WESTSIDE MENTAL HEALTH
192 N State Road 267, Suite 300 – Avon, IN 46123
P: 317-672-6400 / F: 317-672-6401
www.WestsideMentalHealth.org

ADULT NEW PATIENT INTAKE FORM

THE INFORMATION YOU PROVIDE HERE IS PROTECTED AS CONFIDENTIAL INFORMATION. IF YOU NEED ADDITIONAL WRITING SPACE FOR ANY QUESTION PLEASE USE AS MUCH ADDITIONAL PAPER AS NEEDED. PLEASE FILL OUT THIS FORM AND BRING IT TO YOUR FIRST SESSION.

DATE OF VISIT: _____/_____/_____

LAST NAME: ____________________________________ FIRST NAME: _______________________________ MI: _______

PREFERRED NAME:____ GENDER: M F

ADDRESS: ____

____

DOB: ________/________/________ SSN: __________-__________-_________ DL#: ___________________________

PHONE: (H): (_______)___________________ MAY WE LEAVE A MESSAGE: YES / NO

(C): (_______)___________________ MAY WE LEAVE A MESSAGE: YES / NO

(W): (_______)___________________ MAY WE LEAVE A MESSAGE: YES / NO

EMAIL: ____ MAY WE EMAIL YOU: YES / NO

EMERGENCY CONTACT:

NAME: ____ PHONE: (_______)___________________

RELATIONSHIP: ____

PRIMARY CARE PHYSICIAN:

NAME: ____ PHONE: (_______)___________________

GUARDIAN OR LEGAL REPRESENTATIVE:

NAME: ____ PHONE: (_______)___________________

ADDRESS: ____

____RELATIONSHIP: _______________________

REFERRED BY: ____

PATIENT HISTORY

BRIEFLY DESCRIBE THE PROBLEM(S) FOR WHICH YOU ARE SEEKING HELP: ________________________________

____

____

____

____

____

OCCUPATIONAL/EDUCATIONAL/MILITARY HISTORY:

ARE YOU EMPLOYED:_____ RETIRED:_____ DISABLED:_____ OTHER:________________________________

IF EMPLOYED, WHERE?: ____

HIGHEST LEVEL OF EDUCATION?: ____

ARE YOU CURRENTLY IN THE MILITARY? YES / NO PREVIOUSLY?: YES / NO

PERSONAL HISTORY:

MARITAL STATUS:

SINGLE:___ MARRIED:___ SEPARATED:___ DIVORCED:___ WIDOWED:___ OTHER:__________

PARTNER/SPOUSE NAME(S) AND STATUS:

____

____

CHILD/REN NAME(S)/AGE(S) OR OTHERS THAT LIVE WITH YOU, NAME(S)/AGE(S):

____

____

____

HEALTH INFORMATION:

MEDICAL HISTORY:

LIST ANY SIGNIFICANT MEDICAL PROBLEMS/CONDITIONS/SURGERIES/ALLERGIES/ETC.:_________

____

____

____

____

____

____

MEDICATION(S) - CURRENT – PLEASE LIST ALL MEDICATIONS YOU ARE CURRENTLY TAKING:

NAME OF MEDICATION:	DOSAGE:	START DATE:	REASON FOR TAKING:
________________________	___________	____________	___________________________________
________________________	___________	____________	___________________________________
________________________	___________	____________	___________________________________
________________________	___________	____________	___________________________________

MEDICATION(S) - PAST – PLEASE LIST ALL MEDICATIONS YOU HAVE PREVIOUSLY TAKEN:

NAME OF MEDICATION:	DOSAGE:	END DATE:	REASON FOR STOPPING:
________________________	___________	____________	___________________________________
________________________	___________	____________	___________________________________
________________________	___________	____________	___________________________________
________________________	___________	____________	___________________________________

MEDICATION ALLERGIES?; YES / NO

IF YES, PLEASE LIST:____

____

SUPPLEMENT(S)/HERBAL SUPPLEMENT(S):

NAME:	DOSAGE:	START DATE:	SIDE EFFECT:
________________________	___________	____________	___________________________________
________________________	___________	____________	___________________________________
________________________	___________	____________	___________________________________

DO YOU CONSUME ALCOHOL?: YES / NO

IF YES, HOW MUCH AND HOW OFTEN:____

____

DO YOU ENGAGE IN RECREATIONAL DRUG USE?: YES / NO

IF YES, WHAT TYPE(S), HOW MUCH AND HOW OFTEN:____

____

DO YOU USE TOBACCO PRODUCTS, I.E. CIGARETTES/CHEWING TOBACCO/ETC.?: YES / NO

IF YES, WHAT TYPE(S), HOW MUCH AND HOW OFTEN:____

____

DO YOU DRINK CAFFEINATED DRINKS?: YES / NO

IF YES, HOW MUCH: ____

PREVIOUS TREATMENT:

PSYCHIATRIC TREATMENT: YES / NO

IF YES, PLEASE DESCRIBE?:____

____

COUNSELING TREATMENT: YES / NO

IF YES, PLEASE DESCRIBE?:____

____

CHEMICAL DEPENDENCY TREATMENT: YES / NO

IF YES, PLEASE DESCRIBE?:____

____

SYMPTOMS OR BEHAVIORS THAT CONCERN YOU:

DEPRESSED MOOD OR SADNESS:	YES / NO
IRRITABILITY/ANGER:	YES / NO
MOOD SWINGS:	YES / NO
RAPID SPEECH:	YES / NO
RACING THOUGHTS:	YES / NO
ANXIETY:	YES / NO
CONSTANT WORRY:	YES / NO
PANIC ATTACKS:	YES / NO
PHOBIAS:	YES / NO
SLEEP DISTURBANCES:	YES / NO
HALLUCINATIONS:	YES / NO
PARANOIA:	YES / NO
POOR CONCENTRATION:	YES / NO
ALCOHOL/SUBSTANCE ABUSE:	YES / NO
FREQUENT BODY COMPLAINTS (E.G. HEADACHES):	YES / NO
EATING DISORDER:	YES / NO
BODY IMAGE PROBLEMS:	YES / NO
REPETITIVE THOUGHTS (E.G. OBSESSIONS):	YES / NO
REPETITIVE BEHAVIORS (E.G. COUNTING):	YES / NO
POOR IMPULSE CONTROL (E.G. INCREASED SPENDING):	YES / NO
SELF MUTILATION:	YES / NO
SEXUAL ABUSE:	YES / NO
EMOTIONAL ABUSE:	YES / NO
VERBAL ABUSE:	YES / NO

FAMILY HISTORY:

ARE YOUR PARENTS:
- ☐ STILL TOGETHER
- ☐ DIVORCED
- ☐ REMARRIED
- ☐ UNMARRIED
- ☐ DECEASED – WHOM: ____________________

NUMBER OF SIBLINGS:______________ AGES: ______________________________

FAMILY MENTAL HEALTH HISTORY:

HAS ANYONE IN YOUR FAMILY (EITHER IMMEDIATE FAMILY MEMBERS OR RELATIVES) EXPERIENCED DIFFICULTIES WITH THE FOLLOWING":

DIFFICULTY:		FAMILY MEMBER:
BIPOLAR DISORDER:	YES / NO	______________________________
ANXIETY DISORDER:	YES / NO	______________________________
PANIC ATTACKS:	YES / NO	______________________________
SCHIZOPHRENIA:	YES / NO	______________________________
ALCOHOL/SUBSTANCE ABUSE:	YES / NO	______________________________
EATING DISORDERS:	YES / NO	______________________________
LEARNING DISBILITIES:	YES / NO	______________________________
TRAUMA HISTORY:	YES / NO	______________________________
SUICIDE ATTEMPTS:	YES / NO	______________________________
PSYCHIATRIC HOSPITALIZATIONS:	YES / NO	______________________________

IS THERE ANYTHING THAT WE DID NOT ASK THAT WOULD BE IMPORTANT FOR US TO KNOW ABOUT?:_____

____

____

____

____

____

OTHER INFORMATION (OPTIONAL):

WHAT ROLE, IF ANY, DO RELIGION AND/OR SPIRITUALITY PLAY IN YOUR LIFE?: ______________________

____

ARE YOU SATISFIED WITH YOUR SOCIAL SITUATION/INTERPERSONAL RELATIONSHIPS?:______________

____

WHAT DO YOU CONSIDER TO BE YOUR STRENGTHS?: ___________________________________

____

WHAT DO YOU LIKE MOST ABOUT YOURSELF?: _______________________________________

____

WHAT ARE EFFECTIVE COPING STRATEGIES YOU USE WHEN STRESSED?: ______________________

____

WHAT ARE YOUR OVERALL GOALS FOR PSYCHIATRIC TREATMENT AND/OR THERAPY?: ______________

____

____

____

INSURANCE INFORMATION

PLEASE PROVIDE YOUR PROOF OF INSURANCE TO THE RECEPTIONIST AT YOUR FIRST VISIT.

PRIMARY INSURANCE:

INSURANCE CARRIER: ____ MEMBER ID: ________________________

GROUP #: ____ POLICY #: ____

INSURANCE PHONE NUMBER: (_______)___________________

PLEASE COMPLETE THE FOLLOWING IF DIFFERENT FROM PATIENT INFORMATION:

SUBSCRIBER'S NAME: LAST: _________________________________ FIRST: ________________________ MI: ____

SUBSCRIBER'S SSN: __________-__________-_________ SUBSCRIBER'S DOB: ________/________/________

SUBSCRIBER'S ADDRESS: ____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: ____

SECONDARY INSURANCE:

INSURANCE CARRIER: ____ MEMBER ID: ________________________

GROUP #: ____ POLICY #: ____

INSURANCE PHONE NUMBER: (_______)___________________

PLEASE COMPLETE THE FOLLOWING IF DIFFERENT FROM PATIENT INFORMATION:

SUBSCRIBER'S NAME: LAST: _________________________________ FIRST: ________________________ MI: ____

SUBSCRIBER'S SSN: __________-__________-_________ SUBSCRIBER'S DOB: ________/________/________

SUBSCRIBER'S ADDRESS: ____

PATIENT'S RELATIONSHIP TO SUBSCRIBER: ____

WESTSIDE MENTAL HEALTH PROVIDERS ARE IN-NETWORK WITH MOST MAJOR INSURANCE COMPANIES AND MEDICARE. AS A COURTESY TO YOU, WE WORK DIRECTLY WITH YOUR INSURANCE AND WILL MAKE EVERY EFFORT POSSIBLE TO BILL YOUR INSURANCE COMPANY.

WESTSIDE MENTAL HEALTH DOES NOT ACCEPT MEDICAID AND YOU WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.

VERIFICATION OF BENEFIT COVERAGE IS NOT A GUARANTEE OF CLAIM PAYMENT. ALL BENEFITS ARE SUBJECT TO THE TERMS AND CONDITIONS (E.G. AUTHORIZATIONS, NETWORK REQUIREMENTS, ETC.) OUTLINED IN YOUR MEMBER CONTRACT WITH YOUR INSURANCE COMPANY. WE HAVE NO AUTHORITY TO MAKE REPRESENTATIONS TO YOU REGARDING COVERAGE OF ITEMS OR SERVICES COVERED.
I UNDERSTAND THAT I AM RESPONSIBLE FOR PAYMENT FOR SERVICES RENDERED BY WESTSIDE MENTAL HEALTH REGARDLESS OF REIMBURSEMENT FOR THESE SERVICES BY THE INSURANCE COMPANY AND THAT ANY INACCURACY IN INFORMATION ON THIS FORM MAY RESULT IN NONPAYMENT BY MY INSURANCE COMPANY. I AGREE TO NOTIFY WESTSIDE MENTAL HEALTH IMMEDIATELY WHENEVER I HAVE CHANGES IN MY PERSONAL INFORMATION OR HEALTH PLAN COVERAGE IN THE FUTURE.

I AUTHORIZE MY INSURANCE COMPANY TO ASSIGN BENEFITS DIRECTLY TO WESTSIDE MENTAL HEALTH. I AUTHORIZE WESTSIDE MENTAL HEALTH TO RELEASE ANY MEDICAL INFORMATION TO MY INSURANCE COMPANY WHICH MAY BE DEEMED NECESSARY IN ORDER TO PROCESS AN INSURANCE CLAIM. I HEREBY AUTHORIZE THE USE OF THIS SIGNATURE ON ALL INSURANCE SUBMISSIONS.

THE ABOVE INFORMATION IS COMPLETE AND TRUE TO THE BEST OF MY KNOWLEDGE. BY SIGNING THIS FORM, I CERTIFY THAT I HAVE READ, UNDERSTAND AND AGREE TO THE CONDITIONS AND POLICIES STATED ABOVE.

RESPONSIBLE PARTY NAME (PRINT):____

SIGNATURE:____ DATE:______________________

PATIENT'S BILL OF RIGHTS AND RESPONSIBILITIES

THESE RIGHTS ARE PROVIDED TO MAKE YOU AWARE OF THE RIGHTS GUARANTEED TO YOU WHILE YOU ARE PATIENT WITH WESTSIDE MENTAL HEALTH. **THIS INFORMATION SHOULD NOT BE CONSIDERED THE GRANTING OR DENYING OF ANY RIGHTS OR RESTRICTIONS PROTECTED UNDER FEDERAL AND/OR STATE LAW**.

RIGHTS:

YOUR RIGHT TO BE INFORMED OF YOUR RIGHTS, YOU HAVE A RIGHT TO BE GIVEN A COPY OF ALL OF THESE AND/OR ASK QUESTIONS OR BE GIVEN CLARIFICATION.

YOU HAVE THE RIGHT TO BE TREATED WITH RESPECT AND DIGNITY.

YOU HAVE THE RIGHT TO BE FREE FROM MISTREATMENT.

HIGH-QUALITY CARE AND HIGH PROFESSIONAL STANDARDS.

RECEIVE CARE IN A SAFE AND SECURE SETTING.

YOU HAVE THE RIGHT OF AN ENVIRONMENT THAT PRESERVES PERSONAL PRIDE

HAVE CLINICIANS AND STAFF BE CONSIDERATE OF YOUR TIME.

YOUR RIGHT TO ASK QUESTIONS, YOU HAVE THE RIGHT TO ASK YOUR CLINICIAN QUESTIONS, SUCH AS, YOUR TREATMENT PLAN, RECOMMENDATIONS, MEDICATIONS, ETC. OR YOUR CLINICIANS QUALIFICATIONS, BACKGROUND, ETC.

RECEIVE CARE, TREATMENT AND SERVICES REGARDLESS OF RELIGION, RACE, GENDER, MARITAL STATUS, AGE, SEXUAL ORIENTATION, NATIONAL ORIGIN, PREVIOUS INCARCERATION, DISABILITY OR PUBLIC ASSISTANCE STATUS.

YOU HAVE THE RIGHT OF PRIVACY, YOU HAVE THE RIGHT TO HAVE YOUR RECORDS KEPT PRIVATE (UNLESS SPECIFIED BY YOU, OR REQUIRED OR PERMITTED BY FEDERAL (HIPAA) OR STATE LAW.

REFUSE ANY CARE, TREATMENT, DRUGS OR PROCEDURES AND HAVE THE CLINICIAN TELL YOU WHAT MIGHT HAPPEN IF YOU REFUSE CARE.

YOU HAVE THE RIGHT TO AN INDIVIDUALIZED TREATMENT PLAN AND BE INVOLVED IN AND MAKE DECISIONS REGARDING YOUR CARE, TREATMENT AND SERVICES.

EFFECTIVE COMMUNICATION WITH OUR CLINICIANS AND STAFF IN WORDS YOU CAN UNDERSTAND, INCLUDING THE DIAGNOSIS, TREATMENT, OTHER POSSIBLE TREATMENT CHOICES, COMPLICATIONS ETC.

HAVE ANOTHER DECISION-MAKER, AS ALLOWED BY LAW, WHEN YOU CANNOT MAKE DECISIONS ABOUT CARE.

YOU HAVE THE RIGHT TO REQUEST AND RECEIVE A SECOND OPINION FROM ANOTHER PROFESSIONAL TREATMENT PROVIDER AT YOUR OWN EXPENSE.

YOU HAVE THE RIGHT TO INFORMATION ABOUT WESTSIDE MENTAL HEALTH'S CHARGES.

YOU HAVE THE RIGHT TO PLACE GRIEVANCES AND RECOMMEND CHANGES IN POLICIES AND SERVICES TO WESTSIDE MENTAL HEALTH STAFF FREE FROM RESTRAINT, INTERFERENCE, COERCION, DISCRIMINATION, OR REPRISAL

THERE ARE MANY OPTIONS FOR YOU WITHIN THE FIELD OF MENTAL HEALTH. YOU HAVE THE RIGHT TO CEASE TREATMENT AT ANY TIME AS WELL AS THE RIGHT TO SWITCH TO ANOTHER CLINICIAN.

BE INFORMED OF YOUR RESPONSIBILITIES AS A PATIENT.

RESPONSIBILITIES:

TO ACTIVELY PARTICIPATE IN YOUR TREATMENT AND TREATMENT PLANNING.

PROVIDE, AS BEST YOU CAN, ACCURATE AND COMPLETE INFORMATION ABOUT YOUR HEALTH AND MENTAL HEALTH.

REPORT CHANGES IN YOUR CONDITION, PERSONAL INFORMATION OR INSURANCE.

ASK QUESTIONS SO THAT YOU CLEARLY UNDERSTAND THE TREATMENT PLAN, RECOMMENDATIONS, MEDICATIONS, ETC. AND WHAT IS EXPECTED OF YOU.

TO BE CONSIDERATE OF THE CLINICIANS' AND STAFF'S TIME.

KEEP APPOINTMENTS OR NOTIFY WESTSIDE MENTAL HEALTH AS SOON AS POSSIBLE IF YOU ARE UNABLE TO KEEP AN APPOINTMENT.

FOLLOW DIRECTIONS GIVEN BY YOUR CLINICIAN, OR BE RESPONSIBLE FOR THE CONSEQUENCES IF YOU REFUSE TREATMENT OR DO NOT FOLLOW DIRECTIONS

TO TAKE MEDICATION AS PRESCRIBED.

TO MAKE SURE YOU HAVE ENOUGH MEDICATION OR TO REQUEST A REFILL OF YOUR MEDICATION WITHIN A TIMELY MANNER.

FOLLOW THE TREATMENT PLAN THAT YOU AND YOUR CLINICIAN DEVELOP.

BE CONSIDERATE OF THE RIGHTS OF OTHER PATIENTS AND PERSONNEL.

BE RESPECTFUL OF THE PROPERTY OF OTHER PERSONS AND OF THE FACILITY.

HONOR THE CONFIDENTIALITY AND PRIVACY OF OTHER PATIENTS.

RESPONSIBLE PARTY NAME (PRINT):____

SIGNATURE:____ DATE:______________________

AGREEMENT AND CONSENT FOR SERVICES

CONFIDENTIALITY POLICY:

THE STAFF AND CLINICIANS AT WESTSIDE MENTAL HEALTH HOLD YOUR CONFIDENTIALITY IN THE HIGHEST REGARD, AND WE RESPECT YOUR RIGHT TO CONFIDENTIALITY WITH THE INFORMATION THAT YOU SHARE WITHIN THIS CLINICAL SETTING. I UNDERSTAND THAT INFORMATION REGARDING MY SERVICES WITH WESTSIDE MENTAL HEALTH WILL BE MAINTAINED IN THE STRICTEST CONFIDENTIALLY IN ACCORDANCE WITH FEDERAL (HIPAA) AND STATE STATUTES. I HAVE RECEIVED, UNDERSTAND AND AGREE WITH WESTSIDE MENTAL HEALTH'S NOTICE OF PRIVACY POLICY OUTLINING MY RIGHTS TO PRIVACY (HIPAA).

FEE POLICY:

I AGREE TO BE RESPONSIBLE FOR ALL FEES INCURRED AT WESTSIDE MENTAL HEALTH. WESTSIDE MENTAL HEALTH PROVIDERS ARE IN-NETWORK WITH MOST MAJOR INSURANCE COMPANIES AND MEDICARE. IT IS YOUR RESPONSIBILITY TO CHECK WITH YOUR INSURANCE CARRIER REGARDING YOUR COVERAGE FOR EACH PROVIDER AND SERVICES RENDERED.

WESTSIDE MENTAL HEALTH DOES NOT ACCEPT MEDICAID AND YOU WILL BE RESPONSIBLE FOR ALL CHARGES INCURRED.

INFORMATION POLICY:

IT IS YOUR RESPONSIBILITY TO PROVIDE US WITH ANY AND ALL CHANGES TO YOUR PERSONAL INFORMATION, INSURANCE INFORMATION, ETC.

CANCELATION POLICY:

SUCCESSFUL THERAPY/PSYCHIATRIC SERVICES REQUIRES A COMMITMENT ON YOUR PART. YOU ARE ULTIMATELY RESPONSIBLE FOR ATTENDING ALL SCHEDULED APPOINTMENT(S). REMINDER CALLS ARE DONE AS A COURTESY ONLY, YOU STILL RESPONSIBLE FOR YOUR APPOINTMENT IF THE CALL WAS RECEIVED OR NOT. WE REALIZE THAT ON OCCASION YOU WILL NOT BE ABLE TO MAKE A SCHEDULED APPOINTMENT. PLEASE REMEMBER THAT THIS TIME HAS BEEN RESERVED EXCLUSIVELY FOR YOU, SO OUR POLICY IS TO CHARGE UP TO $85 FOR MISSED APPOINTMENTS OR FOR CANCELATIONS WITHOUT 24- HOUR NOTICE. CLIENTS WHO FREQUENTLY (MORE THAN TWO TIMES) FAIL OR CANCEL THEIR APPOINTMENTS WITHOUT A 24-HOUR NOTICE MAY NOT BE RESCHEDULED AND/OR MAY BE SUBJECT TO "SAME DAY" AVAILABILITY. PLEASE CALL US AS SOON AS YOU KNOW THAT YOU WILL NOT BE ABLE TO MAKE A SCHEDULED APPOINTMENT.

AFTER HOURS EMERGENCY POLICY:

CLINICIANS AT WESTSIDE MENTAL HEALTH ARE NOT AVAILABLE BEFORE OR AFTER USUAL BUSINESS HOURS FOR EMERGENCIES (9AM-5PM, MONDAY – THURSDAY, AND 9AM-1PM FRIDAY). FOR AFTER-HOURS EMERGENCIES, OR IF YOU NEED IMMEDIATE ASSISTANCE, CALL **911** OR VISIT YOUR LOCAL EMERGENCY ROOM.

NON-DISCRIMINATION POLICY:

WESTSIDE MENTAL HEALTH DOES NOT DISCRIMINATE ON THE BASIS OF RELIGION, RACE, GENDER, MARITAL STATUS, AGE, SEXUAL ORIENTATION, NATIONAL ORIGIN, PREVIOUS INCARCERATION, DISABILITY OR PUBLIC ASSISTANCE STATUS.

MEDICATION REFILL POLICY:

IT IS YOUR RESPONSIBILITY TO MAKE SURE YOU WILL HAVE ENOUGH MEDICATIONS UNTIL YOUR NEXT APPOINTMENT. IF A REFILL IS REQUIRED, PLEASE ALLOW UP TO THREE BUSINESS DAYS (MONDAY-THURSDAY) FOR PROCESSING TIME FOR ANY REFILL REQUEST. THERE WILL BE NO REFILLS GIVEN ON FRIDAYS, WEEKENDS OR HOLIDAYS. FOR REPEATED OR MULTIPLE REQUESTS, A CHARGE OF $5.00 - $10.00 MAY BE ASSESSED FOR EACH PRESCRIPTION REFILL.

PATIENT BILL OF RIGHTS AND RESPONSIBILITIES POLICY:

I HAVE BEEN PROVIDED WITH, UNDERSTAND, SIGNED AND AGREE TO THE PATIENT BILL OF RIGHTS.

INFORMED CONSENT:

I DO HEREBY SEEK AND CONSENT TO TAKE PART IN THE TREATMENT FROM WESTSIDE MENTAL HEALTH. I UNDERSTAND THAT DEVELOPING A TREATMENT PLAN WITH THE CLINICIAN AND REGULARLY REVIEWING OUR WORK TOWARDS MEETING THE TREATMENT GOALS ARE IN MY BEST INTEREST. I AGREE TO PLAY AN ACTIVE ROLE IN THIS PROCESS. I HAVE RECEIVED, UNDERSTAND AND AGREE WITH ALL WESTSIDE MENTAL HEALTH'S POLICIES, AND ANY QUESTIONS REGARDING ANY OF WESTSIDE MENTAL HEALTH'S POLICIES HAS BEEN EXPLAINED AND/OR SUMMARIZED FOR ME.

RESPONSIBLE PARTY NAME (PRINT):____

SIGNATURE:____ DATE:____________________