



FREEDOM CALLS HEALTH

Jarrold Kanady; PMHNP, FNP
154 Huffman Mill Rd #200 Burlington, NC 27215

CONSENT TO TREAT & NEW PATIENT INTAKE

This form contains legal consents and confidential health information. Please read carefully and complete all sections.

PATIENT INFORMATION

First Name: _____ Last Name: _____

Birth Date: _____ Gender: Male Female Self-describe

Address: _____

City: _____ State: _____ ZIP _____

Email: _____ Cell Phone: _____

Marital Status: Married Single Divorced Widowed Other

Emergency Contact: _____ Phone: _____

Primary Care Provider _____ Address: _____

How did you hear about us?

I live/work in area I was referred by _____

Social media Other _____

INSURANCE INFORMATION

No Insurance (self-pay)

Primary Insurance

Name of Insurance Company: _____ State: _____

Policy Holder Name: _____ Birth Date: _____

Member ID: _____ Group: _____

Name of Employer: _____

Relationship to Insurance holder: Self Parent Child Spouse Other _____

ALLERGIES

Please list all drug allergies and any severe non-drug allergies.

Patient or Guardian Signature

Date

Print Name (Patient or Guardian)

Relationship to Patient (if Guardian)



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Patient Name: _____

Date: _____

MEDICAL & PSYCHIATRIC HISTORY

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PAST MEDICAL HISTORY

Please list any major medical illnesses, surgeries, or chronic conditions (e.g., Diabetes, Hypertension, Heart Disease, Thyroid issues).

Diagnosis	Date of Diagnosis	Treatment/Status
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST PSYCHIATRIC HISTORY

Please list any past psychiatric diagnoses, hospitalizations, or previous mental health providers.

Diagnosis	Date of Diagnosis	Treatment/Status
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

CURRENT MEDICATIONS

Please list ALL prescription medications, over-the-counter medications, and supplements you are currently taking.

Medications	Dose/Frequency	Prescribing Provider
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

PAST PSYCHIATRIC MEDICATIONS THAT WERE NOT EFFECTIVE

List any psychiatric medications you have taken that were discontinued due to lack of effect, side effects, or other reasons.

Medication	Reason for stopping
_____	_____
_____	_____
_____	_____

SOCIAL HISTORY & SUBSTANCE USE

Smoking/Vaping: Never Quit (Date: _____) Current Smoker (Packs per day: _____) Vape/E-cigarettes

Alcohol Use: Never Rarely Socially (Drinks per week: _____) Daily (Drinks per day: _____)

THC/Cannabis: Never Past Use Current Use (Frequency: _____)

Cocaine: Never Past Use Current Use (Frequency: _____)

Opiates: Never Past Use Current Use (Frequency: _____)

Others (Specify): _____

Substance Abuse Treatment History: _____



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CONSENT FOR PSYCHIATRIC EVALUATION AND TREATMENT

This form contains legal consents and confidential health information. Please read carefully and complete all sections.

I hereby voluntarily consent to a psychiatric evaluation and to receive treatment, which may include pharmacologic (medication) and/or non-pharmacologic (therapy, counseling, education) services, as deemed necessary and appropriate by the provider at Freedom Calls Health, PLLC.

I understand that:

- **Nature of Care:** The psychiatric care provided will be based on my individual needs and clinical presentation. Treatment will be explained to me, and I will have the opportunity to ask questions.
- **Voluntary Consent:** My consent for treatment is voluntary. I have the right to refuse or withdraw from any part of the evaluation or treatment at any time without penalty or fear of retribution.
- **Confidentiality:** I have received and reviewed the practice's Notice of Privacy Practices which details how my Protected Health Information (PHI) will be used and disclosed. I understand that, while information is confidential, there are legal exceptions to confidentiality (e.g., mandated reporting of abuse/neglect, credible threats of serious harm to self or others, and court order).
- **Risks and Benefits:** I understand that there are potential risks and benefits associated with all forms of psychiatric treatment, including medication. I will discuss these risks and benefits with my provider before starting any new treatment.
- **Controlled Substances:** I understand that this practice reserves the right to conduct a urine drug screening as deemed necessary by the provider, in compliance with all government regulations.
- **Financial Responsibility:** I understand my financial responsibility as outlined in the Assignment of Benefits and Financial Responsibility Agreement (if applicable).

By signing below, I acknowledge that I have provided accurate information to the best of my knowledge and I authorize Freedom Calls Health, PLLC to provide me with the necessary and appropriate psychiatric care.

Patient or Guardian Signature

Date

Print Name (Patient or Guardian)

Relationship to Patient (if Guardian)