Confidential Brief Health Information Form

Name: _____ Birth Date: ____/____/____

Address: _____ Phone: (H) _____

_____ SSN: _____

Primary Care Physician: _____

Today's Date: ____/____/____

Month and year of last physical: _____

Please check any of the following for which you have received care:

___ allergies	___ headaches	___ heart disease	___ asthma
___ irritable bowel	___ diabetes	___ sleep problems	___ chronic pain
___ epilepsy/seizures	___ emotional problems	___ arthritis	___ hearing problems
___ vision problems	___ stomach problems	___ cancer	___ thyroid problems
___ blood pressure	___ head injury		

Please list any hospitalizations (dates and reasons): _____

Currently under the care of a physician? If so, for what? _____

Please list any prior mental health services received: _____

For children who are the primary identified client, list immunizations, all developmental milestones, any medications, and health concerns: _____

_____

Please check any area where you think you have a problem:

___ anxiety, nervousness	___ dental health	___ work/academic
___ behavioral problems	___ depression	___ ADHD
___ parenting	___ sleep	___ stress
___ physical health	___ reproduction	___ anger
___ guilt	___ relationships	___ eating/nutrition
___ weight/body image	___ self-esteem	___ alcohol/other drugs
___ compulsive behavior		

Briefly describe your:

Eating habits: _____

Sleep/rest: _____

Use of alcohol/other drugs: _____

Caffeine intake: _____

Smoking: _____

Physical exercise: _____

Hobbies/play: _____

Please describe any medical concerns not listed above that you believe relevant:

_____

_____

_____ _____

Signature Date

HOPE SPRINGS
BEHAVIORAL HEALTH

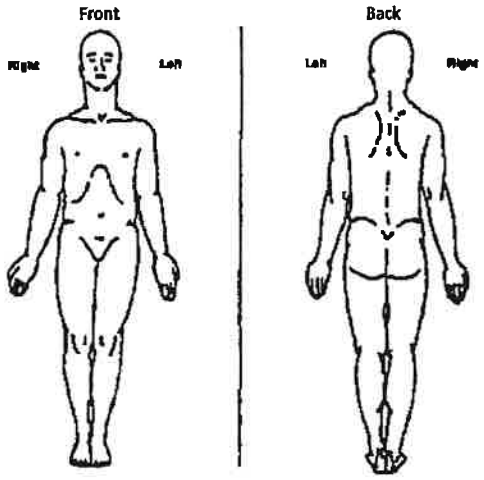
BRIEF PAIN INVENTORY (SHORT FORM)

Patient Initials:
Date of Birth(dd,mm,yyyy):
Visit Date (dd,mm,yyyy) :

1. Throughout our lives, most of us have had pain from time to time (such as minor headaches, sprains, and toothaches). Have you had pain other than these everyday kinds of pain during the last week?

☐ Yes

2. On the diagram, shade in the areas where you feel pain. Put an X on the area that hurts the most.



3. Please rate your pain by circling the one number that best describes your pain at its worst in the last week.

1 2 3 4 5 6 7 8 9 10

4. Please rate your pain by circling the one number that best describes your pain at its least in the last week.

1 2 3 4 5 6 7 8 9 10

5. Please rate your pain by circling the one number that best describes your pain on the average.

1 2 3 4 5 6 7 8 9 10

6. Please rate your pain by circling the one number that tells how much pain you have right now.

1 2 3 4 5 6 7 8 9 10

7.What treatments or medications are you receiving for your pain?

Malnutrition Screening Tool **(MST)**

STEP 1: Screen with the MST

① Have you recently lost weight without trying?

No	0
Unsure	2

If yes, how much weight have you lost?

2-13 lb	1
14-23 lb	2
24-33 lb	3
34 lb or more	4
Unsure	2

Weight loss score: ____

② Have you been eating poorly because of a decreased appetite?

No	0
Yes	1

Appetite score: ____

Add weight loss and appetite scores

MST SCORE: ____

STEP 2: Score to determine risk

MST = 0 OR 1
NOT AT RISK
Eating well with little or no weight loss

MST = 2 OR MORE
AT RISK
Eating poorly and/or recent weight loss

Rapidly implement nutrition interventions. Perform nutrition consult within 24-72 hrs, depending on risk.

STEP 3: Intervene with nutrition for your patients at risk of malnutrition.

Notes: _____

Ferguson, M et al. *Nutrition* 1999 15:458-464

HIPAA 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 this notice carefully.

Understanding Your Protected Health Information (PHI)

When you visit us, a record is made of your symptoms, examinations, test results, diagnoses, treatment plan, and other mental health or medical information. Your record is the physical property of the medical health care provider. The information within belongs to you. Being aware of what is in your record will help you to make more informed decisions when authorizing disclosures to others. In using and disclosing your PHI, it is our objective to follow the Privacy Standards of the Federal Health Insurance Portability and Accountability Act (HIPAA) and requirement of state law.

Your Mental Health and/or Medical Record Serves as:

- A basis for planning your care and treatment.
- A means of communication among the health professionals who may contribute to your care.
- A legal document describing the care you received.
- A means by which you or a third-party payer can verify that services billed were actually provided.
- A source of information for public health officials charged with improving the health of the nation.
- A source of data for facility planning and marketing.
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve.

Responsibilities of (Hope Springs Behavioral Health)

We are required to:

- Maintain the privacy of your PHI as required by law and provide you with notice of legal duties and privacy practices with respect to the PHI that we collect and maintain about you.
- Abide by the terms of this notice currently in effect. We have the right to change our notice of privacy practices and to make the new provisions effective for all protected health information that we maintain, including that obtained prior to the change. Should our information practices change, we will post new changes in the reception room and provide you with a copy.
- Notify you if we are unable to agree to a requested restriction.
- Use or disclose your health information only with your authorization except as described in this notice.

Your Protected Health Information (PHI) Rights

You have the right to:

- Review and obtain a paper copy of the notice of information practices and your health information upon request. A few exceptions apply. Copy charges may apply.
- Request and provide written authorization and permission to release PHI for purposes of outside treatment and health care. This authorization excludes psychotherapy notes and any audio/video tapes that may have been made with your permission for training purposes.
- Revoke your authorization in writing at any time to use, disclose, or restrict health information except

to the extent that action has already been taken.

- Request a restriction on certain uses and disclosures of PHI, but we are not required to agree to the restriction request. You should address your restriction in writing to the Privacy Officer by asking for name of Privacy Officer, address, and phone. We will notify you within 10 days if we cannot agree to the restriction.
- Request that we amend your health information by submitting a written request with reasons supporting the request to the Privacy Officer. We are not required to agree with the requested amendment.
- Obtain an accounting of disclosures of your health information for purposes other than treatment, payment, health care operations, and certain other activities for the past six years but not before April 14, 2003.
- Request confidential communications of your health information by alternative means or at alternative locations.

Disclosures for Treatment, Payment, and Health Operations

(Name of clinic) will use your PHI, with your consent, in the following circumstances:

Treatment: Information obtained by a nurse, physician, psychologist/counselor, dentist, or other member of your health care team will be recorded in your record and used to determine the management and coordination of treatment that will be provided for you.

Disclosure to others outside of the agency: If you give us written authorization, you may revoke it in writing at any time but that revocation will not affect any use or disclosures permitted by your authorization while it was in effect. We will not use or disclose your health information without your authorization, except to report a serious threat to the health or safety of a child and/or vulnerable adult.

For payment, if applicable: We may send a bill to you or to your insurance carrier. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis to obtain reimbursement for your health care or to determine eligibility or coverage.

For health care operations: Members of the mental health staff or members of the quality improvement team may use the information in your health record to assess the performance and operations of our services. This information will be used in an effort to continually improve the quality and effectiveness of the mental health care and services we provide.

We may use or disclose your PHI in the following situations without your authorization: as required by law, public health issues as required by law, communicable diseases, health oversight, abuse/neglect, Food and Drug Administration requirements, legal proceedings, law enforcement, coroners and organ donation, research, or workers' compensation. Under the law, we must make disclosures to you when required by the Secretary of the U.S. Department of Health and Human Services to investigate or determine our compliance with the requirements.

For More Information or to Report a Problem

If you have questions and would like additional information, please ask your clinician. He/she will provide you with additional information or put you in contact with the designated Privacy Officer. If you are concerned that your privacy rights have been violated or you disagree with a decision we have made about access to your health information, you may contact the Privacy Officer. We respect your right to privacy of your health information. There will be no retaliation in any way for filing a complaint with the Privacy Officer of our agency or the U.S. Department of Health and Human Services.

HIPAA Privacy Authorization for Use and Disclosure of Personal Health Information

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and its implementing regulations as amended from time to time. You may refuse to sign this authorization.

By my signature below, I acknowledge that I have received and read the Notice of Health Information Privacy Practices. I have been provided a copy of, read and understand (agency name) HIPAA Privacy Notice containing a complete description of my rights, and the permitted uses and disclosures of my protected health information under HIPAA. Further, I acknowledge that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and is no longer protected under HIPAA.

Name: _____
Last First MI

Address: _____
Street City State Zip

Date of Birth: _____

Today's Date: _____

For office use only

I attempted to obtain written acknowledgment of receipt of our Notice of Privacy Practices, but acknowledgment could not be obtained.

Reason: _____

_____ _____
Clinician Signature Date

Individual HIPAA Provider Number of Clinician Completing Form: _____

HIPAA Organization Number of Clinician Completing Form: _____

Hope Springs Behavioral Health

Client Consent to Treatment

Criteria for Admission,

In order to be admitted to Hope Springs Behavioral Health an individual must have a substance abuse and/or mental health issue and agree to treatment under policies and regulations of the agency. Anyone seeking treatment must be at least twelve (12) years of age. No one who is actively psychotic or has severe hearing or speech impairment will be admitted.

Treatment Approach:

Completion of Treatment

1. Mutual agreement of the therapist and client that the person accomplished all or most clinical goals and maximum clinical benefit has been achieved in the outpatient setting.
2. Therapist and client agree to transfer to another program
3. If a client is stipulated as a condition of probation, completion of treatment will be coordinated with the referring of agency.

Involuntary Discharge/Termination Criteria:

Any acts of physical violence, selling or using drugs on premises, continued once as an assessment of the client is completed, the therapist will develop an individualized treatment plan. This will include an action plan and goals. This will be accomplished through all the modalities of treatment offered at Hope Springs Behavioral Health, including individual, group and family therapy unexcused absences, not following the on-going agreed upon treatment and non- payment of services are causes for termination for the agency.

Hours of Operation:

10:30 AM- 9PM Monday through Thursday

10:30 AM- 5PM Friday

Saturday hours are by appointment only

Fee Schedule For Out of Pocket Clients:

$300.00 Psychiatric Evaluation

$150.00 Medication Management

$100.00 Initial Evaluation

$125.00 per individual Therapy Session

$50.00 per Group Session

Insurance payments are handled on an individual policy basis. We accept cash, check, debit (VISA, MasterCard and Discover Cards).

Consent to Outpatient Treatment

I, _____ , agree to and understand the policies and procedures of Hope Springs Behavioral Health. I further understand that anything shared by other group therapy members in the program is to be kept confidential.

_____ _____

Client's Signature Date

_____ _____

Therapist's Signature Date

Copy Accepted { }

Copy Refused { }

Hope Springs Cancellation Policy

All cancellations must be 48 hours prior to your scheduled appointment. By signing below you acknowledge that if you do not call the office within 48 hours, you agree to pay the following fees:

Psychiatrist Cancellation Fee: $75.00

Therapist Cancellation Fee: $75.00

Client Signature/ Date

Client Rights and Limits of Confidentiality and Acknowledgement

The project shall develop written policies and procedures on client rights and document written acknowledgement by clients that they have been notified of those rights.

(1) A client receiving care or treatment under section 7 of the act (71 P. S. § 1690.107) shall retain civil rights and liberties except as provided by statute. No client may be deprived of a civil right solely by reason of treatment.

(2) The project may not discriminate in the provision of services on the basis of age, race, creed, sex, ethnicity, color, national origin, marital status, sexual orientation, handicap or religion.

(3) Clients have the right to inspect their own records. The project, facility or clinical director may temporarily remove portions of the records prior to the inspection by the client if the director determines that the information may be detrimental if presented to the client. Reasons for removing sections shall be documented in the record.

(4) Clients have the right to appeal a decision limiting access to their records to the director.

(5) Clients have the right to request the correction of inaccurate, irrelevant, outdated or incomplete information in their records.

(6) Clients have the right to submit rebuttal data or memoranda to their own records.

Client Confidentiality

Hope Springs Behavioral Health has a commitment to keeping the information you provide and your clinical record confidential. Beyond our commitment to Ethical Standards, HIPAA, and state law require it. You can give permission to our clinic in writing if you wish your information to be shared with specific persons outside our agency. There are exceptions when we can/must release information without your written permission. Your clinical information will be released without your written consent if (1) it is necessary to protect you or someone else from imminent physical harm; (2) we receive a valid court order or subpoena that mandates we release your information; or (3) you are reporting abuse of children, the elderly, or persons with disabilities.

Clinicians within within the agency may, at times, consult with each other regarding your treatment in order to provide you with the best possible services to meet your needs.

If your child is in treatment with our facility and is a minor, we ask that parents/guardians agree that most details of what their child or adolescent tells the therapist be kept confidential. However, parents/guardians do have the right to general information about progress in treatment. The therapist may also have to share information that indicates the child/adolescent is in in danger.

This is to acknowledge that I have read, understood, and agreed with the above information.

_____ _____

Signature of Client/Parent/Guardian **Date**

_____ _____

Signature of Clinician **Date**

Hope Springs Behavioral Health

Policy on Prescriptions for Benzodiazepines and Amphetamines/Stimulants

Any patients entering into this office were told that this treatment facility does not, as a general practice prescribe Benzodiazepines and/or Amphetamine/Stimulants. However, we will not turn away new or referred patients who are willing to taper down and ween off of these medications.

I _____ accept treatment recommendations made by staff psychiatrist to taper down and ween off of my medications. I was informed that, in order to continue treatment, I must comply with the medication policy stated above. I will not hold Hope Springs Behavioral Health liable if I refuse treatment recommendations. During the period of time to taper my medications, I will take them as prescribed.

_____ _____

Patient Signature/Date Staff Signature/Date

_____

Witness Signature/Date

Hope Springs Behavioral Health Policy on Noncompliance

As a facility that takes a holistic approach to treatment, we will continue to monitor your attendance for psychotherapy and medication management. If you are not consistent with therapies recommended, you will receive a resource list and immediately be discharged from our program.

I understand and consent to the above policy. I will not hold Hope Springs Behavioral Health liable for ceasing treatment due to noncompliance.

_____

Client Signature Date

Informed Consent for Participation in Outcome Assessment

At different times in the course of your treatment we may be asking you to complete certain questionnaires, interviews, tests, or other measurements. These are designed to help us evaluate and improve your treatment plan, progress in treatment, and/or any changes to your plan or referrals to other providers we may need to make. The information we collect will be kept confidential, like the rest of the information in your file at this agency. We will inform you about any decisions or changes that are based on the information we collect in this way. We may also contact you to ask for feedback some time after you have completed treatment with us. This is also to evaluate our program by measuring the long-term benefits we are able to provide our clients. We thank you for your cooperation in this effort.

Please fill out the following form so that we can contact you more easily for this follow-up evaluation and do so in a way that avoids inconveniencing you:

Do you have a phone at home? _____ Phone Number: (___) _____

Do you have a work phone where we may contact you? Phone Number: (___) _____

Do you have an e-mail address where we may contact you? E-mail: _____

What is your mailing address? _____

_____

_____

Please indicate the way you would prefer we contact you. Check one or more:

_____ Telephone _____ E-Mail _____ Letter _____ In-person appointment

_____ Other: _____ Do you prefer that we contact you at _____ home or _____ work?

Is it okay to leave a message if you are not available?_____

Is there a time or day that it is more convenient for us to contact you? _____

I understand that all results of outcome measurement completed by Hope Springs Behavioral Health will be kept confidential at the level of individual identification and will be shared only with the treatment providers at the above mentioned clinic/agency who are involved with my treatment.

Client Signature: _____ Date: ___/___/___

Authorization for Disclosure of Information

Last Name First Name Middle Initial Date of Birth

Address

Telephone

I, _____,
hereby authorize the release and disclosure of the following clinical and/or therapeutic records for the following purpose(s):

[ ] Authorization to release information regarding counseling and therapy care and treatment.

[ ] Authorization to release information held under the Drug Office and Treatment Act of 1972 (PL-92255) and the Comprehensive Alcohol Abuse and Alcoholism Prevention Treatment and Rehabilitation Act Amendments of 1974. I understand that my records are protected under the federal regulations governing confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part 2, and cannot be disclosed without my written consent unless otherwise provided for in the regulations.

[ ] Authorization to release information related to Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS).

Release to:

Name of Provider/Person: _____

Address: _____

Phone: _____

Specific information to be released (**client's initials to approve release**):

_____ Assessments and evaluations (specify:) _____ Psychosocial history

_____ Entire mental health record _____ Discharge summary

_____ Summary of treatment

Correspondence (specify): _____

Other (specify): _____

_____

Purpose(s) for which information is to be released (check all that apply):

_____ continuity of care _____ referral

_____ consultation _____ personal

_____ other (please describe): _____

I do not authorize the release of the following information:

_____

Revocation/Expiration: I understand that I may revoke this authorization in writing at any time, except for actions that have already been taken prior to this request. (Forms are available from the therapist.) This authorization will expire ____ days after the signature below. This agency is hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized.

Client/Guardian's Name: _____ Signature: _____ Date: ___/___/___

Witness Name: _____ Signature: _____ Date: ___/___/___

HOPE SPRINGS
BEHAVIORAL HEALTH

Hope Springs Behavioral Health Email Policy

Please be aware the counselors use email to aid in communication only.

Emails are not checked frequently throughout the day and we usually will respond within 24 hours.

In the event of an emergency, please go to the nearest crisis center or call 911.

_____

Client/Guardian Signature Date

_____

Therapist Signature Date