New Client Form

Please note that everything on this form is CONFIDENTIAL

Client Information

Client's Name:__________________________________ Age:_______________ DOB:____________________

Email:____ SS#:____

Address:_______________________________________ Referral Source: Internet ❒ Friend ❒

____ Dublin Springs ❒ Other:_____________________❒

(City) (State) (Zip)

Contact Preference (please circle one): HOME PH ❒ CELL PH ❒ EMAIL ❒ TEXT ❒ MAIL ❒

Telephone #: ( )_________________________ Cell #: ( )______________________________

OK to leave Confidential Information? YES ❒ NO ❒ OK to leave Confidential Information? YES ❒ NO ❒

Emergency Contact

Contact Name:__________________________________ Telephone #: ( )__________________________

Relationship to You:____________________________

Primary Care Provider

Doctor Name:__________________________________ Doctor Ph #:( )______________________________

Doctor Address:____

Therapist Information

Therapist Name:________________________________ Therapist Ph #: ( )__________________________

Therapist Address: ____

Preliminary Information

Reason for seeking treatment: ____

Medical Issues (current and past):____

Current Prescribed Medications: (please list all meds you are taking, how often and dosages)

Medication	How often	Dose	Medication	How often	Dose

Current Over-The-Counter Medications: (please list all meds you are taking, how often and dosages)

Medication	How often	Dose	Medication	How often	Dose

Your Goals for treatment:

1) ____

2) ____

3) ____

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Provider / Client Agreement

Initials:	Important Information:
_______________	I understand if needed I am to cancel my appointment within 24 hours or else I may be charged a $15 late cancelation fee.
_______________	I understand if I do not call to cancel my appointment, and I do not show up to it I will be charged a $30 "No Call/No Show" fee.
_______________	**I understand that I am to pay for my visit or copay before starting the appointment, and that I can pay by cash, credit card (Visa, Mastercard, Discover or Debit Card) or check. If I do not have my payment at the beginning of my appointment I understand I will be asked to reschedule and will not be seen.**
_______________	If my check does not clear I understand I will be billed for a "bounced check" fee of $30.
_______________	I understand I need to give a 3-5 business day notice if I am running out of a medication to give the provider time to review my case, call in a refill, and/or reschedule an appointment if needed prior to refilling the medication.
_______________	I understand my provider will return my phone calls within 24-48 hours if I leave a message Sunday through Thursday, and within 72 hours if I leave a message Friday or Saturday.
_______________	I understand that if I am having an emergency I should call 911, not my provider.
_______________	I have had a chance to review the "Notice of Privacy Practices" (available at www.bluestonevitality.com under "Client FAQ"), and understand a copy will be made available to me, should I request one.

Controlled Drugs

Initials:	Important Information:
_______________	I understand that a nurse practitioner cannot prescribe Suboxone/Subutex (buprenorphine) or Methadone.
_______________	I understand that this provider cannot prescribe stimulants such as Adderall, Concerta, Dexedrine, Focalin, Medadate, Methylin, Procentra, Ritalin, Vyvance, etc.
_______________	I understand that benzodiazepines (such as Ativan/lorazepam, Dalmane/flurazepam, Klonopin/clonazepam, Librium/chlordiazepoxide, Restoril/temazepam, Serax/oxazepam, Valium/diazepam, and Xanax/alprazolam) that I was previously prescribed may not be continued if it is not found to be the best medication for me as determined by my provider.

Confidentiality and Release of Information

All records are confidential and secured and will not be released without your authorization. Limitations include:

1. Client authorizes release of information with a signature.
2. Client authorizes release of information for reimbursement purposes as defined by the insurance provider.
3. Client's mental condition becomes an issue in a lawsuit.
4. Client presents as a physical danger to self.
5. Client presents as a danger to others.
6. Child or elder abuse/neglect is suspected.

By signing I verify I understand the limitations to confidentiality, and that I have read, understand and accept the office policies.

____ _________________________

Signature Date

If you have any questions regarding any required information on this form or about Bluestone Vitality, LLC please call (614) 636-BLUE (2583), or email info@bluestonevitality.com. Please do not provide any confidential information in a voicemail or email.