ART OF AWARENESS

New Client Referral Packet

Address: Art of Awareness, Inc. 100 Waterman Drive, Suite 201, South Portland, Maine 04106
Phone: 207-805-0131 FAX: 207-742-1779 Email: clientservices@artofawareness.org

Today's Date:_____

Client Name:_____ DOB (MM/DD/YYYY):_____

Legal Name *(If Different)*:_____Gender Identity:_____ Pronouns:_____

Sex Assigned at Birth *(Required for Insurance Purposes Only)*:_____

Phone Number:_____ Email:_____

Mailing Address:_____

Town/City:_____ State:_____ Zip Code:_____

Emergency Contact Name:_____ Relation to Client:_____

Phone Number:_____ Email:_____

Relational Status *(Single, Partnered, Married, Separated, Divorced, etc.)*:_____

Are you Currently Employed?_____ If Yes, Where?_____

Are you Currently a Student?_____ If Yes, Where?_____

Do you have a partner, friend, or family member who is working with an Art of Awareness Therapist? Y☐ N☐

If Yes: Partner, Family Member, etc. Name:_____ Therapist Name:_____

Do you personally know, or are you related to an Art of Awareness staff member?_____

Do you have any allergies that we should be aware of?_____

Primary Care Provider Name & Practice:_____

_____

Are you currently working with any other healthcare providers (e.g. nutritionist, psychiatrist, medical specialists)? Y☐ N☐

Provider Name & Profession:_____

Provider Name & Profession:_____

Are you currently seeing a therapist? Y☐ N☐ Current Therapist's Name:_____

If you are currently seeing another therapist, are you looking to switch providers?_____

_____

Have you sought therapy in the past? Y☐ N☐ Past Therapist's Name:_____

Are you open to telehealth therapy? Whichever is First Available☐ Telehealth Preferred☐ In-Person Preferred☐

Are you open to biweekly therapy sessions? Whichever is First Available☐ Weekly Preferred☐ Biweekly Preferred☐

Do you have a preference for a female or male identifying provider? Whoever is First Available☐ Female☐ Male☐

Which type(s) of therapy service(s) are you seeking? Individual ☐ Relationship ☐ Family ☐ Groups ☐

Which specific days and times are you available for therapy sessions *(Required)*?_____

_____

Topics to be addressed in therapy *(Required)*:_____

_____

_____

_____

_____

Have you ever been hospitalized for a Mental Health, Substance Use Disorder, or an Eating Disorder related concern? Y ☐ N ☐

If Yes, please list when and where:_____

_____

_____

If you are currently taking any medications, please list them below:

_____

_____

Are you currently experiencing any of the following?

- ☐ Poor Sleep
- ☐ Change in Appetite
- ☐ Medical Health Problems

If Yes, please provide more information:_____

_____

_____

Have you experienced any of the following currently, or in the past? **Crisis Line 24/7 Phone: 888-569-1112**

Thoughts of Self Harm	☐ Current	☐ Past	☐ Never/Not Applicable
Thoughts of Suicide	☐ Current	☐ Past	☐ Never/Not Applicable
Suicidal Plan or Intent	☐ Current	☐ Past	☐ Never/Not Applicable
Thoughts of physically harming another person	☐ Current	☐ Past	☐ Never/Not Applicable
Homicidal Plan or Intent	☐ Current	☐ Past	☐ Never/Not Applicable

If you answered "Yes/Current" to any of the above questions, please reach out to the crisis line (listed above) or go to your nearest emergency room. Art of Awareness is not a crisis center, and is a by-appointment only therapy practice. We will get back to you within 2-4 business days upon receipt of your New Client Referral Packet. Please reach out to the crisis line for immediate support.

How much alcohol do you consume on a weekly basis?_____

Do you overuse or abuse any substances/drugs? ☐ Current ☐ Past ☐ Never/Not Applicable

_____

Have you experienced any traumatic events? ☐ Current ☐ Past ☐ Never/Not Applicable

_____

Do you have a family history of mental health concerns, substance use disorder, or eating disorders? ☐ Y ☐ N

Do you have Disordered Eating? ☐ Current ☐ Past ☐ Never/Not Applicable

_____

Overall, on a scale of 1 to 5, to what degree are the symptoms you are experiencing affecting your quality of life and functioning?

(1 being minimally impacting your life, 5 being severely impacting your life) ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

<u>Resources & Support:</u>

What activities do you enjoy?_____

_____

Who is in your current support system?_____

_____

What are your strengths?_____

_____

Additional Notes/Comments:_____

_____

_____

_____

_____

ART OF AWARENESS

Client Insurance and Benefit Form

Please complete the form below to provide Art of Awareness with your insurance coverage details for routine outpatient mental health services. Please note that authorizations and/or estimates for insurance coverage do not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations and exclusions of the contract at the time of services. If needed, we have included an additional form in this packet called the "*Benefit Retrieval Guide for Clients*" as a resource to clients to gain their mental health benefit information.

Client Information:

Client Name:_____ DOB (MM/DD/YYYY):_____

Legal Name *(If Different)*:_____Gender Identity:_____ Pronouns:_____

Sex Assigned at Birth *(Required for Insurance Purposes Only)*:_____

Phone Number:_____ Email:_____

Mailing Address:_____

Town/City:_____ State:_____ Zip Code:_____

For Minors and/or Adult Clients who have an Identified Parent/Guardian/Guarantor Point-of-Contact for Billing Related Matters:

Parent/Guardian/Guarantor Name:_____

Relation to Client:_____

Phone Number:_____ Email:_____

Has a Release of Information Authorization form been signed for Billing purposes? ☐ Y ☐ N

If no, and the client would like to identify a Parent/Guardian as a point of contact for billing related matters, the Release of Information Authorization is included in this packet for the client to complete and submit to clientservices@artofawareness.org.

Insurance Information:

Insurance Company Name:_____

Subscriber Name:_____ Renewal Date (MM/DD/YYYY):_____

Member ID# (Including Alpha-Prefix):_____

Insurance Provider Phone-Number: (_____)-_____-_____

For Reference:

Art of Awareness Tax ID#: 65-125-4395

Art of Awareness Clinical Supervisory Director NPI# (Provider: Emily Roberson, LCSW): 1154484236

Client Benefit Information for Routine Outpatient Mental Health (Office and Telehealth):

Copay Per Session:_____

Deductible:

Individual:_____

Amount Met:_____

Family:_____

Amount Met:_____

Coinsurance %:_____

Max Out-of-Pocket Amount:

Individual:_____

Amount Met:_____

Family:_____

Amount Met:_____

Beneficiary Agreement

Please note that authorizations and/or estimates for insurance coverage do not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the members contract at the time of service. Payment at the time of service for services rendered at Art of Awareness, Inc. is expected to be made.

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

If my health insurance changes or I lose coverage for any reason, I agree to contact the Billing department at Art of Awareness, Inc. as soon as I have my new health insurance information OR as soon as I know I will be losing coverage. If I fail to provide this information I understand that I may be responsible for out-of-network or uncovered charges.

I understand that my payment information, or payment information of the financially responsible party, will be kept on file within a secure electronic health records system. By signing this agreement, I consent to having the card saved on file charged for sessions rendered at Art of Awareness, Inc. at the time of service.

Client and/or Financially Responsible Party Signature:_____

Date:_____

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Release of Information Authorization

Art of Awareness Provider: _____
Address: Art of Awareness, Inc. 100 Waterman Drive, Suite 201, South Portland, Maine 04106
Phone: 207-805-0131 FAX: 207-742-1779 Email: clientservices@artofawareness.org

Client Name: _____Date of Birth: _____
Home/Billing Address:_____
City:_____ State:_____ Zip Code:_____

I hereby authorize the above Provider to release and obtain (verbally and/or in writing) information related to my medical and mental health treatment / history to the following individual, clinic staff, agency or institution:

Name: _____ Phone: _____ FAX:_____
Address:_____
City:_____ State:_____ Zip Code:_____

I authorize the release of information which is checked below:

Billing Related Information ☐ Evaluation/Assessment ☐ Medical History ☐ Treatment Status ☐

Diagnosis ☐ Psychological Test ☐ Aftercare Plan ☐ Treatment Plan ☐ Psychosocial History ☐

Discharge Summary ☐ Other, please describe:_____

SOME INFORMATION IS SPECIALLY PROTECTED. IF YOU WANT ANY OF THE FOLLOWING INFORMATION TO BE SHARED, YOU MUST CHECK A BOX BELOW:

_☐_ I WANT any information about diagnosis and/or treatment of alcohol or drug abuse to be shared
_☐_ I WANT any information about diagnosis and/or treatment of HIV/AIDS to be shared

This information is to be used for: _____

Restriction(s) on material revealed: _____

Revocation: I understand that I can revoke (cancel) this authorization to disclose the above-referenced information at any time, except to the extent that disclosure has been made in reliance upon my authorization before revocation. I am aware that I can revoke my authorization in writing by addressing a letter to that effect to the above Provider; however, it will not be effective until the above Provider receives it.

This consent will expire thirty (30) months from the date hereof, unless I have previously revoked this consent, or unless I have specified a shorter period of expiration of this Consent, as follows: _____. I understand that I may receive a copy of the authorization.

I revoke this authorization to disclose the above-referenced information:_☐__

Client or Guardian Signature:_____ **Date:**_____