PATIENT INFORMATION

Patient's Legal Name (last)______________________________ (first)________________________________(MI)__________________________
Preferred Name_____________________________________ Date of Birth_____/______/______
Address:____City, State, Zip____
Home Phone: (home)____________________________(cell)____________________________ (work)____________________________________
E-Mail:____

Gender Identity: ❑ Female ❑Male ❑Transgender Male to Female ❑Transgender Female to Male ❑ Decline to say ❑ Additional Gender category not listed

Race: ❑American Indian ❑ Asian ❑ Hawaiian/ Pacific Islander ❑ African American ❑ Caucasian ❑ Hispanic ❑ Decline to say

Patient Social Security Number:____________________________

RESPONSIBLE PARTY INFORMATION (if not self)

Responsible party: ❑ Another patient ❑ Guarantor ❑ Self
Responsible party name: (Last)_________________(First)________________Date of birth:____/_____/_____
Sex: ❑ Female ❑ Male Phone number:______________________
Address:____
City, State, ZIP:____

INSURANCE INFORMATION: Provide your insurance card(s) (primary, secondary, etc.) to the front desk or via email.

EMERGENCY CONTACT INFORMATION

Emergency contact name: (Last) _________________________(First)___________________________ Phone number:_______________________
Do you have a living will? ❑ Yes ❑ No
Emergency contact relationship to patient:__________________________________
Guardian Address:____ City, State, Zip____
Home phone:____________________________ Work Phone:________________________ Ext:____________________

CONSENT FOR CARE AND TREATMENT

TO THE PATIENT: This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. Appointments, patient confidentiality, record keeping and payments, will be held to HIPAA standards and can only be released with a signed release of information for a third party or individual.

Telemedicine appointments are available to all patients, via phone or video depending on schedule type. Please always keep us updated with contact information.

You have the right at any time to discontinue services. You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. I voluntarily request a physician, and/or mid-level provider (nurse practitioner, physician assistant, or therapist to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s). I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents. Upon request, a copy of this form is available. You must be a patient for at least 1 year to have third party paperwork completed, appointments are required for the completion to ensure accuracy.

Acknowledgement of Abuse Free Zone: At Riverview CMHC, we respect our staff It is our belief that our staff should have a work environment free from any form of verbal or physical abuse. We expect each one of our patients to treat each staff as you would wish to be treated. Outbursts against any staff member will not be tolerated and can result in being discharged from the practice.

All copayments/ co-insurances/ deductibles are to be paid at the date of service.

Cancellation & Appointment Policy: Patients are expected to be on time for appointments, we allow a 15-minute grace period for ALL appointments. Psychotherapy appointments require a 24-hour cancelation period of time, to which a $40 no-show/ late cancelation fee will be due. We offer a courtesy reminder call for patients.
For more information on our practice and services, visit us at riverviewcmhc.org

Signature of Patient or personal representative: ____ **Date**________________________________

Name of Patient or personal representative: ____

Informed Consent for Psychotherapy

General Information

Welcome to Riverview Community Mental Health Center! This document contains important information about our professional services and business policies. It also contains a summary of information about the Health Insurance Portability and Accountability Act (HIPPA), a federal law that provides privacy protections and patient rights about the use and disclosure of your Protected Health Information (PHI) for the purposes of treatment, payment, and healthcare operations. Although these documents are long and sometimes complex, it is important that you understand them. When you sign this document, it also represents an agreement between us. The therapeutic relationship is unique in that it is highly personal and at the same time, a contractual agreement. Given this, it is important for us to reach a clear understanding about how our relationship with work, and what each of us can expect. This consent will provide a clear framework for our work together. Feel free to discuss any of this with us.

Risks and Benefits of Therapy

You have taken an incredibly positive step by deciding to seek therapy. The outcome of your treatment depends largely on your willingness to engage in this process, which may, at times, results in considerable discomfort. Remembering unpleasant events and becoming aware or feelings attached to those events can bring on strong feelings of anger, depression anxiety, etc. There are no miracle cures. We cannot guarantee that your behavior of circumstance will change.

We can promise to support you and do my absolute best to understand you and repeating patterns, as well as to help you clarify what it is you want to change. You may along the way receive answers you seek in healing lifelong interpersonal issues. You will also be able to identify coping skills, make behavioral changes, reduce symptoms of mental health, improve quality of life, learn to manage emotional response & communication, and learn to live in the present.

Confidentiality

The session content and all relevant materials to the client's treatment will be confidential unless the client requests in writing to have all or portions of such content released to specifically names person(s). Limitations of such client held privilege of confidentiality exist and are itemized below:

1. If a client threatens or attempts to commit suicide or otherwise conducts him/herself in a manner which there is substantial risk of incurring serious bodily harm.
2. If a client threatens grave bodily harm or death to another person.
3. If the therapist has reasonable suspicion that a client or other name victim is the perpetrator, observer of, or actual victim of physical, emotional, or sexual abuse of children under the age of 18 years.
4. If the therapist has reasonable suspicions as stated above in the case of an elderly person who may be subjects to these abuses.
5. If records are court ordered.

Confidentiality and Technology

Some clients may choose to use technology to receive services. This includes but is not limited to online sessions via a HIPAA compliant video chat, telephone, email, text, or chat. Due to the nature of online services, there is always a possibility that unauthorized persons may attempt to discover your personal information. I will take every electronic precaution to safeguard your information but that cannot guarantee unauthorized access to technology used in counseling sessions. Be aware of any friends, family members, significant others, or co-workers who may have access to your computer, phone, or other technology used in your counseling sessions as well as who is present in your environment during a virtual session.

Email and Web Forms

We may ask you to complete forms accessible on the website and transmit them through email. These forms may include but are not limited to: informed consent, assessment, appointment inquiry. You have the right to email or call us instead and request to change or complete these forms in person. If you choose this, we can email you the forms and you can bring them in person to your first session.

We will request a client's email address. You have the right to refuse to provide this information or revoke email use at any time. We may use emails addresses to check in with clients who have ended therapy suddenly. We may also use email to send newsletters with valuable information such as tips for depression, self-care, mindfulness. I may send information through email about subscribing to the blog. Please do not communicate with us regarding treatment via email as we will not respond. Be aware that all emails and forms are retained in the logs of your internet service providers. While it is unlikely that someone will be looking at these logs, they are, in theory available to read by the system administrators of the internet provider. You should also be aware that any emails we receive from you and any responses that we send become part of your legal record.

Please initial one:

1. _________If you would like to receive correspondence through email.
2. _________If you would like to **opt out** of email and web form correspondence.

Record Keeping

We will keep records of our sessions. These records are kept ensuring a direction of your sessions and continuity in service as well as insurance reimbursement. They will not be shared except in respect to the limits of confidentiality discussed in the confidentiality section. Should the client wish to have their records released, they are required to sign a release of information which specifies what information is to be released and to whom. Records will be kept for at least 7 years but may be longer. Records will be kept either electronically or in a paper file and stored in a cabinet in my office.

Communication & Emergencies

Therapists are often not immediately available by telephone. We can not answer phone calls during a session or otherwise unavailable. At these times, you may leave a message on our confidential voicemail, or with office management and your call will be returned as soon as possible. This may take a day or two if it is a non-urgent matter. If you feel you cannot wait for a return call or it is an emergency, please go to your local hospital, call 911 or 211 for crisis assistance. If you need to contact me between sessions, the best way to do so is by phone.

Office Hours & Appointments

Our office hours are Monday- Friday 9:00 AM to 5:00 PM. The last session scheduled is at 4 PM. These are subject to change. Appointments can be from 15-60 minutes in duration, once per week as needed. If you need to cancel or reschedule, we ask that you provide is with a 24 hours' notice. If you miss the appointment without canceling or cancel in less than 24 hours, you will be required to pay for the cancellation fee of $40.00 before rescheduling.

Termination

We reserve the right to terminate services at my discretion. Reasons for termination include but are not limited to: untimely payment of service fees, failure to comply with treatment recommendations, conflicts of interest, failure to participate in sessions, the client needs are outside the therapist scope of practice, or the client is not making progress in therapy. The client also has the right to terminate therapist at his/her discretion. Upon either parties' determination to terminate therapy, the therapist will generally recommend that the client participate in at least one termination session. The purpose of a termination session is to facilitate a positive termination experience and give both parties an opportunity to summarize the therapeutic work completed. This will also allow the therapist time to assist client with a smooth transition to another therapist by offering referrals.

Consent to Therapy

Your signature below indicates that you have read this Agreement and agree to its terms.

Patient Printed Name:______________________________

Patient Signature:______________________Date:______________

Therapist Signature:______________________Date:______________

Mental Health Questionnaire

What is your major complaint?______________________________

Start Date:__________________ Have you previously suffered from this?__________________

Previous therapist seen for this?______________________________

Previous treatment: ______________________________

Aggravating factors: ______________________________

Relieving factors:______________________________

Current Symptoms (check all that apply)

❑ Anxiety ❑Appetite issues ❑Avoidance ❑Crying Spells ❑Depression ❑Excessive energy ❑Fatigue ❑Guilt ❑Hallucinations
❑Impulsivity ❑Irritability ❑Libido changes ❑Loss of interest ❑Panic attacks ❑Racing thoughts ❑Risky activity ❑Sleep changes

Medical History

Exercise frequency:__________________ Exercise type:__________________

Allergies:______________________________

Medications currently taking:______________________________

____

Previous diagnosis/ mental health treatment?______________________________

Previous medical treatment:______________________________

____

Previous surgeries:____

____

Family History

Were you adopted?_________________ If so, what age?______________ How is your relationship with mother?_________________________

How is the relationship with father?__________________ Siblings?__________________________ Relationship with them?_________________

____

Parents married?_____________________ Parents divorced?______________________________ If so, when?__________________________

Family medical issues:____

____

Early Development

Where did you grow up?__________________________________ How often did you move as a child and where?_________________________

____

How old were you when you left home?____________________________ How many immediate family members deceased?________________

How many committed suicide?___________________ Who?________________________

Personal traumas?____

____

Abuse suffered and by whom?____

Highest education level completed: ____

Have you ever served in the military? _________________ If yes, when?____

Dates of service: ____ Highest ranking received: ____________________________________

Present Situation

Work: ❑Full-time ❑Part-time ❑Student ❑Unemployed ❑Disabled ❑Retired

Are you married? _____________________________ If yes, date of marriage: ____

Are you divorced? _____________________________ If yes, dates of divorce: ____

Prior marriages? ______________________________ If yes, how many?

____

What is your sexual orientation? ____ Are you sexually active? ___________________________

How is your relationship with your partner? __________________________________ Do you have children? ___________________________

Dates of birth:____

How is your relationship with your children? ____

List anyone else who lives with you: ____

Are you a member of a religious/ spiritual group?______________________________ If so, what? ____________________________________

What is your level of involvement? ____ Have you ever been arrested? _______________________

If so, when and why?____

Which of the Following Have You Tried (check all that apply)

❑Alcohol ❑Tobacco ❑Marijuana ❑Hallucinogens (LSD) ❑Heroin ❑Methamphetamines ❑Cocaine ❑Stimulants (Pills)

❑Ecstasy ❑Methadone ❑Tranquillizers ❑Pain Killers ❑Other____

Have you ever been treated for alcohol/ drug abuse? ______________________________ If yes, when? ________________________________

For which substances? ____

Do you smoke cigarettes? _______________ If so, how many per day? ____

Do you drink alcohol? __________________ If so, how often? ____

Do you drink caffeinated beverages? ______________________ If so, how many per day? ____

Have you ever abused prescription drugs? _________________ If yes, which ones? ____

Anything Else You Would Like the Provider to Know:

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