INSURANCE INFORMATION

Today's Date: _____

Patient Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Patient's SSN: ___-___-___

_____ Home Phone: _____

_____ Ok to leave msg? Yes No

Employer: _____ Cell Phone: _____

Employer Addr: _____ Ok to leave msg? Yes No

_____

INSURED PARTY INFORMATION (If different from above)

Insured's Name: _____ Date of Birth: _____

Insured's Addr: _____ Insured's SSN: ___-___-___

_____ Home Phone: _____

Employer: _____ Ok to leave msg? Yes No

Employer's Addr: _____ Cell Phone: _____

_____ Ok to leave msg? Yes No

Insurance: _____ ID Number: _____

Ins. Comp. Addr: _____ Group Number: _____

_____ Policy Type: PPO HMO Other

Deductible: _____ Co-Pay: _____

ASSIGNMENT OF BENEFITS & RELEASE OF INFORMATION

I hereby authorize my insurance carrier to make payment directly to Behavioral Pain Management, LLC and Ajeet Charate, benefits due me out of indemnity under the terms of my policy or agreement issued by the above named company. Payment is authorized upon the receipt of Ajeet Charate's itemized statement for services rendered to me or the above for the above name patient. I certify that my policy or agreement was in full force and effect at the time that these services were rendered. Payment of the amounts as herein directed, in whole or part, shall be considered the same as if paid directly to me.
I hereby authorize the release of my information to the insurance carrier necessary to process all claims.

I authorize the release of billing information to collections agencies for unpaid balances if necessary.

Insured's Signature: _____ Today's Date: _____

QEEG Code: _____ Therapy Diagnostic Code: _____

Acknowledgment of Receipt of Notice of Privacy Practices

I hereby acknowledge that I have been provided with a copy of Behavioral Pain Management LLC's, DBA NITI Notice of Privacy Practices. The Notice of Privacy Practices contains information regarding potential uses and disclosures of my protected health information (as that term is defined under the Health Insurance Portability and Accountability Act of 1996 "HIPAA") that may be made by Behavioral Pain Management LLC., and of my rights and Behavioral Pain Management, LLC's legal duties with respect to my protected health information. I have had the opportunity to review the Notice of Privacy Practices and take a copy with me if I so choose.

_____	_____
Patient's Name	Parent/ Guardian Signature (If applicable)
_____	_____
Patient's Signature	Parent/ Guardian's Name (If applicable)
_____	_____
Date	Date

Please sign and return this acknowledgement; it will be maintained in your file.

TELEHEALTH INFORMED CONSENT

By signing this form, I understand and agree with the following:

Telehealth involves the use of electronic communications to enable health care providers at different locations to share individual patient medical information for the purpose of improving patient care. Providers may include physical therapists, counselors, social workers, primary care practitioners, specialists and/or subspecialists, nurse practitioners and other healthcare providers who are part of my clinical care team. In addition to myself and the members of my clinical care team, my family members, caregivers, or other legal representatives or guardians may join and participate on the telehealth service, and I agree to share my personal information with such family members, caregivers, legal representatives or guardians. The information may be used for diagnosis, therapy, follow-up and/or education.

Telehealth requires transmission, via Internet, Zoom or tele-communication device, of health information, which may include:

- Progress reports, assessments, or other intervention-related documents
- Bio-physiological data transmitted electronically
- Data sheets, therapy relevant videos, pictures, text messages, audio and any digital form of data

The laws that protect the privacy and confidentiality of health and care information also apply to telehealth. Information obtained during telehealth/telemedicine that identifies me will not be given to anyone without my consent except for the purposes of treatment, education, billing and healthcare operations. By agreeing to use the telehealth services, I am consenting to BPM, PLLC sharing of my protected health information with certain third parties as more fully described in BPM, PLLC Privacy Policy. I understand, agree, and expressly consent to BPM, PLLC obtaining, using, storing, and disseminating to necessary third parties, information about me, including my image, as necessary to provide the telehealth/telemedicine services.

As with any Internet-based communication, I understand that there is a risk of security breach. Electronic systems used will incorporate network and software security protocols to protect the confidentiality of patient identification and imaging data and will include measures to safeguard the data and to ensure its integrity against intentional or unintentional corruption.

Individuals other than my clinical care team or consulting providers may also be present and have access to my information for the telehealth/telemedicine session. This is so they can operate or repair the video or audio equipment used. These persons will adhere to applicable privacy and security policies.

Telehealth/telemedicine sessions may not always be possible. Disruptions of signals or problems with the Internet's infrastructure may cause broadcast and reception problems (e.g., poor picture or sound

quality, dropped connections, audio interference) that prevent effective interaction between consulting clinician(s), participant, patient or care team.

I hereby release and hold harmless BPM, PLLC and all members of my care team from any loss of data or information due to technical failures associated with the telehealth/telemedicine service.

I understand and agree that the health information I provide at the time of my telehealth service may be the only source of health information used by the healthcare team during the course of my evaluation and treatment at the time of my telehealth visit, and that such professionals may not have access to my full medical record or information held at BPM, PLLC.

I understand that I will be given information about test(s), treatments(s) and procedures(s), as applicable, including the benefits, risks, possible problems or complications, and alternate choices for my medical care through the telehealth/telemedicine visit.

I have the right to withhold or withdraw consent to the use of telehealth/telemedicine services at any time and revert back to traditional in-person clinic services. I understand that if I withdraw my consent for telehealth/telemedicine, it will not affect any future services or care benefits to which I am entitled. All my questions have been answered to my satisfaction.

I hereby consent to the use of telehealth/telemedicine in the provision of care and the above terms and conditions.

By signing below, I certify that I am the legal representative of the participant or that I am the patient and am 18 years of age or older, or otherwise legally authorized to consent. I have carefully read and understand the above statements. I have had all my questions answered. I understand that this informed consent will become a part of my medical record.

_____ _____

Signature of Patient or Patient's Legal Representative Date and Time

_____ _____

Printed Name of Patient or Patient's Legal Representative Relationship to the Patient

INTERPRETER'S ATTESTATION (if applicable): I certify that I am fluent in the language of the person providing consent. I certify that I have accurately and completely interpreted the contents of this form, and that the person giving consent has indicated their understanding of the contents.

_____ _____

Signature of Interpreter Date and Time

Credit Card Authorization Form

By your signature on this form, you authorize charges to your credit card for services rendered.

I authorize Behavioral Pain Management, LLC to charge my credit card through Clover payment system for any insurance related charges. These will be co-pays, deductible balance etc, once your treatment session has been processed by your insurance. you will also be provided with the billing statement. I also agree that my credit card can be charged $20 for any session that is not cancelled at least 24 hours prior to the scheduled session.

I understand that this authorization will remain in effect until I cancel it in writing, and I agree to notify Behavioral Pain Management, LLC in writing of any changes in my account information or termination of this authorization.

I certify that I am an authorized user of this credit card and will not dispute these scheduled transactions with my bank or credit card company as long as the transactions correspond to the terms indicated in this authorization form.

Credit Card Information:

CC number: _____ Exp date: Month: _____ Year _____

3-digit code: _____ Billing zip code: _____

Signature: _____

Date: _____

Receipt to be sent by text: _____

Email: _____

BPM, LLC

INDIVIDUAL TELETHERAPY INTAKE FORM

First name: _____
Last name: _____

Age: _____ Birth day: _____ Month: _____ Year: _____

Ethnicity: _____ Religion: _____
Marital Status: _____

Sex/gender: _____Number of children: _____
Ages of children: _____

Home address:

_____

_____

Who do you live with?

_____

Cell #: _____ Leave message: Yes _____ No _____

Home #: _____ Leave message: Yes _____ No _____

Work #: _____

Email: 1. _____
2._____

Name of emergency contact:

1. _____ Phone: _____
2. _____ Phone _____

For clients under 18 years of age:

Name of parent/legal guardian:

_____

Phone: _____ Leave message: Yes _____ No _____

Name of parent/legal guardian:

_____

Phone: _____ Leave message: Yes _____ No _____

EMPLOYMENT INFORMATION:

☐ On sick leave, as of this date: _____
Return to work date: _____

I was: ☐ Full-time or ☐ Part-time at: _____

☐ Not working because:

_____

ACADEMIC INFORMATION:

☐ Not attending school. _____

Highest level completed: _____

☐ Full-time school at: _____

Grade/year: _____ Program: _____

Typical grades: _____

☐ Part-time in school at: _____

Grade/year: _____ Program: _____

Typical grades: _____

_____

THE REASONS FOR YOUR VISIT:

_____

_____

_____

_____

_____

How intense is your emotional distress? (Mild) 1 2 3 4 5 6 7 8 9 10 (Severe) _____

Please describe:

_____

_____

_____

_____

Overall, how much do the problems affect your ability to perform at work or school, get along with others, and perform daily tasks such as chores?

(Mildly disruptive) 1 2 3 4 5 (Incapacitating) _____

Please describe:

When did these problems start? What was going on in your life at that time?

Please list any psychiatric or "mental" problems you have been diagnosed with:

Please list any medical or "physical" problems that you have been diagnosed with:

Please list any medications you currently take, and what you take them for:

Name of Family doctor: _____ Phone: _____

Last check-up was during the month of: _____ Year: _____

Results:

Name of Psychiatrist: _____ Phone: _____
Last visit was during the month of: _____ Year: _____

Results:

Have you ever been hospitalized for psychological or psychiatric reasons? ☐ No ☐ Yes

If yes, please describe when and where you were hospitalized, and for which reasons.

Please tell us about any other mental health professionals you have consulted with in the past (approximate dates, type of professional seen, reason for the consultation, nature of the treatment, outcome of the treatment).

_____
_____
_____
_____
_____
_____
_____
_____

CURRENT HABITS

Please describe your current habits in each of the following areas:

Smoking: _____
Gambling: _____
Drinking: _____
Drug use: _____
Caffeine intake: _____
Exercise: _____

Eating: _____
Sleeping: _____
Fun and relaxation: _____

Please describe your relationships with each of the following people, if applicable:

Biological Mother: _____
Biological Father: _____
Step-parents: _____
Legal guardians: _____
Siblings: _____
Extended family: _____
Your children: _____
Friends: _____
Romantic partner(s): _____
Colleagues or classmates: _____

Total number of close, supportive relationships (support structure):

_____
_____

STRESSFUL LIFE EVENTS

Please describe any current significant or stressful life events that you have been experiencing:

1._____

2._____

3._____

4._____

Suicidal thoughts / ideation / attempts:

Suicidal Thoughts: (when / how often / last one)

_____

_____

_____

Suicidal Ideations: (when last and frequency)

_____

_____

_____

Suicidal attempts: (when / last one / hospitalizations)

_____

_____

_____

_____

Economic problems: Yes No

Please describe Economic problems.

_____

Have you ever filed for bankruptcy: Yes No

Difficulty accessing health care?

_____

_____

Legal issues or any history of arrests?

_____

_____

Cultural issues?

Family conflict or lack of support?

Social problems? Yes No If yes, please describe

Educational or occupational difficulties?

Housing problems?

Grief or bereavement?

What are your positive qualities and skills?

What do you like about yourself?

What qualities have helped you to succeed at overcoming difficulties in the past?

Please tell us about your plans for the future (career, personal, etc.)

How motivated do you feel to work on identified goals in therapy?

What are your goals for therapy?

What would you like to achieve by attending therapy?

What concerns if any, do you have about attending teletherapy and or working on these problems?

Is there anything else that you would like to mention?