ART OF AWARENESS

100 Waterman Drive Suite 201 South Portland, ME 04106
Phone: 207-799-1331, Fax: 207-799-1350, Email: clientservices@artofawareness.org
Send Intensive Outpatient Program Referrals to: iop@artofawareness.org

NEW CLIENT REFERRAL FORM

Today's Date:

Client Name: DOB (mm/dd/yy):

Legal Name (If Different): Gender Identity: Pronouns:

Mailing Address:

Phone: Is it okay to leave you voicemails? Email:

Relational Status: Are you a Student? School/Grade:

Do you have a partner, friend, or family member who is working with an Art of Awareness Provider?

If so, please provide the name of the therapist & partner/friend/family member:

Are you employed? Where do you work?

Emergency Contact Name, Relation, and PH#:

Do you have any allergies? If yes, please list:

Do you have a PCP? PCP Name & Practice:

Are you currently working with any other healthcare providers (e.g. nutritionist, psychiatrist, medical specialists)?

Please list their Name & Profession:

How did you find out about Art of Awareness?

Are you currently seeing a therapist? Current Therapist's Name:

If Yes, are you looking to switch individual therapists?

Have you sought therapy in the past? Past Therapist's Name:

Are you open to Telehealth Therapy Yes No I am open to whatever is first available

Topics to be addressed in therapy (REQUIRED):

Therapist Preference: Male ☐ Female ☐ Either/First Available ☐

What type(s) of therapy service(s) are you seeking? Individual Couples Family Coping Skills Group

Intensive Outpatient Therapy

Which days and times would work best for you to meet with one of our Clinicians (REQUIRED)?

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The following questions may or may not apply to you. We ask each new client these questions. Please answer them to the best of your ability, thank you.

Have you ever been hospitalized for a Mental Health, Substance Use Disorder, or an Eating Disorder related concern?

Y ☐ N ☐ If Yes, please list when and where:

Are you currently taking medications? ☐Y ☐N If Yes, please list:

Are you currently experiencing any of the following?

Poor Sleep ☐Y ☐N

Change in Appetite ☐Y ☐N

Medical Health Problems ☐Y ☐N If Yes, please list:

Have you experienced any of the following currently or in the past? **(Crisis Line 24/7 PH# 888-568-1112)**

Thoughts of Self Harm	☐ Current	☐ Past	☐ Never/Not Applicable
Thoughts of Suicide	☐ Current	☐ Past	☐ Never/Not Applicable
Suicidal Intent or Plan	☐ Current	☐ Past	☐ Never/Not Applicable
Thoughts of physically harming another person	☐ Current	☐ Past	☐ Never/Not Applicable
Homicidal Intent or Plan	☐ Current	☐ Past	☐ Never/Not Applicable

If you answered "yes/current" to the above questions, please reach out to the crisis line (888-568-1112) or go to your nearest emergency room. Art of Awareness is not a crisis program, we are a by appointment only Therapy Practice and Intensive Outpatient Program. We will get back to you within 72 business hours upon receipt of your New Client Referral. Please reach out to the crisis line if you are in need of immediate support.

How much alcohol do you drink on a weekly basis?

Do you abuse or over-use any drugs? ☐ Current ☐ Past ☐ Never/Not Applicable

Have you experienced any traumatic events? ☐ Current ☐ Past ☐ Never/Not Applicable

Do you have a family history of mental health, substance use disorder, or eating disorders? ☐ Y ☐ N

Do you have Disordered Eating? ☐ Current ☐ Past ☐ Never/Not Applicable

Overall, on a scale of 1 to 5, to what degree are the symptoms you are experiencing affecting your daily life & functioning?

(1 being not at all, 5 being severely impacting your daily life): ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

Resources & Support:

What activities do you enjoy?

Who is in your current support system?

What are your strengths?

Client Insurance and Benefit Form

Please complete the form below to provide Art of Awareness with your insurance coverage details for routine outpatient mental health services. Please note that authorizations and/or estimates for insurance coverage do not guarantee payment or verify eligibility. Payment of benefits are subject to all terms, conditions, limitations, and exclusions of the members contract at the time of service.

If needed, we have included an additional form in this packet called the "**Benefit Retrieval Guide for Clients**" as a resource to clients to gain their mental health benefit information.

General Insurance Information:

Client Name:____ Pronouns:__________/___________

Legal Name (If Different):__________________________________DOB (mm/dd/yyyy):_____/_____/_________

Email:____PH#:_________________________________

For Minors and/or Clients Who Have an Identified Parent/Guardian Point-of-Contact for Billing Related Matters:

Parent/Guardian Name:____ Relation to Client:__________________

Email:____PH#:_________________________________

Has an Authorization to Release Information Form Been Signed for Billing Purposes? Y N

If no, and the client would like to identify a Parent/Guardian as a point of contact for billing purposes, the Authorization to Release Information form is included in this packet for the client to complete and submit with this packet.

Insurance Company Name:____

Subscriber Name:____ Renewal Date:________________________

Member ID#:____ Group Number:_______________________

Please Include Alpha Prefix

Insurance Provider Phone Number: 1-(_________)__________-_____________

This phone number can be found on the back of an insurance card, listed as "Provider Phone Number"

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For Reference:

Art of Awareness Tax ID#: 65-125-4395

Art of Awareness Clinical Director NPI# (Provider: Emily Roberson, LCSW): 1154484236

Client Benefit Information for Routine Outpatient Mental Health (Office and Telehealth):

Copay Per Session:_______________

Deductible: Individual:____________________ Family:____________________

Has the Deductible Been Met? Yes No

Coinsurance %:______________

Max Out-Of-Pocket Amount: Individual:____________________ Family:____________________

Has the Max Out-Of-Pocket Amount Been Met? Yes No

Beneficiary Agreement:

I understand that my health insurance company may deny payment for the services identified above, for the reasons stated. If my health insurance company denies payment, I agree to be personally and fully responsible for payment. I also understand that if my health insurance company does make payment for services, I will be responsible for any co-payment, deductible, or coinsurance that applies.

Client Signature:____ Date:______/______/_________

For Clients that are NOT completing this form through the Valant Patient Portal:

Please send your completed packet to billing@artofawareness.org

Benefit Retrieval Guide for Clients

Tips and Language to Support you in Finding out your Coverage for Outpatient Individual, Couples, and Group Mental Health Services (Not applicable for clients pursuing IOP)

Call member services (number on the back of your card) and ask:

1. Do I have a copay or coinsurance for routine mental health services?
2. Do I have a deductible to meet before coinsurance is applied?
    a. If yes, how much has been met towards my deductible?
3. Is there a session limit?
4. What is the accumulation of my maximum out of pocket expense?
5. Do I need a referral?
6. Are telehealth benefits the same as in office?

If needed, CPT codes are:

90791 for Initial Assessment
90837 for Individual Therapy
90847 for Couples Therapy
90853 for Group Therapy (non IOP)

For HMO Policies - Benefits can be more affordable for clients with a PCP (primary care provider) referral. Consider reaching out to your doctor's office and ask them to provide a referral and have it sent to Art of Awareness at clientservices@artofawareness.org or fax to 207-799-1350. If you may require a referral to access better benefits, best practice would be to request this from your PCP prior to receiving any services.

Other tips to note when making insurance calls:

- AoA's tax ID is 651254395
- The NPI# of Art of Awareness's Clinical Director (Emily Roberson) is: 1154484236
    - Note that this NPI# is only applicable for services received through Art of Awareness, and will not produce accurate benefit information for providers outside of Art of Awareness.
- You can bypass the automated response system by stating "representative" or "agent," or pressing zero "0"
- If you are asked for a diagnosis code, you can say "no diagnosis at this time"

- You will need to provide your legal name associated with your legal sex to receive accurate benefits but can ask to have a preferred name associated with your insurance
    - More movement will be made in the insurance industry with regards to transgender and non-binary gender preferences.
- If your insurance changes (ie change of employment) please inform your therapist and the Billing department at billing@artofawareness.org. This way we can check to make sure your new insurance is in network with your provider.
- *Note that we are not currently in-network with Mainecare*

Once you receive your benefit information:

- Please communicate this to your assigned therapist at Art of Awareness and your therapist will update this information into our Electronic Health Records system, Valant.
- If you find that your benefit information changes, please make sure to update your therapist

ART OF AWARENESS

Authorization to Release and/or Obtain Information

Art of Awareness Provider: ______________________________ **Phone:** 207-799-1331 **FAX:** 207-799-1350
Address: 100 Waterman Drive Suite 201 South Portland, ME 04106 **Email:** clientservices.aoa@gmail.com

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Client: ____ **Date of Birth:** ________________________
Address: ____

I hereby authorize **the above Provider** to release and obtain (verbally or in writing) information related to my medical and mental health treatment / history to the following individual, clinic staff, agency or institution:

Name: ____ **Phone**: ______________ **FAX:**______________
Address: ____

I authorize the release of information, which is circled below:

Evaluation/Assessment	Medical history	Treatment Status
Diagnosis	Psychological Test	Aftercare Plan
Treatment Plan	Psychosocial History	Discharge Summary

Other (Describe in Detail) ____

SOME INFORMATION IS SPECIALLY PROTECTED. IF YOU WANT ANY OF THE FOLLOWING INFORMATION TO BE SHARED, YOU MUST CHECK A BOX BELOW:
____I WANT any information about diagnosis and/or treatment of alcohol or drug abuse to be shared.
____I WANT any information about diagnosis and/or treatment of HIV/AIDS to be shared

This information is to be used for:
____
Restriction(s) on material revealed:
____

I understand that I can revoke (cancel) this authorization to disclose the above-referenced information at any time, except to the extent that disclosure has been made in reliance upon my authorization before revocation. I am aware that I can revoke my authorization in writing by addressing a letter to that effect to the above Provider; however, it will not be effective until the above Provider receives it.

This consent will expire thirty (30) months from the date hereof, unless I have previously revoked this consent, or unless I have specified a shorter period of expiration of this Consent, as follows: _________. I understand that I may receive a copy of the authorization.

__________________________________ __________________________ _____________
Signature of Client or Guardian Print Name Date

______________________________ _____________
Witness Date