VITAG HEALTH LLC		VIDA SARKODIE INC	
	2816 Morris Avenue, Suite 22, Union, NJ 07083		230 Rte 206, Bldg 3, Flanders, NJ 07836
	908-623-3365		973-298-0812
	908-623-3358		973-874-5194

ADULT INTAKE FORM

Today's Date: _____ Drug Allergies: _____

_____

Name, Address and Phone number of Pharmacy:

Name: _____ _____ _____
Last First Middle

Address _____ _____ _____ _____
Street City State Zip

Home Phone: _____ Cell Phone _____

Age: _____ Date of Birth _____ Marital Status: _____ Height: _____ Weight: _____

Occupation: _____ Email: _____

Father's Name _____ Age _____ E-Mail _____

Company/School/Education: _____

Work Phone: _____ Social Security #_____
(For Office Use only)

☐ Wife ☐ Husband ☐ Significant Other

Name _____ E-Mail _____

Age: _____ Occupation: _____

Cell phone # _____ Work phone # _____

Father's Name _____ Age _____ E-Mail _____

Father's Occupation _____ Work phone # _____ Cell phone # _____

Mother's Name _____ Age _____ E-Mail _____

Mother's Occupation _____ Work phone # _____ Cell phone # _____

Stepfather's Name _____ Age _____ E-Mail _____

Stepfather's Occupation _____ Work phone # _____ Cell phone # _____

Stepmother's Name _____ Age _____ E-Mail _____

Stepmother's Occupation _____ Work phone # _____ Cell phone # _____

Children (Include names, ages/marital status/occupation/grandchildren)

Siblings, Step-Siblings, Half-Siblings (Include names, ages/marital status/occupation/nieces or nephews)

Please list referral source: (PLEASE DO NOT LEAVE THIS OUT.)

_____ _____

Referral Source Phone Number of Referral Source

☐ Google Search ☐ Health Grades ☐ Psychology Today ☐ ZocDoc ☐ Yelp ☐ Don't Recall

☐ Other _____

INSURANCE INFORMATION PRIMARY	SECONDARY
Insurance Company	Insurance Company
Insurance Contact Number	Insurance Contact Number:
Insurance ID #	Insurance ID #
Group#	Group#
Copay	Copay:
Name of Insured	Name of Insured
Date of Birth:	Date of Birth
Insured' Employer	Insured' Employer

Worker's Comp: ☐ Yes ☐ No Auto Accident: ☐ Yes ☐ No Date of Accident/Injury: _____

WCB/NF. Insurance Company: _____ Agent Name: _____

Address: _____ Phone Number: _____

Claim Number: _____ **Case/Policy Number:** _____

Please give your insurance card and Picture ID to the receptionist.

I hereby authorize my insurance benefits (e.g. Medicare & Madigan) to be paid directly to VITAG HEALTH LLC/VIDA SARKODIE INC. I will accept financial responsibility for non-covered services. If my account is sent to a collection agency, I agree that I will be responsible for all collection costs. I also authorize the office to release information about services rendered by my provider(s) to my insurance carrier(s) and allow a photocopy of my signature to be used to file insurance claims.

SIGNATURE: _____ DATE: _____

OFFICE PROCEDURES AND INSTRUCTIONS

Please call us during our normal business hours 9:00AM to 5:00PM at phone number 908-623-3365/973-298-0812 If it is a serious emergency situation, do not leave a message in the voice messaging system. Please call back and contact a person. If the office is closed, you will be transferred to our answering service and will be able to talk to an attendant. Please note, we do not check our voicemail or messages when the office is closed or over the weekend and holidays.

If there is a delay in the call back and you are in a serious life-threatening emergency, immediately proceed to the following steps:

- Call 911. In some cases, and depending on the situation, you may call the police or try to reach your PCP, a friend, relative, or neighbor.
- Go to the nearest emergency room for immediate help. If you live close to our offices you may go to the emergency room at Saint Clare's Denville Hospital.
- You may also call 973-625-6000(Morris County) or 908-522-2000(Union County) for psychiatric emergencies.

For regular appointments, please call us at least 1-2 weeks before you run out of your medications. On your regular visits, please inform us of any changes in your health, abnormal lab work, pregnancy or new medications prescribed by other doctors.

On each office visit, please make sure you have enough medication to cover you until your next visit and also over weekends and holidays.

Our office is no longer able to call/fax routine prescriptions to the pharmacy for renewals.

In case you cannot come for your scheduled appointment, please give us at least one to three business days' notice to call your pharmacy. As a courtesy, we will call your pharmacy to cover you until your next visit. Please note that we are unable to call any prescriptions over weekends, holidays, or after our normal business hours.

We do not authorize renewal of narcotics or controlled medications over the phone/fax at any time!

If you need to cancel/reschedule an appointment, we request a 24-hour notice. Our office will charge or bill a fee of $85 for missed appointments/Late Cancellations.

To prevent being billed for unauthorized visits, please provide us with appropriate referrals, authorizations, and changes in your insurance information. Our secretary will gladly help you and provide information. If the office does not have your most current insurance information, you will be responsible for the services provided by the doctor. For billing questions/problems, please contact 908-623-3365/973-298-0812. If you are not satisfied with the response, contact the doctor directly.

I, _____, have read and understood all the above procedures and instructions at VIDA SARKODIE INC.
(Print Name.)

_____ _____

Patient Signature (If under 18, Patient's Parent/guardian) Date

LIMITS OF CONFIDENTIALITY

Content of all therapy sessions are considered to be Confidential. Both Verbal information and written records about a client cannot be shared with another party without the written consent of the client or the client's legal guardian. Noted exceptions are as follows:

Duty to Warn and Protect: When a client discloses intentions or a plan to harm another person, the mental health professional is required to warn the intended victim and report this information to legal authorities. In cases in which the client discloses or implies a plan for suicide, the healthcare professional is required to notify legal authorities and make reasonable attempts to notify the family of the client.

Abuse of Children and Vulnerable Adults: If a client states or suggests that he or she is abusing a child (or vulnerable adult) or has recently abused a child (or vulnerable adult), the mental health professional is required to report this information to the appropriate social service and/or legal authorities.

Prenatal Exposure to Controlled Substances: Mental Health care professionals are required to report admitted prenatal exposure to controlled substances that are potentially harmful.

Insurance Providers (when applicable): Insurance companies and other thirty-party payers are given information that they request regarding services to clients. Information that may be requested includes, but is not limited to types of service, dates/times of service, diagnosis, treatment plan, description of impairment, progress of therapy, case notes, and summaries. I agree to the above limits of confidentiality and understand their meanings and ramifications.

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____, authorize this office and its staff to release protected health information
Patient's Name [Please Print]

related to my evaluation and treatment to the following:

PCP NAME: _____ PCP PHONE NUMBER: _____

THERAPIST NAME: _____ THERAPIST PHONE NUMBER: _____

FAMILY MEMBER NAME: _____ RELATIONSHIP: _____

FAMILY MEMBER PHONE NUMBER: _____

_____ _____

Patient Signature **Date**

EMERGENCY CONTACT

Name: _____ Relationship to you: _____

_____ _____ _____

Daytime Phone: Cell Phone Evening Phone

Answer the following with respect to the symptoms that bring you here today.
IF “1” IS THE WORST YOU EVER FELT AND “10” IS THE BEST, WHERE ARE YOU TODAY?

1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐

CHIEF COMPLAINT
Describe the reason for this visit and the symptoms that you are currently experiencing.

HISTORY OF THE PRESENT ILLNESS
Describe when your current symptoms began and if they have changed over time.

Are you currently in psychotherapy? ☐Yes ☐No

If yes, how long have you been in treatment with your current therapist? _____

If yes, what is the name and phone number of your therapist?

Name: _____ Phone Number: _____

Primary Care Physician: Name: _____

Address: _____

Phone No.: _____ Date of Most Recent Appointment: _____

List all Medications your child is currently taking (including psychiatric, medical and over the counter):

DRUG	DOSE	START DATE	CONDITION BEING TREATED'

Please describe if there are/were side effects to any of the psychiatric medications (even if you are not sure if they are side effects):

What are the names and phone numbers of the physicians who are/were prescribing the medications?

Name	Phone Number	Which Medications?

PAST PSYCHIATRIC HISTORY

Describe past psychiatric history and other treatments for psychiatric symptoms and dates of treatment (include what diagnoses you were told that you had in the past and/or presently have now):

Have you ever been hospitalized for a psychiatric illness? If yes, list the hospitals and dates of admission and discharge.

FAMILY HISTORY

Is there a family history of psychiatric disorder, drug dependency and/or alcoholism? (Include parents, siblings, aunts, uncles and cousins)

PSYCHO - SOCIAL HISTORY – WORK HISTORY

Friends- Relationships – Education - Employment – Most recent Living Situation – Drug and/or Alcohol History:

DEVELOPMENTAL HISTORY

Significant events in your life since childhood other than covered in Social History:

ANY ADDITIONAL PERSONAL HISTORY OR RELEVANT INFORMATION

You Feel Might Be Helpful:

Are you currently having suicidal thoughts? ☐ No ☐ Yes

If yes, do you have a plan? ☐ No ☐ Yes

Have you ever attempted suicide? ☐ No ☐ Yes

If yes, please explain circumstances.

How much coffee, tea or caffeine-containing beverages do you drink a day? _____

Do you smoke? ☐ Yes, ☐ No Number of cigarettes per day: _____

Do you use recreational drugs? ☐ Yes ☐ No If yes, which ones and how often?

_____

Do you drink? ☐ Yes ☐ No Specify number of glasses or bottles per week: _____

Please specify which beer, hard liquor or wine: _____

Do you use Motrin, Advil, Aleve, Ibuprofen or other drugs for pain or inflammations? ☐ Yes ☐ No

Which ones? _____

Have you ever been treated for any of the following?

	YES	NO	COMMENTS *(TO BE ENTERED BY PSYCHIATRIST ONLY)*
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Endocrine (including Diabetes)	☐	☐	
Arthritis or Other Bone Problems	☐	☐	
Neurological Problem/Parkinson's	☐	☐	
Cataracts/other eye problems	☐	☐	
Nose/Mouth/Throat	☐	☐	

Hearing Problems	☐	☐	
Lung/Respiratory Diseases	☐	☐	
Skin Diseases	☐	☐	
Urinary Problems	☐	☐	
Gastro-Intestinal	☐	☐	
Growths/Cancer	☐	☐	
Hospitalizations	☐	☐	
Major Operations	☐	☐	
Sexually Transmitted Diseases	☐	☐	
Kidney Disease	☐	☐	
Liver Disease	☐	☐	
Gynecologic Problems	☐	☐	
Muscular Problems	☐	☐	
Sexual Problems (including. STDs)	☐	☐	
Other Medical Problems	☐	☐	

Has anyone in your family had?

	YES	NO	COMMENTS *(TO BE ENTERED BY PSYCHIATRIST ONLY)*
Blackouts	☐	☐	
Convulsions or Seizures	☐	☐	
Headaches	☐	☐	
Tremors	☐	☐	
Dizziness	☐	☐	
Forgetfulness	☐	☐	
Major Weight Loss/Gain	☐	☐	

BRIEFLY DESCRIBE ANY CURRENT MEDICAL PROBLEMS

Has anyone in your family been treated for?

	YES	NO	COMMENTS *(TO BE ENTERED BY PSYCHIATRIST ONLY)*
Heart Disease	☐	☐	
High Blood Pressure	☐	☐	
Stroke	☐	☐	
Endocrine (including Diabetes)	☐	☐	
Arthritis or Other Bone Problems	☐	☐	
Neurological Problem/Parkinson's	☐	☐	
Cataracts/other eye problems	☐	☐	
Nose/Mouth/Throat	☐	☐	
Hearing Problems	☐	☐	
Lung/Respiratory Diseases	☐	☐	
Skin Diseases	☐	☐	
Urinary Problems	☐	☐	
Gastro-Intestinal	☐	☐	
Growths/Cancer	☐	☐	
Hospitalizations	☐	☐	
Major Operations	☐	☐	
Sexually Transmitted Diseases	☐	☐	
Kidney Disease	☐	☐	
Liver Disease	☐	☐	
Gynecologic Problems	☐	☐	
Muscular Problems	☐	☐	
Sexual Problems (including. STDs)	☐	☐	
Other Medical Problems	☐	☐	

Have you had?

	YES	NO	COMMENTS *(TO BE ENTERED BY PSYCHIATRIST ONLY)*
Blackouts	☐	☐	
Convulsions or Seizures	☐	☐	
Headaches	☐	☐	
Tremors	☐	☐	
Dizziness	☐	☐	
Forgetfulness	☐	☐	
Major Weight Loss/Gain	☐	☐	

Do you have a history of:

☐ Drug Abuse ☐ Alcohol Abuse

BRIEFLY DESCRIBE ANY CURRENT MEDICAL PROBLEMS

Briefly describe any unusual childhood illnesses: (please give age)

Briefly describe any serious adult illnesses: (please give approx. age)

Briefly describe any hospitalizations or surgeries

For women of child bearing age, please record date of last menstrual period: _____

PSYCHOTROPIC MEDICATION INFORMED CONSENT AND CONSENT FOR TREATMENT

NAME_____ DOB _____

I have reviewed the following medications and information with the psychiatrist.

Medication		Date	Initial
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			
11.			
12.			
13.			
14.			

The following topics have been discussed:

- Name and description of the medication
- Potential for interactions
- Risks and benefits
- Expected outcomes
- Potential complications
- Risks and precautions related to driving
- Risks of addictions, withdrawals, and weight gain
- Risks of falls and other accidents
- Reasonable alternative medications and alternative of NO medication
- In females, risks association with pregnancy and lactation. Please inform us immediately if you become pregnant.
- Risk of concomitant drinking or using
- other drugs.
- Risk of tardive
  - dyskinesia Which may be a permanent condition (certain medications

I agree and consent to be treated by Vida Sarkodie or the covering doctor/nurse practitioner when not available.
I understand and give permission to the office to contact me for appointment reminders, billing/health concerns, and other matters.
I agree to allow the office to message, text, or email me.
I have been given the opportunity to ask questions about the information. I agree to take the above medications.
I have discussed treatment options in emergency situations with the doctor.

_____ _____

PATIENT/LEGAL GUARDIAN SIGNATURE PHYSICIAN SIGNATURE

_____ _____

Date Date

Notice of Privacy Practices
Patient Acknowledgement

Patient Name: _____
Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights, how may I exercise these rights, and the practice's legal duties with respect of my information.

I understand that this practice reserves the right to change the terms of its Notice of Privacy Practices, and to make changes regarding all protected health information resident at, or controlled by, this practice.

I understand I can obtain this practice's current notice of Privacy Practice on request.

Signature:_____ Date: _____

Relationship to Patient: _____

(If signed by a personal representative of the patient)