EPIPHANY
PSYCH SERVICES

INTAKE FORM

PATIENT INFORMATION

Full Name :

Date Of Birth : ____________ / ____________ / ____________

Address : ____________________

Phone Number : ____________________ **SSN** : ____________

E-Mail : ____________________

Status : ☐ Single ☐ Married ☐ Divorce ☐ Others

This space is where you can share notes

Note : ____________________

EMERGENCY CONTACT DETAILS

Contact Name : ____________________

Relationship : ____________________ **Mobile Number** : ____________________

PATIENT AUTHORIZATION AND FINANCIAL AGREEMENT

I authorize EpiphanyPsychServices,LLC to charge my credit card/ bank for services provided. I request payment from myself be made to EpiphanyPsychServices, LLC. I certify that the above information I have provided is correct and authorize the release of any necessary information for this or any related claims. I permit a copy of this authorization to be used in place of the original. This authorization may be revoked by me at any time in writing. I understand that nothing herein relieves me of the primary responsibility obligation to pay for medical services provided, when the statement is rendered. I understand if my account becomes assigned to a collection agency, I agree to pay all collection agency fees, court costs, and attorney fees.

Printed Name : ____________________ **Date** : ____________

More Information :

312 Baltimore Street Gettysburg, PA 173257

(717) 398-3828

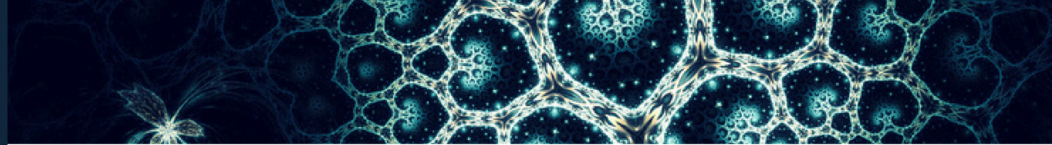
epiphanypsychservices.com

info@epiphanypsychservices.com

____

Patient Signature

THANK YOU



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HOW DID YOU HEAR ABOUT US AND WHY DID YOU REACH OUT

PAST MENTAL HEALTH HISTORY

Do you have a psychotherapist and may we have permission to make contact if necessary? : ☐ No ☐ Yes

Name/Contact :

Please Sign if you wish for us to communicate with them. You may withdraw this consent at any time.

Printed Name : ________________ **Date** : ________________

Patient Signature : ________________

What mental health diagnoses have you been treated for? With whom and where? : ☐ No ☐ Yes

If yes, please describe: ________________

Have you been psychiatrically hospitalized or have been in rehab/ detox facilities? : ☐ No ☐ Yes

If yes, please describe: ________________

Have you attempted or considered suicide? : ☐ No ☐ Yes

If yes, please describe: ________________

What Mental Health medications have you been exposed to?

____

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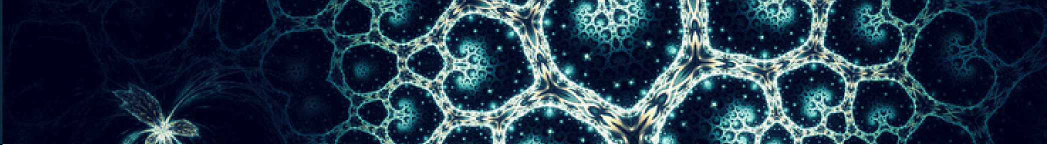

INTAKE FORM

Have you had problems with alcohol, drugs, and have you taken any hallucinogens? : ☐ No ☐ Yes

If yes, please describe: ______________________

____

MEDICAL HISTORY

Who is your medical team and may we have consent to make contact if necessary? What is their contact information? : ☐ No ☐ Yes

Dr. : ______________________

Please Sign if you wish for us to communicate with them. You may withdraw this consent at any time.

Printed Name : ______________________ **Date** : ______________

Patient Signature : ______________________

What medical conditions are you currently being treated or have been hospitalized for?

____

____

Do you have a terminal condition? : ☐ No ☐ Yes

If yes, please describe: ______________________

____

Have you had a history of Head injury/Seizures? Did you lose consciousness or were you hospitalized? : ☐ No ☐ Yes

If yes, please describe: ______________________

____

Do you have a history of Severe Hypertension? : ☐ No ☐ Yes

If yes, please describe: ______________________

____

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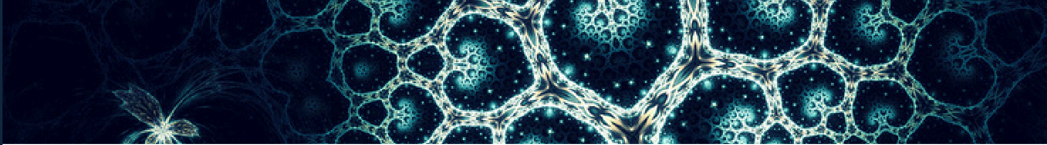

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Have you had a history of Bladder or Urinary problems? : ☐ No ☐ Yes

If yes, please describe: ______________________________

Have you had any reactions to Anesthesia? : ☐ No ☐ Yes

If yes, please describe: ______________________________

Have you had Hyperthyroidism? : ☐ No ☐ Yes

If yes, please describe: ______________________________

Medications: Current prescribed medications and over the counter medications

____

Allergies (list all)

____

Has anyone in your family been treated for a mental health condition or addiction? Whom and what conditions? : ☐ No ☐ Yes

Whom and what conditions? ______________________________

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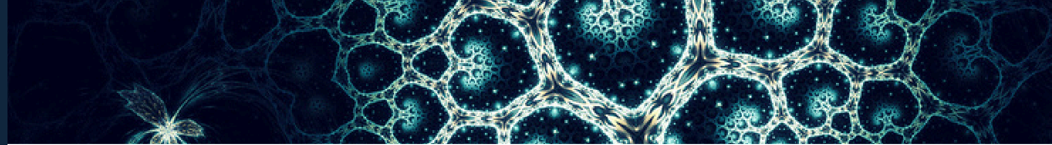

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PERSONAL HISTORY

To the best of your knowledge and recollection:

Where were you born and raised?

____

Did your mother have complications with your birth? No : ☐ No ☐ Yes

If yes, please describe: ______________________________

____

What is your first memory? What was the feeling you experienced? : ☐ No ☐ Yes

If yes, please describe: ______________________________

____

How many siblings do you have and where were you in the birth order? : ☐ No ☐ Yes

If yes, please describe: ______________________________

____

How would you describe your childhood and which parent were you closest to and why?

____

____

Are there repetitive dreams you experience? : ☐ No ☐ Yes

If yes, please describe: ______________________________

____

Have you experienced any physical, emotional, or sexual abuse? : ☐ No ☐ Yes

If yes, please describe: ______________________________

____

____

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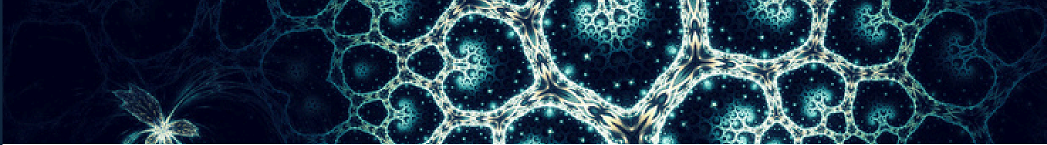

INTAKE FORM

Were you a behavior problem for your parents or in school? : ☐ No ☐ Yes

If yes, please describe: ______________________

____

How do you think you were with social interactions in your youth?

Please describe: ______________________

____

What is your highest level of education?

Please describe: ______________________

____

Have you had legal issues or episodes of violence? : ☐ No ☐ Yes

If yes, please describe: ______________________

____

Do you have a partner? What is their name and how long have you been together? : ☐ No ☐ Yes

If yes, please describe: ______________________

____

____

Do you have children, what are their names and how old are they and are you emotionally close to them? : ☐ No ☐ Yes

If yes, please describe: ______________________

____

What is/was your occupation?

Please describe: ______________________

____

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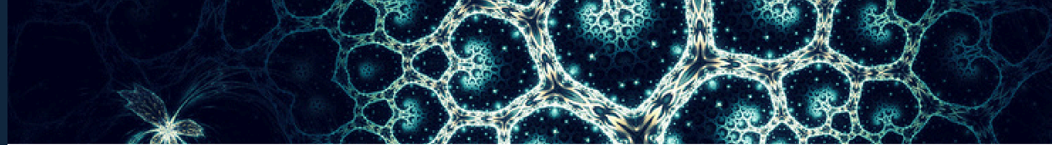

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Summarize your feelings about your life experience below

EXISTENTIAL

Do you identify with any spiritual faith or religion? : ☐ No ☐ Yes

If yes, please describe:

Have you had any deeply moving spiritual experiences? : ☐ No ☐ Yes

If yes, please describe:

Have you had a near death experience or out of body experiences? : ☐ No ☐ Yes

If yes, please describe:

Please tell us some prayers, poems, quotations that inspire you

Where do you like to go for vacation?

What type of music relaxes you?

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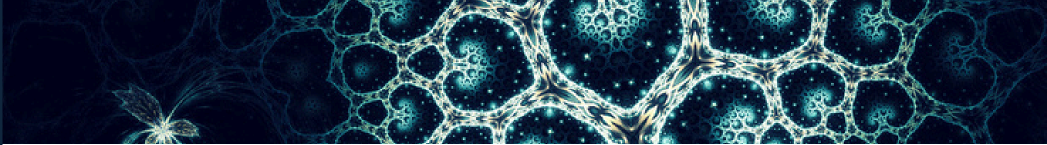

INTAKE FORM

What types of snacks/ drinks (non-alcoholic) do you like? ______________________________

What are your most treasured and meaningful objects and why? (Please describe)

____

____

____

____

Please share with us what your expectations/intentions are regarding treatment?

____

____

____

____

Please upload and e-mail to epiphanypsychservices@gmail.com and bring your hard copy with signatures to your appointment.

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THANK YOU

HIPAA FORM

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

YOU WILL BE ASKED TO ACKNOWLEDGE THAT YOU HAVE RECEIVED OUR NOTICE OF PRIVACY.

Uses and Disclosures for Treatment, Payment, and Health Care Operations

We may use or disclose your protected health information (PHI), for treatment, payment, and health care operations purposes with your consent. To help clarify these terms, here are some definitions:

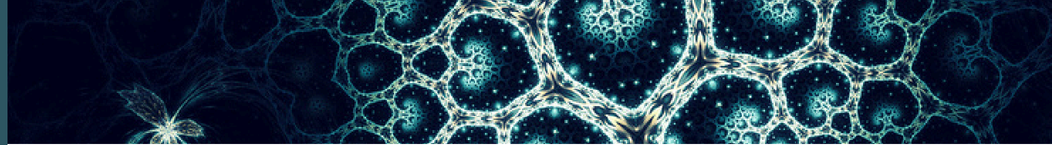
- *"PHI"* refers to information in your health record that could identify you.
- *"Treatment, Payment, and Health Care Operations":*
  - *Treatment* is when we provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when we consult with another health care provider, such as your family physician or another psychologist.
  - *Payment* is when we obtain reimbursement for your healthcare. Examples of payment are when we disclose your PHI to your health insurer to obtain reimbursement for your health care or to determine eligibility or coverage.
  - *Health Care Operations* are activities that relate to the performance and operation of my practice. Examples of health care operations are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.
- "*Use*" applies only to activities within my [office, clinic, practice group, etc.] such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you.
- *"Disclosure"* applies to activities outside of my [office, clinic, practice group, etc.], such as releasing, transferring, or providing access to information about you to other parties.

Uses and Disclosures Requiring Authorization

We may use or disclose PHI for purposes outside of treatment, payment, and health care operations when your appropriate authorization is obtained. An "authorization" is written permission above and beyond the general consent that permits only specific disclosures. In those instances when we are asked for information for purposes outside of treatment, payment, and health care operations, we will obtain an authorization from you before releasing this information.

You may revoke all such authorizations at any time, provided each revocation is in writing. You may not revoke an authorization to the extent that (1.) We have relied on that authorization; or (2.) if the authorization was obtained as a condition of obtaining insurance coverage, and the law provides the insurer the right to contest the claim under the policy.

In rare circumstances, your Medical Notes may be released to third party payors with your explicit Authorization. Insurance companies cannot require your authorization as a condition of coverage nor penalize you in any way for your refusal to provide it.



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Uses and Disclosures with Neither Consent nor Authorization

We may use or disclose PHI without your consent or authorization in the following circumstances:

- **Child Abuse:** If we have reasonable cause to believe that a child has been subject to abuse, we must report this immediately to the Pennsylvania Department of Child Protective Services.

- **Adult and Domestic Abuse:** If we reasonably believe that a vulnerable adult is the subject of abuse, neglect, or exploitation, we may report the information to the county adult protective services provider.

- **Health Oversight:** If the Pennsylvania State Board of Medicine/ Psychology issues a subpoena, we may be compelled to testify before the Board and produce your relevant records and papers.

- **Judicial or Administrative Proceedings:** If you are involved in a court proceeding and a request is made for information about the professional services that we have provided you and/or the records thereof, such information is privileged under state law, and we must not release this information without written authorization from you or your legally appointed representative, or a court order. This privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. We must inform you in advance if this is the case.

- **Serious Threat to Health or Safety:** If you communicate to me a threat of imminent serious physical violence against a readily identifiable victim or yourself or the public and we believe you intend to carry out that threat, we must take steps to warn and protect. We also must take such steps if we believe you intend to carry out such violence, even if you have not made a specific verbal threat. The steps we take to warn and protect may include arranging for you to be admitted to a psychiatric unit of a hospital or other health care facility, advising the police of your threat and the identity of the intended victim, warning the intended victim or his or her parents if the intended victim is under 18, and warning your parents if you are under 18.

- **Worker's Compensation:** If you file a worker's compensation claim, we may be required to release relevant information from your mental health records to a participant in the worker's compensation case, a reinsurer, the health care provider, medical and non-medical experts in connection with the case, the Division of Worker's Compensation, or the Compensation Rating and Inspection Bureau

- When the use and disclosure without your consent or authorization is allowed under other sections of state's confidentiality law. This includes certain narrowly-defined disclosures to law enforcement agencies, to a health oversight agency (such as HHS or a state department of health), to a coroner or medical examiner, for public health purposes relating to disease or FDA-regulated products, or for specialized government functions such as fitness for military duties, eligibility for VA benefits, and national security and intelligence.

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thank you

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Patient's Rights and Medical/ Psychological Doctor Duties

Patient's Rights:

- *Right to Request Restrictions*—You have the right to request restrictions on certain uses and disclosures of protected health information about you. However, we are not required to agree to a restriction you request.
- *Right to Receive Confidential Communications by Alternative Means and Alternative Locations*—You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. (For example, you may not want a family member to know that you are seeing me. Upon your request, we will send your bills to another address.)
- *Right to Inspect and Copy*—You have the right to inspect or obtain a copy (or both) of PHI in my mental health and billing records used to make decisions about you for as long as the PHI is maintained in the record. We may deny your access to PHI under certain circumstances, but in some cases, you may have this decision reviewed. Upon your request, we will discuss with you the details of the request and denial process.
- *Right to Amend*—You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. We may deny your request. Upon your request, we will discuss with you the details of the amendment process.
- *Right to an Accounting*—You generally have the right to receive an accounting of disclosures of PHI for which you have neither provided consent nor authorization (as described in Section III of this Notice). Upon your request, we will discuss with you the details of the accounting process.
- *Right to a Paper Copy*—You have the right to obtain a paper copy of the notice from me upon request, even if you have agreed to receive the notice electronically.

Physician/ Psychologist Duties:

- We are required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI.
- We reserve the right to change the privacy policies and practices described in this notice. Unless we notify you of such changes; however, we are required to abide by the terms currently in effect.
- If we revise my policies and procedures, and you are an active patient, we will inform you of the changes in policy in person. If you have discontinued services, we will provide you with a revised notice upon request.

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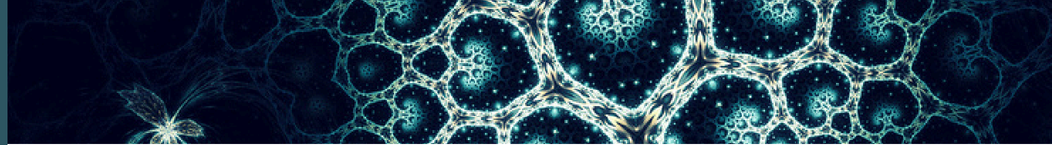

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Questions and Complaints

If you have questions about this notice, disagree with a decision we make about access to your records, or have other concerns about your privacy rights, you may contact Drs. Eugene and Michelle Huang, Epiphany Psych Services, 312 Baltimore Street, Gettysburg, PA 17325.

If you believe that your privacy rights have been violated and wish to file a complaint, you may send your written complaint to Drs. Eugene and Michelle Huang, Epiphany Psych Services, 312 Baltimore Street, Gettysburg, PA 17325. You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services as well as the Pennsylvania Boards of Medicine and Psychology.

You have specific rights under the Privacy Rule. We will not retaliate against you for exercising your right to file a complaint.

Effective Date, Restrictions, and Changes to Privacy Policy

This notice will go into effect immediately but may be retracted by yourself.

Acknowledge of Receipt of HIPAA Notice of Privacy Practices

By signing below I acknowledge that I have been provided a copy of "Notice of Policies and Practices to Protect the Privacy of your Health Information," and have therefore been advised of how health information about me may be used and disclosed by Drs. Eugene and Michelle Huang and how I may obtain access to and control of this information.

Printed Name : ______________________ Date : ______________

____
Patient Signature