Cow Creek Health and Wellness Center

# Behavioral Health

**For Clinic Use**
Date Recieved:
Received by:
Patient #

500 SE Cass Ave, Suite 110, Roseburg OR 97470 | (541) 672-8533

# New Patient Youth Intake Packet

Social Security Number: _____

Patient's Legal First Name: _____

Middle Initial: _____

Patient's Legal Last Name: _____

Patient's Preferred Name: _____ Suffix: _____

Mailing Address: _____

_____

Zip Code: _____

Employment status (please check box that best applies)
❑ Employed ❑ Self-employed ❑ Disabled
❑ Full-time student ❑ Part-time student

❑ Other: _____

Employer: _____

Employer's phone number: _____

If you are employed by a Tribe, which department or business?

_____

Gender assigned at birth: ❑ Male ❑ Female

Gender patient identifies as: _____

Sexual orientation: _____

Date of Birth: _____ Marital status: _____

Ethnicity (please check the boxes that best apply)
❑ American Indian/Alaskan Native ❑ African American ❑ Asian
❑ Caucasian ❑ Native Hawaiian/Other Pacific Islander ❑ Other

If Other, please specify: _____

Are you enrolled in a Tribe? ❑ Yes ❑ No

If yes, which Tribe? _____

Tribal Enrollment Number: _____

Primary language: _____

Cell phone #: _____ Home phone #: _____

Preferred method of contact (please check best answer):
❑ Home phone ❑ Cell phone ❑ Email
❑ Other (please specify): _____

If you would like to be a part of our online Patient Portal, please provide your email address: _____

**Primary Insurance:** ❑ Yes ❑ No

Insurance Name: _____

Insured ID: _____

Group: _____

Name of Policy Holder: _____

Policy Holder Date of Birth: ____/____/_____

**Secondary Insurance:** ❑ Yes ❑ No

Insurance Name: _____

Insured ID: _____

Group: _____

Name of Policy Holder: _____

Policy Holder Date of Birth: ____/____/_____

How were you referred to us?

I, the undersigned, being the patient or legal guardian/person having legal custody/or person otherwise having legal authorization to consent, freely give my consent to Cow Creek Health and Wellness Center and their agents, to examine and treat the patient registered / referenced above.

**By signing this form, I verify that the information provided is true and factual to the best of my knowledge.**

**Printed name of patient or patient's legal representative**

**Relationship to patient**

**Signature of patient or legal representative**

**Date**

# Informed Consent for Behavioral Health Treatment

Welcome to Cow Creek Health and Wellness (CCH&W) Behavioral Health. We hope that your experience with us will be positive, and that our assistance will be beneficial to you on your journey.

## Consent to Services

Participation in behavioral health treatment is voluntary. Behavioral Health (BH) Treatment takes many forms which could include interviews, assessment or testing, psychotherapy, and/or medication management. Treatment may also include various mental health treatment modalities (EMDR, CBT, ACT, DBT, etc.). Your BH team member will discuss various treatment options with you. You are encouraged to work with your team member to develop your plan of care and you should be informed of any new modalities used within your treatment process.

## Risks and Benefits

Behavioral Health treatment has both benefits and risks. Risks may include experiencing uncomfortable feelings, because the process often requires discussing difficult aspects of one's life. However, treatment has been shown to have benefits. It often leads to a significant reduction in feelings of distress, increased satisfaction in relationships, greater awareness and insight, increased skills and resolutions to specific problems. A small number of clients may not improve with treatment. Terminating treatment before it is clinically indicated increases risks. It is important to keep your clinician advised of any difficulty you may encounter during your treatment or if you are considering stopping your treatment sessions before clinically indicated.

As a client of CCH&W, you are not required to accept treatment from CCH&W Behavioral Health Staff at any time, and you have the right to decline part or all of your treatment, including withdrawal from our services should you choose.

## One Medical Record

Cow Creek Health and Wellness has an electronic health record. Anyone who provides treatment for you at CCH&W will have access to all clinical notes in your clinical record.

## Confidentiality

Information shared with a behavioral health professional is confidential and will not be shared outside this agency without your written consent except under the following conditions:

- Any information disclosed regarding threat of harm to self or another must be addressed.
- Any information disclosed regarding harm done to a child, elder, or disabled person will bedisclosed to law enforcement or other appropriate agencies.
- Behavioral health professionals may be court ordered to testify about treatment at Cow Creek.

Patients who are seen at CCH&W are asked to protect the confidentiality of all patients who attend treatment at Cow Creek Behavioral Health Program. This means not discussing the treatment of any individual who is, or has been, in any Cow Creek Behavioral Health program with anyone. As AA so eloquently states, "Who you see here and what you hear here, let it stay here."

## Grievance

If you have questions regarding your treatment, you may speak openly about them with your behavioral health team. If problems persist, you may request a treatment review by the Behavioral Health Manager and/or the Health/Medical Director.

## Missed Appointments

If you miss three or more appointments in a 12-month period, your current treatment episode will be closed. However, you always have the ability to request services at a later date. Please refer to the Behavioral Health Late Patient, Late Cancellation, and No-Show Policy on page 7 for more details.

**Printed name of patient or patient's legal representative** _____ **Relationship to patient** _____

**Signature of patient or legal representative** _____ **Date** _____

# Behavioral Health Treatment of Child & Adolescents

## Purpose:

To ensure appropriate mental health services to children and adolescents that promote wellness, stability, and holistic growth and development, and that meet the mandates of Tribal and state requirements.

## Policy:

- Minors (under 14 years of age) will not be seen without consent of parents or legal guardians.
- Therapists will not treat children under the age of 6.
- Children under the age of 12 shall be supervised at all times by a parent or guardian while at the clinic.
- Children and adolescents will be prohibited from receiving services from relatives who are Behavioral Health providers.

By signing below, I indicate that I have read and understood the policy listed above.

**Signature of patient or patient's representative** **Date**

**Printed name of patient or patient's representative** **Date**

# Behavioral Health Telemental Health Informed Consent

I, _____, hereby consent to participate in telemental health
(print patient's name)

with _____ as part of my psychotherapy.
(print therapist's name)

By signing below, I indicate that I understand that telemental health is the practice of delivering clinical health care services via technology-assisted media or other electronic means between a practitioner and a client who are located in two different locations.

**By signing, I indicate that I understand the following with respect to telemental health:**

1. I understand that I have the right to withdraw consent at any time without affecting my rightto future care, services, or program benefits to which I would otherwise be entitled.
2. I understand that there are risks, benefits, and consequences associated with telemental health, including but not limited to, disruption of transmission by technology failures, interruption and/or breaches of confidentiality by unauthorized persons, and/or limitedability to respond to emergencies.
3. I understand that there will be no recording of any of the online sessions by either party. All information disclosed within sessions and written records pertaining to those sessions are confidential and may not be disclosed to anyone without written authorization, except where the disclosure is permitted and/or required by law.
4. I understand that the privacy laws that protect the confidentiality of my protected health information (PHI) also apply to telemental health, unless an exception to confidentiality applies (i.e. mandatory reporting of child, elder, or vulnerable adult abuse; danger to self or others; or I raise mental/emotional health as an issue in a legal proceeding).
5. I understand that if I am having suicidal or homicidal thoughts, actively experiencing psychotic symptoms, or experiencing a mental health crisis that cannot be resolved remotely, it may be determined that telemental health services are not appropriate, and that a higher level of care is required.
6. I understand that during a telemental health session, we could encounter technical difficulties resulting in service interruptions. If this occurs, I should end and restart the session. If I and my therapist are unable to reconnect within ten minutes, I should call my therapist to discuss the situation, since we may have to re-schedule.
7. I understand that my therapist may need to contact my emergency contact and/or appropriate authorities in case of an emergency (see Emergency Protocols below).

## Emergency Protocols

In case of an emergency, your therapist needs to know the following information:

1. Your location at the beginning of each session.
2. A person whom your therapist can contact on your behalf only in a life-threateningemergency. This person would only be contacted to go to your location or take you to the hospital in the event of an emergency.

By signing below, I agree to inform my therapist of the address where I am at the beginning of each session.

In case of an emergency, my location is:

_____

My emergency contact person's name, address, and phone number are:

_____

**By signing below, I indicate that I have read the information provided above and have discussed it with my therapist. I understand that the information contained in this form, and indicate that all of my questions have been answered to my satisfaction.**

_____ _____

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

_____ _____

**Signature of Therapist** **Date**

# Permission to Speak with Designated Person(s)

**Please note that this form is NOT a release for medical records.**

**Print Patient's Name:** _____

Please provide a list of all the parties we may speak with or leave a detailed message with regarding the patient's care, including health issues, HIV/Sexually Transmitted Diseases (STD) related records, appointment scheduling, or payment information. Use another form for additional parties.

**Please initial next to MEDICAL (MED), BEHAVIORAL HEALTH (BH), HIV/STD to allow permissions:**

**Emergency Contact (first and last name)**: _____

**Relationship to Patient**: _____ **Phone Number**: _____

Allowed to be given the following related information (please initial): **MED** _____ **BH** _____ **HIV/STD** _____

**Permission to speak to (first and last name)**: _____

**Relationship to Patient**: _____ **Phone Number**: _____

Allowed to be given the following related information (please initial): **MED** _____ **BH** _____ **HIV/STD** _____

**Permission to speak to (first and last name)**: _____

**Relationship to Patient**: _____ **Phone Number**: _____

Allowed to be given the following related information (please initial): **MED** _____ **BH** _____ **HIV/STD** _____

- **Signing below indicates that Cow Creek Health & Wellness staff are authorized to contact these individuals from the date of the signature below until the patient notifies staff otherwise.**
- **If they cannot contact you, may Cow Creek Health & Wellness staff leave a message on your answering machine or voice mail?** (please initial) Yes _____ No _____
- **Please verify YOUR phone number (s) for our records:** _____
- **May Cow Creek Health & Wellness contact you at work?** (please initial) Yes _____ No _____
- If you initialed yes, please list your work phone number: _____

By signing, I authorize the staff of Cow Creek Health & Wellness Center to speak with the above person(s) about my health and healthcare as indicated above. I understand that this permission shall remain in effect as indicated above or until I revoke it in writing.

**Printed name of patient or patient's legal representative** | **Relationship to patient**

**Signature of patient or legal representative** | **Date**

# Authorization to Release Protected Healthcare Information to Cow Creek Health and Wellness Center

**Patient Name:** _____ **Date of Birth:** _____

**Previous Names:** _____ **Social Security Number:** _____

_____ **Phone Number:** _____

**MINORS:** The signature of a patient between the ages of 15 and 17 is required to release any of that patient's PHI. The signature of a patient between the ages of 14 and 17 is required to release PHI related to mental illness or alcohol or drug use. The signature of any patient 17 or younger is needed to release PHI related to reproductive care (contraception or pregnancy) or the diagnosis or treatment of sexually transmitted infections.

**I request and authorize:** _____ _____
(Name of clinic sending information) (Fax number of clinic sending information)

**To release healthcare information about the above-mentioned patient to:**

**Name:** Cow Creek Health and Wellness Center

**Address:** 2589 NW Edenbower Blvd., Roseburg, OR 97471

**Phone:** (541) 672-8533 **Fax:** ❑ North Clinic (855) 670-1788 ❑ South Clinic (855) 670-1791

**Purpose:** ❑ Transfer of care ❑ Continuation of care
❑ Other: _____

**By initialing the spaces below, I specifically authorize the release of the following to Cow Creek Health and Wellness Center:**

_____ **All Records** (not including HIV/AIDS, Genetic testing, Reproductive care, Mental health diagnosis and treatment, SUD/drug/alcohol diagnosis, treatment or referral or sexually transmitted infections or diseases).

_____ **Initials Required** *on every line if any of the following records are being requested:*

_____ HIV/AIDS
_____ Genetic testing
_____ Reproductive care
_____ Mental health diagnosis and treatment
_____ SUD/drug/alcohol diagnosis, treatment, or referral
_____ Sexually transmitted infections or diseases

**OR only** the following *(please initial)*:

_____ Clinician office notes
_____ Laboratory reports
_____ Dental notes
_____ Diagnostic imaging reports
_____ Pathology reports
_____ Vaccine records
_____ Other (be specific) _____

**Please indicate how much and what kind of SUD information you are authorizing to be disclosed:**

_____ By initialing here, I specifically consent to the release of all of my SUD diagnosis, prognosis, treatment, and referral information.

_____ By initialling here, I wish to limit the release and disclosure of my SUD diagnosis, prognosis, treatment, and referral information to the following: _____

**Printed name of patient or patient's legal representative** **Relationship to patient**

**Signature of patient or legal representative** **Date**

# Behavioral Health Late Patient, Late Cancellation, and No-Show Policy

It is the policy of CCH&WC to offer accessible services. In order to do so, we need all clients to share in the responsibility of managing the appointments.

**Please be aware of the following concerning late patients, late cancellations, and no-shows:**

1. **Late**. If a patient is late up to 15 minutes, the clinic can try to accommodate the patient. However, the patient will be told that they may need to wait to be seen, or that the appointment may be brief. The patient is encouraged to call if they are going to be late. Calling will not guarantee an appointment. All late offenses will be documented in the patient's chart. Three consecutive late appointments in a one-year period of time will result in escalation to the provider for further action.
    a. The first offense will be waived, and the team will make every attempt to see the patient.
    b. After the second offense, office staff will talk with the patient and other direct team members to see or reschedule the patient.
    c. After the third offense, the appointment will be cancelled and rescheduled. If there is acute need, the patient will need to reschedule or go to the Emergency Room.
2. **Cancellation**. CCH&WC requests that patients give our clinic 24 hours notice in the event the appointment needs to be canceled or rescheduled. If transportation is a barrier, our clinic can offer a telemedicine visit using video technology, depending upon the purpose of the visit. The patient will be asked if they are interested in this option when calling to cancel. If the patient does not call our clinic to cancel/reschedule the appointment in the time allotted, the clinic will apply the following. Three consecutive cancelations without 24-hour notice in a one-year period of time will result in escalation to the provider for further action.
    a. The first offense will be waived.
    b. After the second offense, the patient will have to re-sign the agreement to abide by it.
    c. After the third offense, the provider and office staff will speak with the patient regarding the disruption of patient care, and the importance of cancelling with more than 24 hours notice.
3. **No-Show**. CCH&WC requests that patients call and cancel so that another patient can fill that appointment spot. If a patient fails to show up for a scheduled appointment, we will apply the following. Three consecutive no-shows in a one-year period of time will result in escalation to the provider for further action.
    a. First no-show. Office staff will call the patient to discuss the no-show and to reschedule. The PCC will document the no-show in the Electronic Health Record (EHR).
    b. Second no-show. Office staff will send a form letter within the EHR, and email the form letter to the patient using liquid files.
    c. Third no-show. Office staff will send a form letter within the EHR and email the form letter to the patient using liquid files. Office staff will then put an alert in the EHR notifying the office staff prior to making another appointment. Office staff will call and talk with the patient to discuss the history of no-shows and have the patient re-sign the policy and agree to abide by it.

*Behavioral Health and Substance Use Disorder patients may receive alternative communication from the clinic.

By signing below, I indicate that I have read and understood the Behavioral Health Late Patient, Late Cancellation, and No-Show Policy, and that I am in agreement with this policy:

**Printed name of patient or patient's legal representative** | **Relationship to patient**

**Signature of patient or legal representative** | **Date**

# Intake Questionnaire, Page 1

## Patient Information

**Date of Birth**: _____ **Health Record Number**: _____ **Medicaid Number**: _____

**Ethnicity**: _____ **Gender**: (circle one) M F Other

**Veteran**: (circle one) Yes No **Marital Status**: (circle one) Single Married Divorced Widowed

**Tribal Affiliation**: _____ **Highest Education Completed**: _____

**Employment Status**: (circle one) Full-Time Part-Time Retired/Disabled Student

**Patient Address**: _____

**County of Residence**: _____ **Zip Code**: _____

**Number of Children in Home**: _____ **Total Number of Dependents in Home**: _____

**Currently Pregnant?** (circle one) Yes No

## Financial Information

**Gross Yearly Household Income**: _____ **Source of Income**: _____

**Primary Health Insurance**: _____

**Source of Insurance**: _____

**County of Responsibility for Insurance**: _____

## Behavioral Information

**Tobacco Use**? (circle one) Yes No **Legal Status**: _____

**Number of Arrests in the Past Month**: _____ **Total Number of Arrests**: _____

**Number of DUI Arrests in the Past Month**: _____ **Total Number of DUI Arrests**: _____

**Attending School?** (Circle one) No Yes: _____

**Is Narcan Available at Home?** (circle one) Yes No

**Infectious Disease Risk Assessment**: (circle one)
Low to Moderate Moderate to High (no referral) Moderate to High (referral made)

**Improvement**: Attendance _____ Academics _____ Behavioral _____

**Diagnosis Codes**: _____

**Treatment Plan Indicator**: _____

**Substance Use in the Last 90 Days**: _____

# Intake Questionnaire, Page 2

## Behavioral Information, Continued

**Primary Substance**: _____

AFU: _____

Current Frequency of Use: _____

Usual Route: _____

**Secondary Substance**: _____

AFU: _____

Current Frequency of Use: _____

Usual Route: _____

**Tertiary Substance**: _____

AFU: _____

Current Frequency of Use: _____

Usual Route: _____

**Positive I-JDS Past Reporting 3 Months?** _____

**Frequency of Attendance in Self-Help Programs:** _____

**Medication Assisted TX:** _____

**Addiction Assessed LOC:** _____

**Current Addiction LOC:** _____

**Notes:**

# Patient Health Questionnaire (GAD-7)

**ID Number:** _____ **Date:** _____

**Over the past two weeks, how often have you been bothered by any of the following problems?** *(use a check mark to indicate your answer)*

| | Not at all | Several Days | More than half the days | Nearly every day |
|---|---|---|---|---|
| 1. Feeling nervous, anxious, or on edge | 0 | 1 | 2 | 3 |
| 2. Not being able to stop or control worrying | 0 | 1 | 2 | 3 |
| 3. Worrying too much about different things | 0 | 1 | 2 | 3 |
| 4. Trouble relaxing | 0 | 1 | 2 | 3 |
| 5. Being so restless that it is hard to sit still | 0 | 1 | 2 | 3 |
| 6. Becoming easily annoyed or irritable | 0 | 1 | 2 | 3 |
| 7. Feeling afraid, as if something awful might happen | 0 | 1 | 2 | 3 |

*(Healthcare professional: for interpretation of TOTAL, please refer to accompanying scoring card)*

Add columns: _____ + _____ + _____

TOTAL: _____

8. If you checked off any problems, how difficult have have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

Source: Primary Care Evaluation of Mental Disorders Patient Health Questionnaire (PRIME-MD-PHQ). The Pi-IQ was developed by Drs. Robert L. Spitzer, Janet B.W. Williams, Kurt Kroenke, and colleagues. For research information, contact Dr .Spitzer at ris8@columbia.edu. PRIME-MD@ is a trademark of Pfizer Inc. 

# PHQ-9 Modified for Adolescents (PHQ-A)

**Name:**_____ **Clinician:**_____ **Date:**_____

**Instructions:** How often have you been bothered by each of the following symptoms during the past **two weeks**? for each symptom, check the box beneath the answer that best describes how you have been feeling.

| | (0) Not at all | (1) Several days | (2) More than half the days | (3) Nearly every day |
|---|---|---|---|---|
| 1. Feeling down, depressed, irritable, or hopeless? | ☐ | ☐ | ☐ | ☐ |
| 2. Little interest or pleasure in doing things? | ☐ | ☐ | ☐ | ☐ |
| 3. Trouble falling asleep, staying asleep, or sleeping too much? | ☐ | ☐ | ☐ | ☐ |
| 4. Poor appetite, weight loss, or overeating? | ☐ | ☐ | ☐ | ☐ |
| 5. Feeling tired, or having little energy? | ☐ | ☐ | ☐ | ☐ |
| 6. Feeling bad about yourself, or feeling that you are a failure, or that you have let yourself or your family down? | ☐ | ☐ | ☐ | ☐ |
| 7. Trouble concentrating on things like school work, reading, or watching TV? | ☐ | ☐ | ☐ | ☐ |
| 8. Moving or speaking so slowly that other people could have noticed? Or the opposite: being so fidgety or restless that you were moving around a lot more than usual? | ☐ | ☐ | ☐ | ☐ |
| 9. Thoughts that you would be better off dead, or of hurting yourself in some way? | ☐ | ☐ | ☐ | ☐ |

| | |
|---|---|
| In the **past year**, have you felt depressed or sad most days, even if you felt okay sometimes? | Yes ☐ No ☐ |
| If you are experiencing any of the problems on this form, how **difficult** have these problems made it for you to do your work, take care of things at home, or get along with other people? | Not difficult at all ☐ Somewhat difficult ☐ Very difficult ☐ Extremely difficult ☐ |

| | |
|---|---|
| Has there been a time in the past month when you have had serious thoughts about ending your life? | Yes ☐ No ☐ |
| Have you EVER, in your WHOLE LIFE, tried to kill yourself or made a suicide attempt? | Yes ☐ No ☐ |

**If you have had thoughts that you would be better off dead or of hurting yourself in some way, please discuss this with your Health Care Clinician, go to a hospital or emergency room, or call 911.**

(Office Use Only) Severity Score: _____

Modified with permission from the PHQ (Spitzer, Williams & Kroenke, 1999) by J. Johnson (Johnson, 2002)