epic
BEHAVIORAL HEALTHCARE

Client Information *(Please complete all areas)*

NAME First: _____ Middle: _____ Last_____
Referral Date: _____ Gender: _____
Birthdate:_____ Language: _____
Age: _____ Ethnicity: _____
Social Security Number: _____-_____-_____ Race: _____
Preferred Name: _____ Marital Status:_____
Pregnant (check one): Yes___ No ___ Male NA____
Any Allergies: _____
_____
Primary Address _____
City_____ State_____ Zip _____ County _____
Secondary Address _____
City_____ State_____ Zip _____ County _____

Phone/Communications
Home: _____
Work: _____
Cell: _____

Emergency Contact
Name: _____
Relationship: _____
Phone number: _____

Medical History

Family Doctor/ Pediatrician Name: _____
Location: _____
Children Immunizations current? Yes___ No ____ Did you bring Documentation? _____

Exam History
Physical Date: _____ Doctor: _____
Dental Date: _____ Doctor: _____
Hearing Date: _____ Doctor: _____
Eye/Vision Date: _____ Doctor: _____

Recent Lab Results
Test 1 Date: _____ Lab Type: _____ Results: _____
Test 1 Date: _____ Lab Type: _____ Results: _____

DRUG PROFILE - CURRENT MEDICATIONS:

SIGNATURE & DATE	MEDICATION	DOSE/SIG	DOCTOR	DATE ON	DATE OFF

Comments:
_____
_____

MEDICAL PROBLEMS/HISTORY: (Check appropriate box and complete necessary information)

Yes No Are you/client being treated for any ongoing medical problems at this time? If yes, specify below
_____
Name of treating doctor, if other than family doctor: _____

Yes No Are you/client having any medical problems and not receiving treatment? If yes, specify below
_____
Yes No Have you/client had any significant medical problems in the past? If yes, specify below
_____

Yes No Is there a history of any serious illnesses or chronic medical problems in your family? If yes, specify below

_____

Yes No Have you/client had any accidents/injuries requiring medical attention? If yes, specify below

_____

No Yes Have you/client had any operations? If yes, specify below (reason, when. where)

_____

Are you/client currently experiencing physical pain, or have you/client experienced pain in the recent past?

If yes, describe intensity/character of pain (Circle appropriate #): 1 (Very little) 2 3 4 5 (Severe pain)

Known/Suspected Cause:_____

Frequency of the pain:_____ Duration of the Pain:_____ Location of the pain:_____

When did you experience pain last:_____

What helps the pain (include medications, treatments; by whom, include self-treatments, etc.) :

_____

For women, have you had past pregnancies/deliveries? If yes, specify number_____

Any complications in pregnancy and/or delivery: _____

HEALTH RELATED BEHAVIORS:

Yes No Do you/client receive routine dental care?

Date of last exam: _____ With: _____

Yes No Do you/client have vision problems requiring glasses?

Date of last exam: _____ With: _____

Yes No Do you/client have hearing problems requiring a hearing aid?

Date of last exam: _____ With: _____

Yes No Do you/client smoke cigarettes /use tobacco? If yes, how many per day? _____

Yes No Do you/client drink alcohol or use drugs recreationally or to reduce stress?

If yes, what, how much, how often? _____

Yes No Do you/client exercise regularly?

Yes No Do you/client have problems with mobility that interferes with day-to-day activities?

Yes No Do you/client have concerns about your current weight? _____ Height _____ Weight

Yes No Are you a registered sex offender?

Additional Information/ Comments:

_____

_____

_____

_____

How did you hear about us?

_____

Releases of Information

Contact: Last Name ______________________ Frist Name: _________________________

Organization: ____

Address: ____

City: _______________________ State: ______ Zip: ________ Fax: __________________

Any limitations: ____

Contact: Last Name ______________________ Frist Name: _________________________

Organization: ____

Address: ____

City: _______________________ State: ______ Zip: ________ Fax: __________________

Any limitations: ____

Contact: Last Name ______________________ Frist Name: _________________________

Organization: ____

Address: ____

City: _______________________ State: ______ Zip: ________ Fax: __________________

Any limitations: ____

Contact: Last Name ______________________ Frist Name: _________________________

Organization: ____

Address: ____

City: _______________________ State: ______ Zip: ________ Fax: __________________

Any limitations: ____

Contact: Last Name ______________________ Frist Name: _________________________

Organization: ____

Address: ____

City: _______________________ State: ______ Zip: ________ Fax: __________________

Any limitations: ____

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BEHAVIORAL HEALTHCARE

EPIC
Notice of Privacy Practices

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

EPIC is required by law to maintain the privacy of certain health care information about our clients. The law also requires health care providers like EPIC to give you a Notice like this one and to follow its standards.

EPIC and Your Protected Health Care Information
As a part of our day-to-day activities, EPIC may need to use and disclose (share) your protected health care information for several purposes without first getting your written approval. Those purposes include:

- Your treatment. For example, EPIC might discuss your condition with your doctor.
- Payment for your treatment. For example, EPIC may need to discuss your condition and the treatments EPIC provided to you with your insurance or billing company.
- EPIC operations. For example, appropriate EPIC staff must discuss your condition in order to provide you proper treatment.
- EPIC may contact you based upon your protected health care information. For example, EPIC may call to arrange your appointments, provide you with information about new medications, treatments, benefits and services that are available to you, and also to raise funds for EPIC.
- EPIC may provide information to government officials who oversee health care or are working on threats to public safety from unsafe products, diseases, abuse, neglect, domestic violence and other crimes.
- EPIC may provide information to licensed researchers who are under strict rules regarding how they use and disclose protected health care information.

No other uses and disclosures of your protected health care information will occur without your written authorization. And, if you sign such an authorization, you have the right to cancel it at any time.

Your Rights Regarding Your Protected Health Care Information
Under the law, you have several rights that EPIC is committed to upholding. Those rights include:

- The right to request restrictions on some of the ways EPIC uses and disclosures your information. These restrictions can go beyond the restrictions already in the law. To request restrictions on protected healthcare information, provide a written request to your counselor, or the front office. The written request should detail any restrictions on uses of

Protected Healthcare information. However, EPIC may not always agree to implement these additional restrictions.

- The right to receive confidential communications, including the right to request it be provided through alternative means. While EPIC cannot promise to communicate in every possible way clients might request, we will work with you to find a practical way of communicating with you in strict confidence if you wish. To request confidential communications of Protected Healthcare information including communications to be received in an alternative way, provide a written request to your counselor, or the front office. The written request should acknowledge that the information may endanger the individual. If the request is not provided in person, steps should be taken to validate the authenticity of the sender (ie. Notary, e-verification, ect.)
- The right to inspect and get copies of your health care information held by EPIC. To request inspection or copies of your protected healthcare information, provide a written request to your counselor, or the front office. If the provision of records may endanger another person, weather an employee or other, EPIC reserves the right to deny the request within 60 days. EPIC may charge a reasonable fee to cover only the cost of providing this information. Records may not be immediately accessible, adequate time for research is to be expected.
- The right to request that EPIC amend or correct information about you. To make such a change, EPIC will ask you to make the request in writing with a description of the reason you want your record changed provide the request to your counselor, or the front office. EPIC may not always agree to such requests.
- The right to a list of EPIC disclosures of your protected health care information that were not authorized by you and the disclosures that were unrelated to treatment, payment and EPIC operations To request a list of disclosures, provide a written request to your counselor, or the front office.

If you have any questions or complaints about the way EPIC handles your protected health care information or if you believe your privacy rights have been violated, contact the EPIC Privacy Officer, Brandon Colee, at (904) 829-2273 or in person. You can also contact the Secretary of the U.S. Department of Health and Human Services. Please note that there will be no retaliation against you for filing a complaint or making requests regarding your health care information, or for disagreeing with EPIC-related decisions.

EPIC may need to change its privacy practices from time to time. Before making such changes, however, EPIC will modify this Notice and begin distributing it to clients when they are treated by EPIC. These new practices will then apply to all information held by EPIC. At any time, anyone has a right to get a paper copy of the latest version of this Notice by asking the EPIC's receptionist.