

# SunDance Behavioral Resources, LLC

## Adult Registration & History Form

Name: \_\_\_\_\_ Sex: M / F Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_  
Occupation: \_\_\_\_\_  
City State Zip Employer: \_\_\_\_\_  
Best phone number for appointment reminder: \_\_\_\_\_  
Select all that apply:  
Alt Phone: \_\_\_\_\_  Single  Married  Separated  Divorced  Widowed  
Employed:  Full-time  Part-time  Homemaker  
Student:  Full-time  Part-time  
Emergency contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
Relationship to patient: \_\_\_\_\_

### Insurance Information

Name of policy holder: \_\_\_\_\_ Sex: M / F Date of Birth \_\_\_/\_\_\_/\_\_\_ Age: \_\_\_\_\_  
Address if different: \_\_\_\_\_  
Insurance plan: \_\_\_\_\_ ID#: \_\_\_\_\_  
Patient's relationship of insured:  Self  Spouse  Child  Other  
Authorization number (if required by your insurance): \_\_\_\_\_  
Copay: \$ \_\_\_\_\_ Deductible: \$ \_\_\_\_\_ Limit of sessions per year: \_\_\_\_\_

Children's names and ages: \_\_\_\_\_

Additional members of household (please include relationship & ages): \_\_\_\_\_

Where can we send a thank you note for this referral? (Please include name, address or phone number if available): \_\_\_\_\_

### Medical History

Please list any current medications (please indicate if it is an injectable medication): \_\_\_\_\_

Please list any past medications: \_\_\_\_\_

Who is/was the prescriber for these medications? \_\_\_\_\_

Please list any medication allergies: \_\_\_\_\_

What is the approximate date of your last physical exam? \_\_\_\_\_

Please list any doctors or therapists that you are currently seeing outside of SunDance: \_\_\_\_\_

Please indicate if you have had any of the following conditions:

<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Thyroid Disorder	<input type="checkbox"/> Chronic Bronchitis
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Glaucoma
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Cancer	<input type="checkbox"/> Rheumatic Fever
<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Venereal Disease	<input type="checkbox"/> Heart Disease
<input type="checkbox"/> Asthma	<input type="checkbox"/> Allergies	<input type="checkbox"/> Stroke
<input type="checkbox"/> Jaundice	<input type="checkbox"/> Anemia	<input type="checkbox"/> Hepatitis
<input type="checkbox"/> Liver Disease	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Stomach Ulcer
<input type="checkbox"/> High Blood Pressure	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Other:

Have you recently experienced any of the following symptoms?

<input type="checkbox"/> Excessive Fatigue	<input type="checkbox"/> Numbness of Tingling	<input type="checkbox"/> Swollen/Sore Glands
<input type="checkbox"/> Loss of Hearing	<input type="checkbox"/> Ringing in the Ears	<input type="checkbox"/> Difficulty Swallowing
<input type="checkbox"/> Chronic Cough	<input type="checkbox"/> Blood with Cough	<input type="checkbox"/> Abnormal Chest X-ray
<input type="checkbox"/> Wheezing	<input type="checkbox"/> Heart Murmur	<input type="checkbox"/> Other Heart Problem
<input type="checkbox"/> Changes in Bowles	<input type="checkbox"/> Rectal Bleeding	<input type="checkbox"/> Pain/Difficulty Urinating
<input type="checkbox"/> Weight Change	<input type="checkbox"/> Recurrent Stomach Pain	<input type="checkbox"/> Black Stools
<input type="checkbox"/> Chest pain	<input type="checkbox"/> Blood in Urine	<input type="checkbox"/> Shortness of Breath
<input type="checkbox"/> Swelling in Limbs	<input type="checkbox"/> Easy Bleeding/Bruising	<input type="checkbox"/> Frequent Headaches
<input type="checkbox"/> Heart Palpitations	<input type="checkbox"/> Blurred Vision	<input type="checkbox"/> Dizziness
<input type="checkbox"/> Sexual Difficulties	<input type="checkbox"/> Suicidal Thoughts	<input type="checkbox"/> Balance Problems
<input type="checkbox"/> Atypical Vaginal Bleeding	<input type="checkbox"/> Infertility/Impotence	<input type="checkbox"/> Sexual Pain
<input type="checkbox"/> Excessive Perspiration	<input type="checkbox"/> Trembling/Shaking	<input type="checkbox"/> Flashbacks
<input type="checkbox"/> Sadness/Crying	<input type="checkbox"/> Feelings of Guilt	<input type="checkbox"/> Poor Concentration
<input type="checkbox"/> Feelings of Unreality	<input type="checkbox"/> Loss of Interest	<input type="checkbox"/> Change in Appetite
<input type="checkbox"/> Sleep Difficulty	<input type="checkbox"/> Excessive Sleep	<input type="checkbox"/> Avoiding Situations
<input type="checkbox"/> Irritability	<input type="checkbox"/> Obsessions	<input type="checkbox"/> Compulsiveness
<input type="checkbox"/> Low Energy	<input type="checkbox"/> Feelings of Worthlessness	<input type="checkbox"/> Easily Distracted
<input type="checkbox"/> Feeling Overwhelmed	<input type="checkbox"/> Wishing to Run Away	<input type="checkbox"/> Restlessness

Please describe any additional current medical problems: \_\_\_\_\_

What tobacco products do you use? \_\_\_\_\_

How frequently do you use alcohol? \_\_\_\_\_

What other drugs have you used in the past year? \_\_\_\_\_

Please list any previous mental health diagnosis: \_\_\_\_\_

Please list any history of mental health hospitalizations: \_\_\_\_\_

Please list any history of self-harm or suicide attempts: \_\_\_\_\_

Are you court ordered to have mental health or substance abuse treatment? If yes, please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Are you seeking disability benefits? \_\_\_\_\_  
What is/are the main reason(s) you are seeking mental health treatment at this time? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

### Release of Information

By signing this form, I authorize SunDance Behavioral Resources, LLC to release information to and receive information as indicated from the following individuals:

1. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

This person may (mark each, as appropriate):

make appointments  cancel appointments  discuss treatment  refill prescriptions  other \_\_\_\_\_

2. Name: \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone Number: \_\_\_\_\_

This person may (mark each, as appropriate):

make appointments  cancel appointments  discuss treatment  refill prescriptions  other \_\_\_\_\_

### Patient/Guardian Consent To Treatment/Agreements

**Please initial beside each section to indicate that you have read and understand each policy:**

\_\_\_\_\_ **Copays and Fees for Non-Insured Clients are due at the time of service.**

If client is unable to pay copay, a \$10.00 billing fee is charged. SunDance is unable to carry a balance in excess of \$50.00. Non compliance in payment arrangements may result in termination of treatment at SunDance.

\_\_\_\_\_ **Cancellations and Missed Appointments**

Missed appointments cancelled with less than 24 hours notice prior to the appointment must be paid in full by the patient or guardian. **The charges for missed therapy appointments are \$65.00 and for a Psychiatrist \$50.00 per session.** Insurance companies do not pay for these. SunDance strictly adheres to this policy. Missing three unexcused appointments may result in a termination of treatment at SunDance. If you are under the care of a psychiatrist, a transition prescription will be provided.

\_\_\_\_\_ **Prescription Refills**

Insurance companies do not reimburse for prescriptions researched and filled between appointments. **You will be charged \$15 for any prescriptions filled outside of an appointment and only up to your next appointment.** Some schedule II prescriptions are required by law to be written every 30 days, and are excluded.

\_\_\_\_\_ **Paperwork and Letters**

Disability, FMLA, or Insurance paperwork will not be filled out by SunDance providers unless you are an existing patient of one year. Letters requested by therapists and doctors outside of an appointment will include a \$25.00 charge.

**Collections and Legal Fees**

Returned checks are charged at \$20 each. Should any of your charges with SunDance become 30 days past due, a finance charge of 1.5% will be added each month. Should collection become necessary, your signature on this document indicates your agreement to pay an additional 40% of the amount overdue as a collection fee in addition to all legal fees connected to the collection, with or without suit, including attorney fees and court costs.

**Binding Arbitration Agreement**

This agreement requires that you submit all future claims to arbitration instead of having the claim heard in court by a judge or jury. This agreement is included to minimize the cost of any disputes that may arise from your contact with SunDance. You may decline to sign the arbitration agreement and still receive health care at SunDance. Simply write "I decline the binding arbitration agreement" above your signature below. You have the right to have all of your questions about arbitration answered.

**Costs of Services Not Covered by Insurance and other 3<sup>rd</sup> Party Payers.**

On occasion there is need for SunDance to provide services that are not covered by insurance or other 3<sup>rd</sup> Party payers. These may include, but are not limited to letters, reports, conversations or other communication to attorneys, government agencies, school or employment entities etc. This also includes any required response to subpoenas, court orders, etc. SunDance will always make a good faith effort to notify the patient or responsible party and will release records only as required by law. In such an event any costs incurred will be billed to the corresponding patient or responsible party.

**Primary Care Physician**

In order to offer the best care possible, we would like to notify your primary care physician of your care at SunDance. **This is recommended, but not required.** Please Initial One:

\_\_\_\_\_ I authorize SunDance Behavioral Resources to release important information about my mental and physical treatment to my doctor.

Doctor's Name

Address

Phone Number

\_\_\_\_\_

\_\_\_\_\_ I do not authorize notification to my doctor

**Your signature below indicates that you were given this Consent to Treatment and agree to its terms including the cancellation policy, prescription charges, collections and legal fees, fees and billing policies, and binding arbitration agreement and that you have received the HIPAA Notice form. It also indicates your agreement to give SunDance all rights to payments from your insurance company or other third party payer.**

Signed,

\_\_\_\_\_ Date: \_\_\_\_\_

**We encourage you to use our website [www.sundancebehavioral.com](http://www.sundancebehavioral.com) to contact us re: appointments, medication refills, and any communication with our providers**