PROVIDERS FOR HEALTHY LIVING

Child, Adolescent, and Adult Psychiatry & Therapy Services

Welcome to Providers for Healthy Living!

We acknowledge and appreciate the trust you have placed in us to work with you to help you reach your mental health goals.

Our mission is to provide top-quality evidence-based interventions in a caring environment, while empowering patients to take responsibility for their own mental health treatment.

We hope your visit today is a positive one. We realize that one of the most frustrating parts of our jobs is that it often takes a while for patients to recognize that progress is being made. However, through open communication, honest feedback, evidence-based practices, and regular visits, we will work hard to help you achieve your goals.

If you have questions, comments, or concerns after today's visit, feel free to contact us. We look forward to working with you. **You can email your feedback to our Chief Medical Officer at feedback@providersforhealthyliving.com.**

Sincerely,

Providers for Healthy Living Staff

PROVIDERS FOR HEALTHY LIVING

Child, Adolescent, and Adult Psychiatry & Therapy Services

INFORMED CONSENT FOR TREATMENT

Services Offered

Providers for Healthy Living offers the following services:

- Medication management by licensed medical professionals
- Psychotherapy/counseling by licensed counselors and social workers
- Psychological testing/evaluation by licensed psychologists

Medication management is assessment and evaluation of mental health problems and uses a combination of medications and psychotherapy to alleviate these problems. Medication management works best when it is done in collaboration with psychotherapy. Medication management sessions usually last 15 to 30 minutes (after the initial evaluation session), and are scheduled as often as clinically appropriate.

Counseling/therapy is a collaboration between you and your therapist for the purpose of addressing personal, relational, and/or mental health problems. It consists of confidential disclosure, support, diagnostic information, other forms of feedback, a plan of treatment, ideas for possible alleviation of your concerns, encouragement for important behavioral changes, strategies for managing difficult relationships, suggestions for reading and education, referrals to other helpful professionals when needed, etc. Therapy sessions usually last 40 to 60 minutes and are scheduled weekly, bi-weekly, or monthly.

Psychological evaluation takes time and is a collaborative process. The more information you provide, the more accurate the results will be. As with any medical procedure, there are risks involved. We will discuss any concerns you have about information requested. The information gathered will be integrated with the test results obtained, and an assessment and recommendations will be provided. Your treatment provider will work with you to incorporate these into your treatment plan, as is clinically appropriate.

Here are some important things to know about your treatment:

- We are professionals. The treatments we provide are supported by research, and we only use techniques, assessment tools, and strategies in which we are trained. We maintain ongoing professional development, and strive to keep abreast of the latest research in our field. You can ask to review our professional qualifications at any time.
- Consistency is important. Attending regular appointments is the best way to help yourself reach your goals.
- There are risks involved. It is not uncommon for behavioral problems to get worse before they get better. Sometimes when painful memories are uncovered, it brings back unwanted feelings. Medications sometimes have unwanted side effects. We will discuss all of these risks with you during sessions, and the decision to proceed is always yours. We welcome and value your feedback at every step along the way, and will always take this feedback into consideration to help determine the next step of treatment.

- Healing takes time. Problems that take years to develop can often take months or years to resolve. Be patient, and give it a chance to work. The first approach sometimes doesn't work. With your feedback, we can make adjustments to your treatment plan to address your concerns.
- While we will do our absolute best to help you improve your situation, we cannot guarantee that you will achieve the outcome you want.
- You have the right to end services or not follow our recommendations whenever you choose.

Confidentiality

What you disclose is kept confidential, as it is one of the essential elements of an effective therapeutic relationship. At times, you may choose to give us permission to disclose confidential information. For example, you may want us to consult with your family doctor, key family members, or other important people in your life. This permission will be given in writing, and you will specify who can receive the information. We are fully committed to maintaining confidentiality except in cases where intervention is a professional or legal mandate, including, but not limited to the following:

- If you are a danger to yourself or someone else. If you are threatening to harm yourself or someone else, we are obligated to do what we can to keep that from happening. This includes alerting others or trying to contact the intended victim. (This does not mean, however, that every time suicide is mentioned in session we will take outside action.)
- In cases of abuse. It is our duty to report actual or suspected child abuse/neglect and vulnerable adult abuse/neglect.
- In cases of a court order. Sometimes a judge orders us to disclose information if it is important to a court case. We are required to follow these orders.
- When you want your insurance company to reimburse us for services. As with all medical care, your insurance company may request clinical information before paying for your outstanding claims.

For clients under eighteen, both parents have the right to know what occurs in appointments without a release of information. If you are a parent of a child, we would strongly advise you to allow much of what your child says to remain confidential. Even though you are entitled to it, insisting on information will likely damage our professional relationship with your child and could lead to regression in treatment. We will be happy to keep you informed about how treatment is progressing, and what you can do to support your child throughout treatment.

Crisis Situations

In the event of a mental health emergency or crisis situation, there are options for you. **In the event of a crisis, you must take action**, as your therapist may not be immediately available.

- Call 911 or proceed to the nearest hospital emergency room
- In Franklin County, call Netcare at 276-2273 and/or proceed to Netcare (www.netcareaccess.org) for an evaluation
- In Richland County, call the Mental Health and Recovery Services Crisis Helpline at 419-522-HELP (4357)
- If you live outside Franklin and Richland Counties, contact your local mental health center for crisis services
- Call a suicide hotline: 1-800-SUICIDE or 1-800-273-TALK

After taking action, call to make us aware of the situation. It is rare that we will be immediately able to see a client in crisis, so we strongly encourage you and your family to have a plan in place so you know what to do if a crisis occurs. We will do everything we can to support you in crisis.

PROVIDERS FOR HEALTHY LIVING
NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

If you have any questions about this Notice please contact our Privacy Officer who is Emily Talbott, LISW-S.

This Notice of Privacy Practices describes how we may use and disclose your protected health information to carry out treatment, payment or health care operations and for other purposes that are permitted or required by law. It also describes your rights to access and control your protected health information. "Protected health information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health or condition and related health care services.

We are required to abide by the terms of this Notice of Privacy Practices. We may change the terms of our notice, at any time. The new notice will be effective for all protected health information that we maintain at that time. Upon your request, we will provide you with any revised Notice of Privacy Practices. You may request a revised version by accessing our website, or calling the office and requesting that a revised copy be sent to you in the mail or asking for one at the time of your next appointment.

1. USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Your protected health information may be used and disclosed by your physician, our office staff and others outside of our office who are involved in your care and treatment for the purpose of providing health care services to you. Your protected health information may also be used and disclosed to pay your health care bills and to support the operation of your physician's practice.

Following are examples of the types of uses and disclosures of your protected health information that your physician's office is permitted to make. These examples are not meant to be exhaustive, but to describe the types of uses and disclosures that may be made by our office.

Treatment: We will use and disclose your protected health information to provide, coordinate, or manage your health care and any related services. This includes the coordination or management of your health care with another provider. For example, we would disclose your protected health information, as necessary, to a home health agency that provides care to you. We will also disclose protected health information to other physicians who may be treating you. For example, your protected health information may be provided to a physician to whom you have been referred to ensure that the physician has the necessary information to diagnose or treat you. In addition, we may disclose your protected health information from time-to-time to another physician or health care provider (*e.g.*, a specialist or laboratory) who, at the request of your physician, becomes involved in your care by providing assistance with your health care diagnosis or treatment to your physician.

Payment: Your protected health information will be used and disclosed, as needed, to obtain payment for your health care services provided by us or by another provider. This may include certain activities that your health insurance plan may undertake before it approves or pays for the health care services we recommend for you such as: making a determination of eligibility or coverage for insurance benefits, reviewing services provided to you for medical necessity, and undertaking utilization review activities. For example, obtaining approval for a hospital stay may require that your relevant protected health information be disclosed to the health plan to obtain approval for the hospital admission.

Health Care Operations: We may use or disclose, as needed, your protected health information in order to support the business activities of your physician's practice. These activities include, but are not limited to, quality assessment activities, employee review activities, training of medical students, licensing, fundraising activities, and conducting or arranging for other business activities.

We will share your protected health information with third party "business associates" that perform various activities (for example, billing or transcription services) for our practice. Whenever an arrangement between our office and a business associate involves the use or disclosure of your protected health information, we will have a written contract that contains terms that will protect the privacy of your protected health information.

We may use or disclose your protected health information, as necessary, to provide you with information about treatment alternatives or other health-related benefits and services that may be of interest to you. You may contact our Privacy Officer to request that these materials not be sent to you.

We may use or disclose your demographic information and the dates that you received treatment from your physician, as necessary, in order to contact you for fundraising activities supported by our office. If you do not want to receive these materials, please contact our Privacy Officer and request that these fundraising materials not be sent to you.

Other Permitted and Required Uses and Disclosures That May Be Made Without Your Authorization or Opportunity to Agree or Object

We may use or disclose your protected health information in the following situations without your authorization or providing you the opportunity to agree or object. These situations include:

Required By Law: We may use or disclose your protected health information to the extent that the use or disclosure is required by law. The use or disclosure will be made in compliance with the law and will be limited to the relevant requirements of the law. You will be notified, if required by law, of any such uses or disclosures.

Public Health: We may disclose your protected health information for public health activities and purposes to a public health authority that is permitted by law to collect or receive the information. For example, a disclosure may be made for the purpose of preventing or controlling disease, injury or disability.

Communicable Diseases: We may disclose your protected health information, if authorized by law, to a person who may have been exposed to a communicable disease or may otherwise be at risk of contracting or spreading the disease or condition.

Health Oversight: We may disclose protected health information to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections. Oversight agencies seeking this information include government agencies that oversee the health care system, government benefit programs, other government regulatory programs and civil rights laws.

Abuse or Neglect: We may disclose your protected health information to a public health authority that is authorized by law to receive reports of child abuse or neglect. In addition, we may disclose your protected health information if we believe that you have been a victim of abuse, neglect or domestic violence to the governmental entity or agency authorized to receive such information. In this case, the disclosure will be made consistent with the requirements of applicable federal and state laws.

Food and Drug Administration: We may disclose your protected health information to a person or company required by the Food and Drug Administration for the purpose of quality, safety, or effectiveness of FDA-regulated products or activities including, to report adverse events, product defects or problems, biologic product deviations, to track products; to enable product recalls; to make repairs or replacements, or to conduct post marketing surveillance, as required.

Legal Proceedings: We may disclose protected health information in the course of any judicial or administrative proceeding, in response to an order of a court or administrative tribunal (to the extent such disclosure is expressly authorized), or in certain conditions in response to a subpoena, discovery request or other lawful process.

Law Enforcement: We may also disclose protected health information, so long as applicable legal requirements are met, for law enforcement purposes. These law enforcement purposes include (1) legal processes and otherwise required by law, (2) limited information requests for identification and location purposes, (3) pertaining to victims of a crime,

(4) suspicion that death has occurred as a result of criminal conduct, (5) in the event that a crime occurs on the premises of our practice, and (6) medical emergency (not on our practice's premises) and it is likely that a crime has occurred.

Coroners, Funeral Directors, and Organ Donation: We may disclose protected health information to a coroner or medical examiner for identification purposes, determining cause of death or for the coroner or medical examiner to perform other duties authorized by law. We may also disclose protected health information to a funeral director, as authorized by law, in order to permit the funeral director to carry out their duties. We may disclose such information in reasonable anticipation of death. Protected health information may be used and disclosed for cadaveric organ, eye or tissue donation purposes.

Criminal Activity: Consistent with applicable federal and state laws, we may disclose your protected health information, if we believe that the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of a person or the public. We may also disclose protected health information if it is necessary for law enforcement authorities to identify or apprehend an individual.

Military Activity and National Security: When the appropriate conditions apply, we may use or disclose protected health information of individuals who are Armed Forces personnel (1) for activities deemed necessary by appropriate military command authorities; (2) for the purpose of a determination by the Department of Veterans Affairs of your eligibility for benefits, or (3) to foreign military authority if you are a member of that foreign military services. We may also disclose your protected health information to authorized federal officials for conducting national security and intelligence activities, including for the provision of protective services to the President or others legally authorized.

Workers' Compensation: We may disclose your protected health information as authorized to comply with workers' compensation laws and other similar legally-established programs.

Inmates: We may use or disclose your protected health information if you are an inmate of a correctional facility and your physician created or received your protected health information in the course of providing care to you.

Uses and Disclosures of Protected Health Information Based upon Your Written Authorization
Other uses and disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law as described below. You may revoke this authorization in writing at any time. If you revoke your authorization, we will no longer use or disclose your protected health information for the reasons covered by your written authorization. Please understand that we are unable to take back any disclosures already made with your authorization.

Other Permitted and Required Uses and Disclosures That Require Providing You the Opportunity to Agree or Object
We may use and disclose your protected health information in the following instances. You have the opportunity to agree or object to the use or disclosure of all or part of your protected health information. If you are not present or able to agree or object to the use or disclosure of the protected health information, then your physician may, using professional judgement, determine whether the disclosure is in your best interest.

2. YOUR RIGHTS

Following is a statement of your rights with respect to your protected health information and a brief description of how you may exercise these rights.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you for so long as we maintain the protected health information. You may obtain your medical record that contains medical and billing records and any other records that your physician and the practice uses for making decisions about you. As permitted by federal or state law, we may charge you a reasonable copy fee for a copy of your records.

Under federal law, however, you may not inspect or copy the following records: psychotherapy notes; information compiled in reasonable anticipation of, or use in, a civil, criminal, or administrative action or proceeding; and laboratory

results that are subject to law that prohibits access to protected health information. Depending on the circumstances, a decision to deny access may be reviewable. In some circumstances, you may have a right to have this decision reviewed. Please contact our Privacy Officer if you have questions about access to your medical record.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of treatment, payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If your physician does agree to the requested restriction, we may not use or disclose your protected health information in violation of that restriction unless it is needed to provide emergency treatment. With this in mind, please discuss any restriction you wish to request with your physician. You may request a restriction by notifying us in writing.

You have the right to request to receive confidential communications from us by alternative means or at an alternative location. We will accommodate reasonable requests. We may also condition this accommodation by asking you for information as to how payment will be handled or specification of an alternative address or other method of contact. We will not request an explanation from you as to the basis for the request. Please make this request in writing to our Privacy Officer.

You may have the right to have your physician amend your protected health information. This means you may request an amendment of protected health information about you in a designated record set for so long as we maintain this information. In certain cases, we may deny your request for an amendment. If we deny your request for amendment, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement and will provide you with a copy of any such rebuttal. Please contact our Privacy Officer if you have questions about amending your medical record.

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information. This right applies to disclosures for purposes other than treatment, payment or health care operations as described in this Notice of Privacy Practices. It excludes disclosures we may have made to you if you authorized us to make the disclosure, for a facility directory, to family members or friends involved in your care, or for notification purposes, for national security or intelligence, to law enforcement (as provided in the privacy rule) or correctional facilities, as part of a limited data set disclosure. You have the right to receive specific information regarding these disclosures that occur after April 14, 2003. The right to receive this information is subject to certain exceptions, restrictions and limitations.

You have the right to obtain a paper copy of this notice from us, upon request, even if you have agreed to accept this notice electronically.

3. COMPLAINTS

You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us by notifying our Privacy Officer of your complaint. We will not retaliate against you for filing a complaint.

You may contact our Privacy Officer, **Emily Talbott, LISW-S**, at (614) 664-3595 for further information about the complaint process.

This notice was published and becomes effective on September 23, 2013. It is a revision of the previous policy previously published on December 1, 2011.

Office Policies

Welcome to our practice. The following policies will help you understand our processes and procedures. Please initial each section and sign and date at the end.

INFORMED CONSENT/TREATMENT AUTHORIZATION
By initialing here, you acknowledge that you have received copies of the Privacy Notices, Office Policies, and Informed Consent for Treatment of Providers for Healthy Living and its providers and were given the opportunity to answer clarifying questions to your satisfaction. After weighing the benefits and risks, you hereby give your consent for evaluation and treatment by Providers for Healthy Living and its providers.

Initial: _____

INSURANCE BENEFITS REASSIGNMENT AUTHORIZATION AND REIMBURSEMENT
If you have a health benefits insurance policy, it may provide mental health coverage. We will bill your insurance directly for services rendered; however, you are responsible for full payment of the session fees. It is your responsibility to contact your insurance company to obtain prior authorization for services provided. Please be aware that most insurance agreements require you to authorize us to provide a clinical diagnosis, and sometimes additional clinical information such as treatment plan or summary, or in rare cases, a copy of the entire record. We are required to submit this information on your behalf if you choose to obtain insurance reimbursement. In cases where your insurance does not pay for your session, you will be billed and will be expected to pay the amount that the insurance company was contracted to pay on your behalf. By initialing here, you agree to assign your insurance benefits (current and future), if any, to Providers for Healthy Living and its providers, otherwise payable to you for services rendered. You further authorize the use of your signature on all insurance submissions.

Initial: _____

CONTACTING US
Our phone number at 614-664-3595 is monitored at all times. We will make every effort to return your call on the same day you make it with the exception of weekends and holidays. When you call, please leave some times and phone numbers where you can best be reached. If you are calling and consider the call an emergency, there are instructions on the voicemail with numbers to calls for emergency help. Please do not leave a message in case of an emergency as these situations are best handled by calling 911 or going to the nearest ER. With respect to electronic mail (e-mail), please be aware that while all of our providers are available via e-mail, it is not a confidential means of communication. Furthermore, we cannot ensure that e-mail messages will be received or responded to in a timely fashion as we check our e-mail on an irregular basis. E-mail is not an appropriate way to communicate confidential information or emergency issues or urgent issues that need to be handled after regular clinical hours.

Initial: _____

CANCELLATIONS AND NO-SHOW POLICY
Once your appointment is scheduled, you will be expected to attend unless you provide at least 24 hours advanced notice of cancellation. If you do not provide at least 24 hours notice, or fail to show for a scheduled NEW medication or therapy appointment, you will be responsible for a $150 no-show/ late cancellation charge and if you fail to show for a scheduled FOLLOW-UP appointment, you will be responsible for a no-show/late cancellation charge ($100 for medication or psychology appointments missed and $75 for therapy appointments missed). Missing a group will result in a $30 no-show/late cancellation charge, and missing a testing appointment will result in a $225 charge. Please Note: this fee must be paid before future appointments will be scheduled or medication refills will be given. If you arrive late and miss half of your scheduled appointment time, you will be rescheduled, and a late cancellation charge or no show fee may apply.

Initial: _____

EXCESSIVE NO SHOWS OR LATE CANCELLATIONS
Consistency is the key to improving and maintaining your mental health. To this end, after three (3) missed appointments without notification, or after three (3) cancellations (less than 24-hours notice) of your appointments, you will likely be dismissed from our practice. A certified letter will be sent notifying you of this decision, in the unfortunate and unlikely event that this may occur.

Initial: _____

BILLING AND PAYMENTS
You are expected to pay appropriate co-payments, deductibles, and account balances for each session at the time of the appointment. We accept cash, checks, and credit cards for payment. Services will not be rendered if payment is not made. If your account has payment overdue for over 60 days, we have the option of referring your account to a collection agency and closing your account with our office. Initial: _____

CHARGES FOR PHONE CALLS AND EMAILS
If medication changes are made during email or phone exchanges that would've otherwise been made during an office visit, you will be billed for an equivalent session and you will be responsible for any fees associated with these billed sessions as insurance generally doesn't cover these charges. Likewise, phone calls with a therapist that would otherwise have been conducted in the office will be billed, and you will be required to pay for these sessions.

Initial: _____

PRESCRIPTION REFILLS
It is your responsibility to call in advance for medication refills. Refill requests should be placed at least 48 hours in advance. Medication refills are not considered emergency phone calls on weekends or after hours. Please monitor your medications closely and plan accordingly by calling in advance. We do our very best to provide medication coverage from one visit to the next. If you miss an appointment, you will likely run out of medication. If this happens, we will prescribe enough medication to cover until your next scheduled appointment. Some medications cannot be called in to the pharmacy or sent electronically. These medications require you to physically come to the clinic to pick up a prescription. Controlled prescriptions (all stimulants for ADHD, most sleep medications, and benzodiazepines for anxiety) are regulated by the federal government and cannot be filled early regardless of the reason.

Initial: _____

PAPERWORK/LETTERS/DISABILITY FORMS
We have decided as a practice to charge a fee to complete forms, letters, and disability paperwork. Disability forms, FMLA paperwork, letters for school and work, etc. may be completed by the clinician, if appropriate, but payment in advance is expected based on the number of pages and the complexity of the documentation. In general, our practice does not support patients being off work for disability. It is our goal to help patients function at their best, and supporting a disability claim is a direct contradiction to our mission. Therefore, we will not complete disability forms unless we recommend the process. We will, however, provide records in all cases if requested.

Initial: _____

CONFIDENTIALITY
Confidentiality is important, lawful, and necessary for appropriate mental health care. There are some exceptions when we are required by law to break confidentiality, however: (a) to take appropriate steps to ensure your safety if there is a threat of self-harm, (b) to take appropriate steps to ensure safety of others if there is a threat of harm to others, (c) to report child, elder, or dependent abuse, and (d) legal testimony if subpoenaed by a court. These exceptions are rare, and we do our best to maintain confidentiality. No information is given to anyone without your consent. Without a signed release of information from all individuals 18 or older, no information can be released without their consent.

Initial: _____

DISRUPTIVE OR ABUSIVE LANGUAGE/BEHAVIOR
We strive to create and maintain a respectful environment at all times, and expect the same from all interactions we have with patients. Any profanity, abusive language or behaviors, demeaning comments, disruptive behaviors, threatening remarks, etc., will not be tolerated, and may lead to immediate dismissal from our practice.

Initial: _____

By signing below, I indicate that I have read the above policies and fees and agree to be held by them. I was given the opportunity to ask clarifying questions to my satisfaction. If the parent of a minor, by signing below, I indicate that I am the custodial parent and am authorized to make final treatment decisions on my child's behalf.

Name of Patient (print): _____

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian (if applicable): _____

Signature of Staff: _____

EMERGENCY CONTACT SHEET

For medical emergencies, call your primary care physician, call 911, or go to the nearest emergency room.

For psychiatric emergencies (suicidal thoughts or actions, homicidal thoughts or actions, hearing voices commanding a harmful action, boundless energy without need for sleep, or serious medication side effect such as fever with muscle stiffness or confusion or rash) do one of the following based on the severity and appropriateness of the situation:

1. Call the Suicide Hotline at 1-800-SUICIDE.

2. In Franklin County, call Netcare (24-hour psychiatric emergency service) at 614-276-2273. Adult crisis services are available at both locations.

3. In Richland County, call the Mental Health and Recovery Services Crisis Helpline at 419-522-HELP (4357).

4. If you live outside Franklin County, contact your local mental health center for crisis services.

5. Call 911 or go to the nearest ER.

You can also contact us at 614-664-3595 for non-urgent matters. Your call will be returned within 24 hours. Please do not leave messages of an urgent or emergent nature on the voicemail.

Adult Intake Form

Name: _____ Date: _____

DOB: _____

PRESENTING PROBLEMS AND CONCERNS

Describe the problem that brought you here today: _____

_____

Please check all of the behaviors and symptoms that you consider problematic:

- ☐ Distractibility
- ☐ Hyperactivity
- ☐ Impulsivity
- ☐ Boredom
- ☐ Poor memory/confusion
- ☐ Seasonal mood changes
- ☐ Sadness/depression
- ☐ Loss of pleasure/interest
- ☐ Hopelessness
- ☐ Thoughts of death
- ☐ Self-harm behaviors
- ☐ Crying spells
- ☐ Loneliness
- ☐ Low self worth
- ☐ Guilt/shame
- ☐ Fatigue
- ☐ Other:_____
- ☐ Change in appetite
- ☐ Lack of motivation
- ☐ Withdrawal from people
- ☐ Anxiety/worry
- ☐ Panic attacks
- ☐ Fear away from home
- ☐ Social discomfort
- ☐ Obsessive thoughts
- ☐ Compulsive behavior
- ☐ Aggression/fights
- ☐ Frequent arguments
- ☐ Irritability/anger
- ☐ Homicidal thoughts
- ☐ Flashbacks
- ☐ Hearing voices
- ☐ Visual hallucinations
- ☐ Suspicion/paranoia
- ☐ Racing thoughts
- ☐ Excessive energy
- ☐ Wide mood swings
- ☐ Sleep problems
- ☐ Nightmares
- ☐ Eating problems
- ☐ Gambling problems
- ☐ Computer/Phone addiction
- ☐ Problems with pornography
- ☐ Parenting problems
- ☐ Sexual problems
- ☐ Relationship problems
- ☐ Work/school problems
- ☐ Alcohol/drug use
- ☐ Recurring, disturbing memories

Are your problems affecting any of the following?

- ☐ Handling everyday tasks
- ☐ Work/School
- ☐ Recreational activities
- ☐ Self esteem
- ☐ Housing
- ☐ Sexual activity
- ☐ Relationships
- ☐ Legal matters
- ☐ Health
- ☐ Hygiene
- ☐ Finances

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt yourself? If yes, please describe:_____

☐ Yes ☐ No Have you ever had thoughts, made statements, or attempted to hurt someone else? If yes, please describe:_____

☐ Yes ☐ No Have you recently been physically hurt or threatened by someone else? If yes, please describe:_____

☐ Yes ☐ No Do you have access to guns or weapons? If yes, please describe: _____

_____

☐ Yes ☐ No Have you gambled in the past 6 months? If yes, let us know the following:

- ☐ Yes ☐ No Have you ever felt the need to bet more and more money?
- ☐ Yes ☐ No Have you ever had to lie to people important to you about how much you gambled?

Clinician Notes: Mood recently has been " ". Rates mood as out of 10 (10 the best).
Sleep: In bed by _____. Asleep by _____. Awake by _____.
Init: ____

Adult Psychiatric Symptom Checklist

Date _____ Name _____

1. Do you seem to have trouble paying attention, getting things done, listening, or sitting still?

☐ NO → Skip to Question #2

☐ YES → Answer A Through R

Do you often...

	Never	Some	Often	Very Often
A. Fail to give close attention to details or make careless mistakes?	☐	☐	☐	☐
B. Have difficulty keeping your attention on tasks?	☐	☐	☐	☐
C. Seem not to listen, even when spoken to directly?	☐	☐	☐	☐
D. Have trouble with follow through and completing assignments or work duties?	☐	☐	☐	☐
E. Have trouble getting organized with tasks or activities?	☐	☐	☐	☐
F. Avoid or try to get out of activities that might require sustained attention?	☐	☐	☐	☐
G. Lose things necessary for tasks, school, work, or play?	☐	☐	☐	☐
H. Get easily distracted by the smallest noise or object?	☐	☐	☐	☐
I. Forget important activities, events, or deadlines?	☐	☐	☐	☐
J. Fidget with your hands or feet, or do you squirm in your seat?	☐	☐	☐	☐
K. Leave your seat when sitting in one place is expected?	☐	☐	☐	☐
L. Run about or climb in places where you know you should not or feel restless?	☐	☐	☐	☐
M. Have trouble doing much of anything quietly?	☐	☐	☐	☐
N. Seem to be "on the go"' or "driven by a motor"?	☐	☐	☐	☐
O. Talk too much?	☐	☐	☐	☐
P. Blurt out answers even before the question is completed?	☐	☐	☐	☐
Q. Have trouble waiting your turn?	☐	☐	☐	☐
R. Interrupt others or intrude into other people's space or conversations?	☐	☐	☐	☐

2. Do you seem to have an "attitude" more often than not? Do you seem to be hostile, negative, and contrary most days?

☐ NO → Skip to Question #3

☐ YES → Answer A Through I

	Never	Some	Often	Very Often
A. Are you often negative, hostile, and defiant?	☐	☐	☐	☐
B. Do you lose your temper often?	☐	☐	☐	☐
C. Do you often argue with other adults/authority figures?	☐	☐	☐	☐
D. Do you often actively defy, or refuse to abide by, supervisor requests or rules?	☐	☐	☐	☐
E. Do you often deliberately annoy people?	☐	☐	☐	☐
F. Do you often blame others for your mistakes or "bad" behavior?	☐	☐	☐	☐
G. Are you often touchy or easily annoyed by others?	☐	☐	☐	☐
H. Are you often angry and resentful?	☐	☐	☐	☐
I. Are you often spiteful and unforgiving?	☐	☐	☐	☐

3. Do others say, or do you think, that you have problems with your mood? Are you sad or irritable for several days in a row, have less energy, or have become withdrawn or isolated?

☐ NO → Skip to Question #4

☐ YES → Answer A Through H

	Never	Some	Often	Very Often
A. Does your mood seem down OR irritable most of the day nearly every day?	☐	☐	☐	☐
B. Have you had a significant decrease in interest or pleasure in things?	☐	☐	☐	☐
C. During this time, has there been weight loss when not dieting?	☐	☐	☐	☐
D. Are you sleeping less or sleeping more recently?	☐	☐	☐	☐
E. Do you feel or have others said that you appear slowed down OR restless?	☐	☐	☐	☐
F. Do you feel worthless or feel excessively guilty about something for no reason?	☐	☐	☐	☐
G. Do you have a hard time making decisions or can't seem to think or remember?	☐	☐	☐	☐
H. Are you having thoughts of suicide or death?	☐	☐	☐	☐

4. Do you have periods where you feel the opposite of depressed, are "high on life," have boundless energy and drive, and don't need to sleep to feel refreshed?

☐ NO → Skip to Question #5

☐ YES → Answer A Through I

During these periods...	Never	Some	Often	Very Often
A. Is your mood abnormally irritable, elevated, or uninhibited?	☐	☐	☐	☐
B. Do you feel your self-esteem is elevated, or do you feel extra special?	☐	☐	☐	☐
C. Do you seem to need much less sleep (feel rested after only a few hours)?	☐	☐	☐	☐
D. Are you much more talkative and does your speech seem pressured to get words out?	☐	☐	☐	☐
E. Do your thoughts seem to come from "nowhere", difficult to follow, or understand?	☐	☐	☐	☐
F. Are you much more distractible?	☐	☐	☐	☐
G. Do you have much more energy to complete tasks?	☐	☐	☐	☐
H. Have you been physically aggressive?	☐	☐	☐	☐
I. Do you become involved in activities that have a potential for painful consequences?	☐	☐	☐	☐

5. Do you see or hear things that others don't see or hear?

☐ YES ☐ NO

6. Do you have unusual beliefs or perceptions that defy logic?

☐ YES ☐ NO

7. Do you pull your own hair, resulting in noticeable hair loss?

☐ YES ☐ NO

8. Do you pick your own skin, resulting in skin lesions?

☐ YES ☐ NO

9. Do you have trouble with nervousness or fearfulness in situations where other people usually do not? Do you have fears or worries that seem to cause significant distress?

☐ NO → Skip to Question #10

☐ YES → Answer A Through P

	Never	Some	Often	Very Often
A. Do you have fears that seem excessive or unreasonable?	☐	☐	☐	☐
B. Do these fears come about when you think about a certain object or situation?	☐	☐	☐	☐
C. Do you have unusual or uncomfortable thoughts, images, or impulses that enter into your mind and cause distress? (Note: These are not simply excessive worries about real-life problems)	☐	☐	☐	☐
D. Do you attempt to ignore or suppress these thoughts/images by doing rituals or repeated acts or thoughts?	☐	☐	☐	☐
E. Do you realize that these thoughts/images are a product of your mind?	☐	☐	☐	☐
F. Do you think these worries or thoughts are excessive, extreme, or unreasonable?	☐	☐	☐	☐
G. Are these acts or images very time consuming or interfere with normal life?	☐	☐	☐	☐
H. Do you have excessive anxiety about being away from home or being away from significant individuals in your life?	☐	☐	☐	☐
I. When separation is anticipated or occurs, is there excessive and recurrent distress?	☐	☐	☐	☐
J. Do you worry excessively about something bad happening to significant others?	☐	☐	☐	☐
K. Is there a fear that some event (being kidnapped or lost, etc.) may cause separation from significant others?	☐	☐	☐	☐
L. Is there a reluctance or refusal to go places because of the fear of separation?	☐	☐	☐	☐
M. Is there excessive fear of being alone (or without significant others)?	☐	☐	☐	☐
N. Do you have trouble sleeping without a significant other or when away from home?	☐	☐	☐	☐
O. Do you have nightmares involving themes of separation?	☐	☐	☐	☐
P. Do you have physical complaints when separation is anticipated or occurs?	☐	☐	☐	☐

10. Do you seem to just worry excessively about many things at once (school/work performance, the future, etc.), rather than just one area, as described above? If so, do you seem to have difficulty controlling the worry? Are you irritable and physically affected by the worry (restless, fatigued, tensed muscles, can't sleep etc.)?

☐ YES ☐ NO

11. Do you worry about being in a social or performance situation where you might be studied or examined (eating in public, talking in front of people)? If so, do you have an intense fear that you may embarrass yourself?

☐ YES ☐ NO

12. Do you seem to have a lot of physical complaints (<u>not just to avoid obligations, school, or separation</u>)?

☐ YES ☐ NO

13. (Females only) Do you have consistent moodiness, anger, or increased anxiety before your menstrual periods that seems better soon after your menstrual period starts?

☐ YES ☐ NO

14. Have you been exposed to a trauma which threatened your life or caused serious injury to you or someone close to you?

☐ NO → Skip to Question #15

☐ YES → Answer A Through F

	Never	Some	Often	Very Often
A. Do you have repeated and intrusive memories of the event?	☐	☐	☐	☐
B. Do you have distressing dreams that appear to relate to the trauma?	☐	☐	☐	☐
C. Do the events seem to be relived or seem to happen again out of the blue?	☐	☐	☐	☐
D. Are you distressed when exposed to thoughts or objects that represent the trauma?	☐	☐	☐	☐
E. Do you avoid things or places that are associated with the trauma?	☐	☐	☐	☐
F. Are you more on edge or agitated since the trauma (can't sleep, startle easily, irritable)?	☐	☐	☐	☐

15. Do you frequently have bad dreams (not related to trauma)?

☐ YES ☐ NO

16. Do you snore loudly and/or wake up gasping for breath in the middle of the night?

☐ YES ☐ NO

17. Do you have trouble falling or staying asleep, or do you wake up very early and feel tired the next day?

☐ YES ☐ NO

18. Do you have a real and persistent interest in being the opposite sex?

☐ YES ☐ NO

19. Do you notice any repetitive twitches, tics, or noises that bother you or others around you?

☐ YES ☐ NO

20. Do you stutter (repeat words or beginning sounds of words)?

☐ YES ☐ NO

21. Do you have a great deal of concern about your weight? If so, are you overly concerned with becoming fat, gaining weight, or do you overeat and make yourself vomit?

☐ NO → Skip to Question #22

☐ YES → Answer A Through F

	Never	Some	Often	Very Often
A. Do you have trouble maintaining a "normal" body weight?	☐	☐	☐	☐
B. Do you have an intense fear of gaining weight or becoming fat?	☐	☐	☐	☐
C. Do you deny the seriousness of your low body weight and see yourself as overweight despite being thin?	☐	☐	☐	☐
D. Do you binge eat and feel a lack of control over eating while doing so?	☐	☐	☐	☐
E. Do you attempt to prevent weight gain by vomiting, using laxatives, fasting or exercising excessively?	☐	☐	☐	☐

22. Over the course of your life, have any of the following been an ongoing problem?

	Never	Some	Often	Very Often
A. Fear of abandonment	☐	☐	☐	☐
B. Unstable and intense relationships	☐	☐	☐	☐
C. Unstable self-image or sense of self	☐	☐	☐	☐
D. Impulsivity in at least two areas that are potentially self-damaging (e.g., spending, sex, substance use, reckless driving, binge eating)	☐	☐	☐	☐
E. Recurrent suicidal behavior, gestures, or threats, or self-harming behavior	☐	☐	☐	☐
F. Frequent mood swings due to people or situations	☐	☐	☐	☐
G. Chronic feelings of emptiness	☐	☐	☐	☐
H. Inappropriate, intense anger or difficulty controlling anger	☐	☐	☐	☐
I. Paranoid feelings or feelings of being unattached from your body when stressed	☐	☐	☐	☐

Past Psychiatric Medications: If you have ever taken any of the following medications, please indicate the dates, dosage, how helpful they were, and any side effects you remember.

Dates ***Dosage*** ***Response/Side Effects***

Antidepressants

Prozac/Sarafem/Selfemra/Rapiflux (fluoxetine) _____

Zoloft (sertraline) _____

Luvox (fluvoxamine) _____

Paxil/Pexeva/Brisdelle (paroxetine) _____

Celexa (citalopram) _____

Lexapro (escitalopram) _____

Effexor (venlafaxine) _____

Pristiq/Khedezla (desvenlafaxine) _____

Cymbalta (duloxetine) _____

Fetzima (levomilnacipran) _____

Wellbutrin (bupropion) _____

Brintillex (vortioxetine) _____

Viibryd (vilazodone) _____

Remeron (mirtazapine) _____

Ludiomil (maprotiline) _____

Serzone (nefazodone) _____

Anafranil (clomipramine) _____

Pamelor/Aventyl (nortrptyline) _____

Vivactil (protriptyline) _____

Adapin/Silenor (doxepin) _____

Tofranil (imipramine) _____

Surmontil (trimipramine) _____

Elavil (amitriptyline) _____

Emsam/Zelepar/Eldepryl (selegiline) _____

Parnate (tranylcypromine) _____

Marplan (isocarboxazid) _____

Nardil (phenelzine) _____

Other _____

Mood Stabilizers

Tegretol (carbamazepine)_____

Lithium_____

Depakote (valproate) _____ _____

Lamictal (lamotrigine) _____

Tegretol (carbamazepine) _____

Topamax (topiramate) _____

Other _____

Dates ***Dosage*** ***Response/Side Effects***

Antipsychotics/Mood Stabilizers

Seroquel (quetiapine) _____

Zyprexa (olanzepine) _____

Geodon (ziprasidone) _____

Risperdal (risperidone) _____

Abilify (aripiprazole) _____

Saphris (asenapine) _____

Invega (paliperidone) _____

Latuda (lurasidone) _____

Fanapt (iloperidone) _____

Clozaril/FazaClo/Versacloz (clozapine) _____

Haldol (haloperidol) _____

Prolixin/Permitil (fluphenazine) _____

Compazine (prochlorperazine) _____

Stelazine (trifluoperazine) _____

Trilafon (perphenazine) _____

Mellaril (thioridazine) _____

Serentil (mesoridazine) _____

Orap (pimozide) _____

Moban (molindone) _____

Loxitane/Adasuve (loxapine) _____

Navane (thiothixene) _____

Other _____

Sleep Medications

Ambien/Zolpimist (zolpidem) _____

Sonata (zaleplon) _____

Lunesta (eszopiclone) _____

Rozerem (ramelteon)_____

Belsomra (suvorexant) _____

Restoril (temazepam) _____

Desyrel (trazodone) _____

Xyrem (sodium oxybate) _____

Benadryl (diphenhydramine) _____

Melatonin _____

Neurontin (gabapentin) _____

Clonidine _____

Hetlioz (tasimelteon) _____

Other _____

Dates ***Dosage*** ***Response/Side Effects***

ADHD Medications

Adderall (amphetamine) _____

Dexedrine (dextroamphetamine) _____

ProCentra (dextroamphetamine) _____

Liquadd (dextroamphetamine) _____

Vyvanse (lisdexamfetamine) _____

Concerta (methylphenidate) _____

Ritalin (methylphenidate) _____

Focalin (dexmethylphenidate) _____

Daytrana (methylphenidate) _____

Metadate (methylphenidate) _____

Methylin (methylphenidate) _____

Quillivant XR (methylphenidate) _____

Intuniv (guanfacine) _____

Strattera (atomoxetine) _____

Kapvay (clonidine) _____

Other _____

Anti-anxiety Medications

Buspar (buspirone) _____

Vistaril/Atarax (hydroxyzine) _____

Xanax (alprazolam) _____

Ativan (lorazepam) _____

Klonopin (clonazepam) _____

Valium (diazepam) _____

Tranxene (clorazepate) _____

Halcion (triazolam) _____

Seconal (secobarbital) _____

Luminal/Solfoton (phenobarbital) _____

Nembutal (pentobarbital) _____

Other _____

Name: _____

FAMILY AND DEVELOPMENTAL HISTORY

Relationship	Name	Age	Quality of Relationship
Mother			
Father			
Stepmother			
Stepfather			
Siblings			
Spouse/Partner			
Children			

Family Mental Health Problems	Who?
ADHD	
PTSD	
Depression	
Bipolar Disorder	
Suicide or Attempts	
Anxiety	
Panic Attacks	
OCD	
Anger/Abusive	
Schizophrenia	
Eating Disorder	
Alcohol Use	
Drug Use	

☐ Parents legally married or living together
☐ Parents temporarily separated
☐ Parents divorced or permanently separated

☐ Mother remarried: Number of times _____
☐ Father remarried: Number of times _____

Please check if you have experienced any of the following types of trauma or loss:

☐ Emotional abuse
☐ Sexual abuse
☐ Physical abuse
☐ Parent substance abuse
☐ Teen pregnancy
☐ Neglect
☐ Violence in the home
☐ Crime victim or witness
☐ Parent illness
☐ Placed a child for adoption
☐ Lived in a foster home
☐ Multiple family moves
☐ Homelessness
☐ Loss of a loved one
☐ Financial problems

Clinician Notes:
Init: ____

PREVIOUS MENTAL HEALTH TREATMENT

Yes	No	Type of Treatment	When?	Provider/Program	Reason for Treatment
		Outpatient Counseling			
		Medication (mental health)			
		Psychiatric Hospitalization			
		Drug/Alcohol Treatment			
		Support Groups			

Clinician Notes:
Init: ____

Name: _____

SUBSTANCE USE HISTORY

Substance Type	Current Use (last 6 months)				Past Use			
	Y	N	Frequency	Amount	Y	N	Frequency	Amount
Tobacco								
Caffeine								
Alcohol								
Marijuana								
Cocaine/crack								
Ecstasy								
Heroin								
Inhalants								
Methamphetamines								
Pain Killers								
PCP/LSD								
Steroids								
Benzodiazepines								

☐ Yes ☐ No Have you had problems in the past while using alcohol? If yes, please describe (be specific):

_____

☐ Yes ☐ No Have you had problems in the past while using any drugs? If yes, please describe (be specific):

_____

Clinician Notes:
Init: ____

MEDICAL INFORMATION

Date of last physical exam: _____ Height: _____ Weight: _____

Have you experienced any of the following medical conditions during your lifetime?

☐ Allergies	☐ Asthma	☐ Headaches	☐ Stomach aches
☐ Chronic pain	☐ Surgery	☐ Serious accident	☐ Head injury/Concussions
☐ Dizziness/fainting	☐ Meningitis	☐ Seizures	☐ Vision problems
☐ High fevers	☐ Diabetes	☐ Hearing problems	☐ Miscarriage
☐ Sexually transmitted disease	☐ Heart problems	☐ Sleep disorder	☐ Other: _____

Please list any CURRENT health concerns: _____

Current prescription medications: ☐ None

Medication	Dosage	Date First Prescribed	Prescribed By

Current over-the-counter medications (including vitamins, herbal remedies, etc.): _____

_____

Allergies and/or adverse reactions to medications: ☐ None
If yes, please list: _____

Clinician Notes:
Init: ____

Name: _____

INTERPERSONAL/SOCIAL/CULTURAL INFORMATION

Please describe your social support network (check all that apply):
☐ Family ☐ Neighbors ☐ Friends ☐ Students ☐ Co-workers ☐ Support/Self-Help Group
☐ Community Group ☐ Religious/Spiritual Center (which one? _____)

To which cultural or ethnic group do you belong? _____
If you are experiencing any difficulties due to cultural or ethnic issues, please describe:_____
_____

How important are spiritual matters to you? ☐ Not at all ☐ Little ☐ Somewhat ☐ Very much
☐ Yes ☐ No Would you like spiritual/religious beliefs to be incorporated into your counseling?

Please describe your strengths, skills, and talents? _____
_____
Describe any special areas of interest or hobbies (art, books, physical fitness, etc.):_____
_____

Clinician Notes:
Init: ____

Employment

Employer: _____ Position: _____
Length of time in this position: _____ Job Duties: _____
Stress level of this position: ☐ Low ☐ Medium ☐ High
Other jobs you have held: _____

Education

☐ Yes ☐ No Are you currently attending school? If so, where? _____

☐ High School Graduate? or ☐GED? Year _____
☐ Associate's Degree Year _____ Major area of study _____
☐ Undergraduate Degree Year _____ Major area of study _____
☐ Graduate Degree Year _____ Major area of study _____

Military Service

☐ Yes ☐ No Have you been/are you currently in the military? (If no, skip remainder of this section)

Branch _____ Date of Discharge _____ Type of Discharge _____ Rank _____
☐ Yes ☐ No Were you in combat?

Legal

☐ Yes ☐ No Have you ever been convicted of a misdemeanor or felony? If yes, please explain_____
_____

☐ Yes ☐ No Are you currently involved in any divorce or child custody proceedings? If yes, please explain _____

Clinician Notes:
Init: ____

Mental Status Exam (MSE) Form

1. Appearance	☐ *casual dress, normal grooming and hygiene* ☐ *other (describe):*
2. Attitude	☐ *calm and cooperative* ☐ *other (describe):*
3. Behavior	☐ *no unusual movements or psychomotor changes* ☐ *other (describe):*
4. Speech	☐ *normal rate/tone/volume without pressure* ☐ *other (describe):*
5. Affect	☐ *reactive and mood congruent* ☐ *normal range* ☐ *labile* ☐ *depressed* ☐ *tearful* ☐ *constricted* ☐ *blunted* ☐ *flat* ☐ *other (describe):*
6. Mood	☐ *euthymic* ☐ *anxious* ☐ *irritable* ☐ *depressed* ☐ *elevated* ☐ *other (describe):*
7. Thought Processes	☐ *goal-directed and logical* ☐ *disorganized* ☐ *other (describe):*
8. Thought Content	**Suicidal** ideation: ☐ *None* ☐ *passive* ☐ *active* If *active*: yes no plan ☐ ☐ intent ☐ ☐ means ☐ ☐ **Homicidal** ideation: ☐ *None* ☐ *passive* ☐ *active* If *active*: yes no plan ☐ ☐ intent ☐ ☐ means ☐ ☐ ☐ *delusions* ☐ *obsessions/compulsions* ☐ *phobias* ☐ *other (describe):*
9. Perception	☐ *no hallucinations or delusions during interview* ☐ *other (describe):*
10. Orientation	*Oriented:* ☐ *time* ☐ *place* ☐ *person* ☐ *self* ☐ *other (describe):*
11. Memory/Concentration	☐ *short term intact* ☐ *long term intact* ☐ *other (describe):* ☐ *distractable/inattentive*
12. Insight/Judgment	☐ *good* ☐ *fair* ☐ *poor*

DIAGNOSTIC IMPRESSION(S):

_____ _____

_____ _____

_____ _____

TREATMENT PLAN (developed with patient):

Treatment Goals [after each item selected, indicate outcome measures (i.e. "as evidenced by")]:

_____ Reduce Risk Factors: _____

_____ Reduce Major Symptoms: _____

_____ Decrease Functional Impairments: _____

_____ Develop Coping Strategies: _____

_____ Stabilize (short term) Crisis: _____

_____ Maintain (long term) Stabilization of Symptoms: _____

_____ Medication Referral for: _____

_____ Other: _____

Planned Interventions/Patient Participation (consistent with treatment goals):

___ Assertiveness Training

___ Anger Management

___ Affect Identification and Expression

___ Cognitive Restructuring

___ Communication Training

___ Grief Work

___ Imagery/Relaxation Training

___ Parent Training

___ Problem Solving Skills Training

___ Solution Focused Techniques

___ Stress Management

___ Supportive Therapy

___ Self/Other Boundaries Training

___ Decision Option Exploration

___ Pattern Identification and Interruption

___ Dialectical Behavior Therapy

___ Engage Significant Others in Treatment: _____

___ Facilitate Decision Making Regarding: _____

___ Monitor: _____

___ Teach Skills of: _____

___ Educate regarding: _____

___ Other: _____

Clinician's Name and Signature_____ Date_____

_____

Last Name First Name MI

Date of Birth: _____

ACKNOWLEDGMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES and CONTACT PREFERENCES DISCLOSURE

I authorize contact by Providers for Healthy Living using the following means:

Cell/Home Phone: _____

You may leave a message at this number: Yes No

Work Phone: _____

You may leave a message at this number: Yes No

Email: _____

I further authorize Providers for Healthy Living to send receipts for payments by the following means:

Email: _____

Text: _____

Emergency Contact #1 Name, Phone Number, and Relationship:

_____

Emergency Contact #2 Name, Phone Number, and Relationship:

_____

By signing below, I certify that I have received a copy of this office's Notice of Privacy Practices and authorize contact to and by the means of communication detailed above.

Signature: _____

Relationship to Patient: _____

Date: _____

Office Policies

Welcome to our practice. The following policies will help you understand our processes and procedures. Please initial each section and sign and date at the end.

INFORMED CONSENT/TREATMENT AUTHORIZATION
By initialing here, you acknowledge that you have received copies of the Privacy Notices, Office Policies, and Informed Consent for Treatment of Providers for Healthy Living and its providers and were given the opportunity to answer clarifying questions to your satisfaction. After weighing the benefits and risks, you hereby give your consent for evaluation and treatment by Providers for Healthy Living and its providers.

Initial: _____

INSURANCE BENEFITS REASSIGNMENT AUTHORIZATION AND REIMBURSEMENT
If you have a health benefits insurance policy, it may provide mental health coverage. We will bill your insurance directly for services rendered; however, you are responsible for full payment of the session fees. It is your responsibility to contact your insurance company to obtain prior authorization for services provided. Please be aware that most insurance agreements require you to authorize us to provide a clinical diagnosis, and sometimes additional clinical information such as treatment plan or summary, or in rare cases, a copy of the entire record. We are required to submit this information on your behalf if you choose to obtain insurance reimbursement. In cases where your insurance does not pay for your session, you will be billed and will be expected to pay the amount that the insurance company was contracted to pay on your behalf. By initialing here, you agree to assign your insurance benefits (current and future), if any, to Providers for Healthy Living and its providers, otherwise payable to you for services rendered. You further authorize the use of your signature on all insurance submissions.

Initial: _____

CONTACTING US
Our phone number at 614-664-3595 is monitored at all times. We will make every effort to return your call on the same day you make it with the exception of weekends and holidays. When you call, please leave some times and phone numbers where you can best be reached. If you are calling and consider the call an emergency, there are instructions on the voicemail with numbers to calls for emergency help. Please do not leave a message in case of an emergency as these situations are best handled by calling 911 or going to the nearest ER. With respect to electronic mail (e-mail), please be aware that while all of our providers are available via e-mail, it is not a confidential means of communication. Furthermore, we cannot ensure that e-mail messages will be received or responded to in a timely fashion as we check our e-mail on an irregular basis. E-mail is not an appropriate way to communicate confidential information or emergency issues or urgent issues that need to be handled after regular clinical hours.

Initial: _____

CANCELLATIONS AND NO-SHOW POLICY
Once your appointment is scheduled, you will be expected to attend unless you provide at least 24 hours advanced notice of cancellation. If you do not provide at least 24 hours notice, or fail to show for a scheduled NEW medication or therapy appointment, you will be responsible for a $150 no-show/ late cancellation charge and if you fail to show for a scheduled FOLLOW-UP appointment, you will be responsible for a no-show/late cancellation charge ($100 for medication or psychology appointments missed and $75 for therapy appointments missed). Missing a group will result in a $30 no-show/late cancellation charge, and missing a testing appointment will result in a $225 charge. Please Note: this fee must be paid before future appointments will be scheduled or medication refills will be given. If you arrive late and miss half of your scheduled appointment time, you will be rescheduled, and a late cancellation charge or no show fee may apply.

Initial: _____

EXCESSIVE NO SHOWS OR LATE CANCELLATIONS
Consistency is the key to improving and maintaining your mental health. To this end, after three (3) missed appointments without notification, or after three (3) cancellations (less than 24-hours notice) of your appointments, you will likely be dismissed from our practice. A certified letter will be sent notifying you of this decision, in the unfortunate and unlikely event that this may occur.

Initial: _____

BILLING AND PAYMENTS
You are expected to pay appropriate co-payments, deductibles, and account balances for each session at the time of the appointment. We accept cash, checks, and credit cards for payment. Services will not be rendered if payment is not made. If your account has payment overdue for over 60 days, we have the option of referring your account to a collection agency and closing your account with our office.

Initial: _____

CHARGES FOR PHONE CALLS AND EMAILS
If medication changes are made during email or phone exchanges that would've otherwise been made during an office visit, you will be billed for an equivalent session and you will be responsible for any fees associated with these billed sessions as insurance generally doesn't cover these charges. Likewise, phone calls with a therapist that would otherwise have been conducted in the office will be billed, and you will be required to pay for these sessions.

Initial: _____

PRESCRIPTION REFILLS
It is your responsibility to call in advance for medication refills. Refill requests should be placed at least 48 hours in advance. Medication refills are not considered emergency phone calls on weekends or after hours. Please monitor your medications closely and plan accordingly by calling in advance. We do our very best to provide medication coverage from one visit to the next. If you miss an appointment, you will likely run out of medication. If this happens, we will prescribe enough medication to cover until your next scheduled appointment. Some medications cannot be called in to the pharmacy or sent electronically. These medications require you to physically come to the clinic to pick up a prescription. Controlled prescriptions (all stimulants for ADHD, most sleep medications, and benzodiazepines for anxiety) are regulated by the federal government and cannot be filled early regardless of the reason.

Initial: _____

PAPERWORK/LETTERS/DISABILITY FORMS
We have decided as a practice to charge a fee to complete forms, letters, and disability paperwork. Disability forms, FMLA paperwork, letters for school and work, etc. may be completed by the clinician, if appropriate, but payment in advance is expected based on the number of pages and the complexity of the documentation. In general, our practice does not support patients being off work for disability. It is our goal to help patients function at their best, and supporting a disability claim is a direct contradiction to our mission. Therefore, we will not complete disability forms unless we recommend the process. We will, however, provide records in all cases if requested.

Initial: _____

CONFIDENTIALITY
Confidentiality is important, lawful, and necessary for appropriate mental health care. There are some exceptions when we are required by law to break confidentiality, however: (a) to take appropriate steps to ensure your safety if there is a threat of self-harm, (b) to take appropriate steps to ensure safety of others if there is a threat of harm to others, (c) to report child, elder, or dependent abuse, and (d) legal testimony if subpoenaed by a court. These exceptions are rare, and we do our best to maintain confidentiality. No information is given to anyone without your consent. Without a signed release of information from all individuals 18 or older, no information can be released without their consent.

Initial: _____

DISRUPTIVE OR ABUSIVE LANGUAGE/BEHAVIOR
We strive to create and maintain a respectful environment at all times, and expect the same from all interactions we have with patients. Any profanity, abusive language or behaviors, demeaning comments, disruptive behaviors, threatening remarks, etc., will not be tolerated, and may lead to immediate dismissal from our practice.

Initial: _____

By signing below, I indicate that I have read the above policies and fees and agree to be held by them. I was given the opportunity to ask clarifying questions to my satisfaction. If the parent of a minor, by signing below, I indicate that I am the custodial parent and am authorized to make final treatment decisions on my child's behalf.

Name of Patient (print): _____

Signature of Patient: _____ Date: _____

Signature of Parent/Guardian (if applicable): _____

Signature of Staff: _____

PROVIDERS FOR HEALTHY LIVING
Child, Adolescent, and Adult Psychiatry & Therapy Services
phone & fax 614-664-3595
phone 419-605-9817 fax 419-775-3225

Authorization for Release of Information

Name: _____ Date of Birth: _____

Address: _____ City, State, Zip: _____

☐ **I authorize Providers for Healthy Living to exchange information with:**

Name: _____

Address: _____

Phone: _____ Fax: _____

PURPOSE OF THIS REQUEST: ☐ **Healthcare** ☐ Insurance Coverage ☐ Personal ☐ Other

TYPE OF RECORDS AUTHORIZED: ☐ **Psychiatric/Psychological Evaluation and/or Treatment**

☐ Drug/Alcohol Evaluation and/or Treatment

SPECIFIC INFORMATION AUTHORIZED: (select one or more as appropriate)

☐ **ALL INFORMATION CAN/SHOULD BE EXCHANGED AS NECESSARY**

☐ Assessments ☐ Progress Notes ☐ Laboratory Test Results

☐ Diagnostic Impression ☐ Discharge Summary ☐ Treatment Plans ☐ Treatment Summary

☐ Other: (please describe) _____

Periodic Use/Disclosure: I authorize the periodic use/disclosure of the information described above to the person/provider/organization/facility/program(s) identified as often as necessary to fulfill the purpose identified in this document. My authorization will expire when I am no longer receiving services from Providers for Healthy Living.

I understand that:

- I do not have to sign this authorization and that my refusal to sign will not affect my abilities to obtain treatment.
- I may cancel this authorization at any time by submitting a *written* request to Providers for Healthy Living.
- If the person or facility receiving this information is not a healthcare or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- If the authorized information is protected by Federal Confidentiality Rules 42CFR, Part 2, it may not be disclosed without my written consent unless otherwise provided for in the regulations.
- Release of HIV-related information requires additional information.
- If the medical record information is not sent to another care provider, there may be a charge of the requested records.

Signature of Patient or Representative: _____

Printed Name of Person Signing Form: _____

Relationship to Patient (*if requester is not the patient*): ☐ Parent ☐ Legal Guardian ☐ Other: _____

Date: _____