NORKRIS SERVICES, INC.
Attentive Therapeutic Expressive Minds Working
For Children and Families Mental Wellbeing

Today's Date: _____ Referred by: _____

Patient's Name (first, mi, Last) _____

Date of Birth: _____ Social Security(optional) _____

Cell Phone: _____ Home Phone: _____

May we leave a voicemail Circle: Yes or No Email: _____

Home Address: _____

City: _____ State: _____ Zipcode: _____

Emergency Contact: Name: _____ Phone: _____

Relationship: _____

Emergency Contact (2): Name: _____ Phone: _____

Relationship: _____

Primary Care Doctor: _____ Phone Number: _____

Current Therapist: _____ Phone Number: _____

Preferred Pharmacy: _____ Zipcode: _____

Phone Number: _____

Primary Insurance

Insurance Provider: _____ Member ID #: _____

Primary Insurance Holder: _____ Holder's DOB: _____

Secondary Insurance

Insurance Provider: _____ Member ID #: _____

Primary Insurance Holder: _____ Holder's DOB: _____

I certify that the above information is correct and that I give Norkris Services Inc permission to render services to me and to release information about me to insurance carrier(s) for payment and medication authorization

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HIPPA "Summary of Privacy Practices"

A federal regulation called HIPPA requires that you be given information about how your personal health information is handled.

Your Records & Confidentiality

Norkris Services Inc Will not send your medical information out, or provide information about you to someone else, without your Written (which you can revoke at any time). Norkris Services can receive information about you from others, though we are not allowed to confirm that you are a patient of ours. We must take care to not reveal information about you in the process of listening to others. Examples of us receiving information about you include receiving a voicemail about you from a family member.

Consent for Assessment & Treatment

I understand that as a patient of Norkris Services, I may receive a range of mental health and wellness services. The type and extent of services that I receive be will determined following an initial assessment. The goal of the assessment is to determine the best course of treatment for me.

I consent to participate in the evaluation and treatment offered to me by Norkris Services. I understand that either Norkris Services or I may discontinue treatment at any time.

Though my provider will do her/his best to fully advise me on the pros, and cons of treatment options, I understand that it is also my responsibility to speak up and ask questions if I am confused about any of the recommended therapies. I acknowledge that there is no guarantee that I will be cured, or that a given treatment will be effective for me personally. I intend that this consent form is to cover the entire course of treatment for my present condition and any future conditions for which I am seeking treatment.

Your Information Your Rights our Responsibilities

Your Rights:

- Get a copy of your paper or electronic medical record
- Correct your paper or electronic medical record
- Request confidential communication
- Ask us to limit the information we share
- Get a list of those with whom we've shared your information
- Get a copy of this privacy notice
- Choose someone to act for you

- File a Complaint if you believe your privacy rights have been violated

Your Choices:

- Tell Family and friends about your condition
- Provide disaster relief
- Include you in a hospital Directory
- Provide Mental Health Care
- Market our services and sell your information
- Raise Funds

Our Use and Disclosures:

- Treat you
- Run our organization
- Bill for your services
- Help with Public Health and Safety Issues
- Do research
- Comply with the law
- Address worker's compensation, law enforcement, and other government requests.
- Respond to lawsuits and legal actions

The patient represents that he/she is giving his/her consent knowingly and voluntarily without any elements of force, deceit duress or other form of constraint or coercion, with a general knowledge of the medical and psychiatric procedures outlined above, is aware of the circumstances and is physically and mentally competent to give consent.

- Patient's Signature _____ Date: _____

- Patient's Parent/ Guardian Signature: _____

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Prescription Refills

Please allow us ATLEAST 72 hours for medication refills.

_____ (Patient/Authorized Representative Initials) I acknowledge that a copy of Notice of Privacy Practices is available to me at the time I am signing the document.

_____

Patient / Authorized Representative Signature Date

NORKRIS SERVICES, INC.
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Credit Card Authorization Form

Your completion of this authorization form helps us to protect you, our valued patients, from credit card fraud. Norkris Services Inc, PC will keep all information entered on this form strictly.
NOTE: We will not charge your credit card without your explicit consent.

Patient to Sign Below:

If the name on the credit card is different from my own (e.g. if the below credit card belongs to my parent or spouse), I do hereby grant permission for Norkris Services Inc to disclose information regarding appointment dates kept and missed to the credit-card holder as necessary in order to collect payment.
Patient's Signature & Date: _____

Cardholder to Complete:

Name on Card: _____
Relationship to patient (e.g. parent) _____
I, _____, hereby authorize Norkris Services Inc, PC, to charge my credit card for the amounts invoiced.

Type of Card: AMERICAN EXPRESS/VISA/MASTERCARD/OTHER
If other, please specify: _____
Credit Card Number: _____
Expiration Date: _____
CVC Code: _____

Credit Card Billing Address:
Street: _____
City: _____ State: _____ Zipcode: _____

As a credit card holder, I also authorize Norkris Services Inc , PC to charge my credit card for future services, communication(e.g. phone & email) fees, and also for late cancellations of failed appointments. Any dispute that I have regarding charges will be addressed directly with Norkris Services Inc. I will not dispute the charges to my credit card company.

_____ _____
Cardholder's Signature Date

NORKRIS SERVICES, INC.
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Patient Name: _____

ELECTRONIC COMMUNICATIONS RELEASE

E-MAIL

E-mail can offer an easy and convenient way for patients and doctors to communicate. If you decide to e-mail us, here are things for you to know.

- E-mail is not confidential. My staff may read your emails to handle routine, non-clinical matters. You Should also know that if sending e-mails from work, your employer has a legal right to read your email if he or she chooses.
- E-mail communications become part of your medical record and will likely be printed and placed in your chart.
- E-mails may be forwarded to my staff for handling, if appropriate.
- E-mail should be limited to a brief question, requiring one sentence response.
- If you have any questions about changing your medication regimen (stopping, starting or changing dose), you will need to schedule an appointment, since email communication will not be adequate to fully inform you of the risks and benefits.
- E-mail is never, ever, appropriate for urgent or emergency problems! In an emergency, please call "911", or go to the nearest Emergency Room.
- If you agree to the option of communication via E-mail:
  We may not spam you
  You can have automatically- generated reminders e-mailed to you (which you can opt-out of)

PLEASE CHECK ONE:

- o I DO want to communicate with my provider (Norkris Services INC) electronically. I have read the above information and understand the limitations of security on information transmitted.
  - E-Mail Address: _____
- o I do NOT want to communicate with any provider electronically. However, if I DO email my provider or Norkris Services, I am automatically authorizing them to email me in return.
- o I consent to Telehealth Services
- o I do not consent to Telehealth Services
- o Patient Signature: _____ Date: _____

Text Messaging

You may choose to receive appointment reminders as a text message to your mobile phone. This option is for your convenience. Be advised that text messages – like emails- are not encrypted to HIPPA-compliant standards.

PLEASE CHECK ONE:

- o I DO want to receive appointment reminders via text message
- o I do NOT want to receive appointment reminders via text messaging.

Patient Signature: _____ Date: _____