INTRODUCTORY REPORT

PATIENT :____DOB__________________
PARENT/GUARDIAN:____
ADDRESS:__________________________________CITY:_______________________
STATE:___________________________ZIP CODE:____________________________
PHONE:_________________MOM CELL_______________DAD CELL____________
INSURANCE CO:____
THERAPIST/REFERRAL SOURCE:____
PHONE:__________________________________
PRIMARY CARE PHYSICIAN: NAME:_____________________________________
PHONE #: ________________________ FAX #______________________________
SCHOOL AND GRADE ATTENDING:_______________________________________
PARENTS: (please circle appropriate selection) MARRIED/DIVORCED/SEPERATED
MEDICAL DECISION MAKING: (please circle the appropriate selection) Both Parents/Mother Only/Father Only/Other:__________________________________
CHIEF PROBLEM: ____

MEDICAL/DEVELOPMENTAL ISSUES__: ____________________________________

PRIORTREATMENT/HOSPITALIZATIONS/MEDS:____________________________

FAMILY PSYCHIATRIC HISTORY: ____

SUICIDALITY:____SELF-INJURY:____
EATING DISORDER ISSUES:____
FIGHTING/ARRESTS:____
DRUGS/ALCOHOL: ____

I hearby give my permission to contact the above therapist and/or doctor to coordinate care: Yes No
Signed:_____________________________ Date:________________

I have received and accept the HIPAA agreement, as found in Dr. Richker's New Patient Packet, located on the website www.arvadamentalhealthbilling.com
☐ Yes ☐ No Signed: __________________________________ Date: ________________

I understand Dr. Richker only bills for the United Healthcare Network (eg UHC, UBH, Golden Rule, UMR, Life Strategies, Cover Co, Pacificare), Mines and Associates, and that all other insurances will be considered "Self Pay" at the fee of $375 per initial session and $125 per follow up appointment. ☐ Yes