐ Yes ☐No If yes, when? _____

Where or with whom: _____

For what reason: _____

_____

Was it helpful? ☐ Yes ☐No

Why or why not? _____

_____

_____

Have you ever attempted suicide? ☐ Yes ☐No If yes, when? _____

Any psychiatric hospitalizations? ☐ Yes ☐No If yes, when? _____

Please state why you are currently seeking therapy services: _____

_____

_____

_____

_____

_____

What are your goals for therapy? _____

_____

_____

_____