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

Requested Provider: _____

Social Security Number: _____ Patient's Preferred Name: _____

Patient's Legal First Name: _____ Middle Initial: _____

Patient's Legal Last Name: _____ Suffix: _____

Physical Address: _____

City: _____ State: _____ Zip Code: _____

Mailing Address: _____

City: _____ State: _____ Zip Code: _____

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 (please specify): _____

Are you enrolled in a Tribe? ❑ Yes ❑ No If yes, which Tribe? _____

Tribal Enrollment Number: _____ Are you a veteran? ❑ Yes ❑ No

Preferred Pharmacy: _____

Primary language: _____

Would you like an interpreter to help you overcome a language barrier? ❑ Yes ❑ No ❑ Sign Language

Please list the child's parents or legal guardians/representatives:

_____ _____
Parent/Legal Guardian/Representative's Name Phone Number

_____ _____
Parent/Legal Guardian/Representative's Name Phone Number

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:

_____

New Patient Youth Registration Form

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? _____

If you wish to share your financial information, you may qualify for a sliding fee scale for reduced cost services.

Houshold income: _____ ❑ Annual ❑ Monthly

Number of persons living in your household: _____

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: _____ **Previous Names:** _____

Date of Birth: _____ **Social Security Number:** _____ **Phone Number:** _____

MINORS: A minor patient's signature is required in order to release the following information: (1) conditions relating to the minor's reproductive care, including, but not limited to: contraception, pregnancy and pregnancy termination, sterilization, and sexually transmitted diseases (ages 14 and older); (2) alcohol and/or drug abuse (age 13 and older); and (3) mental health conditions (age 13 and older).

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

_____ **Entire Record** (does not include sensitive information not marked below)
OR only the following (please check):
❑ 2 years from the last date of service: _____
❑ 5 years from the last date of service: _____
❑ Only the period of events from _____ to _____
❑ Other (specify Billing, Labs, Imaging, etc.): _____

Initials Required ***(If you would like any of the following sensitive information disclosed)***

_____ Alcohol/Drug Abuse Treatment/Referral
_____ HIV/AIDS-Related Treatment
_____ Sexually-Transmitted Infections or Diseases
_____ Reproductive Care
_____ Psychotherapy Notes ONLY (By initialing this line, I am waiving any psychotherapist-patient privilege)
_____ Mental Health (Other than psychotherapy notes)

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:

Expiration and Revocation

This authorization will expire (complete one):

- On date: _____
- On occurrence of the following event:

If no expiration date, event, or condition is listed, this consent form will expire **one year** from the date it is signed.

I understand that I may revoke this authorization IN WRITING at any time. If I revoke my authorization, the information described above may no longer be used or disclosed for the purposes described in this written authorization. The only exception is when a covered entity has taken action in reliance on the authorization was obtained as a condition of obtaining insurance coverage.

I understand that information disclosed by this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the HIPAA Privacy Rule.

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**

Patient Rights and Responsibilities

Purpose:

Cow Creek Health & Wellness Center's (CCH&WC) "Patient's Rights & Responsibilities" document reflects the legal rights you have as a patient, as well as your responsibilities and participation in your services and care. As a patient centered medical home in Oregon, we commit to empowering you and informing you. Here's what you need to know at the start of our care relationship.

Clinic Hours and Access

Our hours of business are Monday through Friday from 7:30 AM to 5:00 PM. During business hours we can be reached at (541) 672-8533 (North Clinic), or (541) 839-1345 (South Clinic). Our after-hours nursing line can be reached by calling the main numbers for either clinic.

Voicemails left with our reception staff will be returned within 24 hours. Questions for your provider will be returned within 48 hours or may require a visit with your provider. We request that you call the pharmacy 72 hours before your prescription is due for our team to process the refill.

If you need a language translator, large print, or information in another format, call us at 541-839-1345 and our care team will gladly assist.

Expectations for Patients, Families, and Caregivers

- Please arrive on time for your appointments and bring with you an up-to-date medication list or bring your medications with you to each and every appointment.
- Participate actively in your medical decision making and make us aware of any updates to your health status. If you have questions, please ask us!
- Indicate to your care team who you would like to have access to your healthcare information and have them sign a release of information.
- Respect clinic procedures, staff and other patients.
- Let us know of any demographic changes including changes to your: home address, telephone number, cell phone number and emergency contacts.

Clinic Policies and Procedures

Cancellations: Please notify our team 24 hours prior to any appointment cancellations. When calling to cancel an appointment our team will try to accommodate you with a telehealth appointment when appropriate.

Late Arrivals: A patient arriving up to 15 minutes late may have an abbreviated appointment or be requested to be rescheduled. If you are going to be late, please call our office ahead of time.

No Shows: If a patient doesn't show for an appointment they will be called to reschedule, and a letter will be sent out and this will be documented in the patient's chart. After a second no-show a letter will be sent out requesting the patient work with our care management team to identify barriers and to ensure they understand the seriousness of no-show appointments. A third no-show by a patient may impact the patient with scheduling restrictions.

Update Insurance: Provide us with an updated insurance card at the time of your visit.

Payment: Ensure your financial obligations are met and if you need to set up a payment plan, coordinate this with our team. Don't hesitate to ask us about our sliding fee scale.

No Weapons: We are a weapon-free campus, please do not bring any form of weapon into the clinic or on your person at any time.

Patient Rights and Responsibilities, Continued

Health Care Team Roles

Your care team consists of a primary care provider, nursing staff, laboratory staff, behavioral health providers, medical assistants and auxiliary staff who collaborate as a team to meet your care needs.

Your primary care provider manages both your chronic and acute care needs. They order laboratory tests and schedule specialty consults when indicated. These can include behavioral health appointments, appointments with our dietetic team and much more.

Our nursing staff ensures the quality of your health by assisting with triage and acute care needs as well as providing education on disease processes, medications, wound care, and other homecare routines.

Our medical assistants make sure you are up to date on your vaccines and screenings, ensure your questions are answered by the provider expediently, and prepare your medications for refills by the provider. Our medical assistants also coordinate with our support staff for status updates on referrals and prior authorizations.

Patient Rights: You have the right to:

- Participate in your healthcare decisions.
- Have informed consent for their care. Including informed consent to medical, mental health, substance use treatment and to refuse treatment as an adult or for a minor that has not reached legal age of consent. We follow consent policies that track the Oregon consent laws for medical and dental (ORS 109-640) mental health, drug or alcohol treatment (ORS 109-675) family planning, sexual or reproductive health (ORS 109-640) A detailed review of the Oregon laws can be found at: Understanding minor consent and confidentiality in health care in Oregon.
- Have confidentiality of your medical records.
- To receive care with dignity and respect without discrimination.
- Receive feedback on any grievance or complaint in a timely manner.
- To never face reprisal for making a complaint or voicing a grievance.
- Have your confidentiality protected by applicable Federal HIPAA policy and guidelines.
- Transfer your care upon request. Releasing your information to your new provider upon the signing of the release of information.
- Inspect your medical record in accordance with applicable rules that track Oregon law (ORS 179.505).
- The right to consent to your medical record disclosures in whole or part.
- Receive detailed information about services rendered and charges for care.
- Have access to care based upon CCH&WC service abilities and eligibility standards.
- Be informed of suicide risk and receive counseling and safety planning with your care team should the need arise.
- Consent for treatment along with a service and support plan will be updated and agreed to with the patient and/or their caregiver, parent or guardian.
- To be notified of transfers of care unless by doing so would pose a threat to your health and safety.
- CCH&WC does not use seclusion and restraint for any patients or clients they serve.
- Patients' rights and responsibilities are posted within our clinics, and you may request a copy at any time.

Patient Rights and Responsibilities, Continued

Complaints and Grievance Process

You may file a complaint or grievance at any time electronically, verbally, by phone or by mail. Grievances and complaints are processed by our Health Operations Administrator and reviewed by our leadership team. You will receive a response from the Health Operations Administrator within 72 business hours of filing a complaint that the complaint has been received and notified in writing of a resolution within 30 days of the complaint. You will never be penalized or retaliated against due to filing a complaint.

Financial Responsibility Acknowledgement

I acknowledge that I am financially responsible for all charges incurred for services provided by Cow Creek Health and Wellness Center (CCHWC) including those not covered by my insurance, Medicare, or any third-party payor. I understand that co-pays, deductibles, and any non-covered services are my responsibility and are due at the time of service unless otherwise arranged.

If it becomes necessary to pursue collections for any unpaid balance, I agree to pay all costs associated with collection efforts, including but not limited to collection agency fees, court costs, and reasonable attorney fees.

I authorize CCHWC to release information necessary to process my claims and secure payment form insurance companies, Medicare, or other responsible third parties. I acknowledge that CCHWC is governed by, and construed in accordance with, the laws of the Cow Creek Band of Umpqua Tribe of Indians ("Tribe") regardless of the laws that might otherwise govern under applicable principles of conflicts of laws thereof. I understand and agree that services provided by CCHWC establishes a consensual relationship between the parties for purposes of the Tribe's Tribal Court (the "Tribal Court") jurisdiction. I agree that the Tribal Court shall authority to resolve any dispute arising out of or relating to services provided by CCHWC. Services provided by CCHWC in no way waive or shall be interpreted as waiving the sovereign immunity of CCHWC, the Tribe or any party or third party. Providing services shall in no way expose or be interpreted as exposing CCHWC to the regulatory authority of any other tribal or state government, and references to local, state and/or federal laws and regulations as standards governing CCHWC's work shall in no way, and for no purpose, be interpreted as a waiver of CCHWC's or the Tribe's sovereign immunity.

CCHWC does not keep cash on hand to make change. Cash will still be accepted, but not to make change. If cash is your only option, overpayment will be accepted and applied to future balances on your account.

By signing below, I acknowledge the receipt of the Patient Rights and Responsibility Policy and agree to the terms and conditions set forth by said 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. Copyright© 1999 Pfizer Inc. All rights reserved. Reproduced with permission.

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)

Email Communication Authorization and Acknowledgement Form, Page 1

If you are submitting the New Patient Registration Packet or Annual Patient Update Form by email to patientintake@cowcreek-nsn.gov, this form must be submitted along with them for processing.

If you are not submitting your forms by email, you do not need to fill out this form.

Once intake is complete, a receptionist will contact you to schedule your new patient appointment.

Patient's Name: _____ **Date:** _____

Patient's Email Address: _____

By signing this form, I authorize Cow Creek Health & Wellness Center (CCH&WC) to receive my completed patient packet (registration and administrative forms that may contain protected health information [PHI]) via email for patient registration and administrative purposes only.

I understand that:

- Email communication is patient-initiated and not a secure method of transmitting PHI.
- CCH&WC offers more secure communication options, including the patient portal.
- CCH&WC will not send or respond with PHI via email.
- Any follow-up communication will occur by phone or in person.
- If you require immediate assistance or have serious or worsening condition, you should not rely on email. Instead, you should call CCH&WC for an appointment or take other measures as appropriate.

Acknowledgement of Email Risks:

- I understand and acknowledge the following risks associated with the electronic transfer of my health information via email communication:
- Email communication may not be secure, and there is a risk that my health information could be intercepted, accessed, or disclosed by unauthorized individuals. CCH&WC and its staff are not responsible for any unauthorized disclosure of my health information.
- Emails may be delivered to the wrong recipient if an incorrect email address is used.
- Standard email is not encrypted and may be intercepted during transmission.
- Emails may be stored on servers outside the control of CCH&WC.
- Once sent, CCH&WC cannot guarantee the privacy or security of the email.
- Even after the deletion of an email, back-up copies may exist on a computer.

Email Communication Authorization and Acknowledgement Form, Page 2

By signing this form, I authorize Cow Creek Health & Wellness Center (CCH&WC) to receive my completed patient packet (registration and administrative forms that may contain protected health information [PHI]) via email for patient registration and administrative purposes only.

Patient Acknowledgement: (Please initial next to each item below)

_____I understand the risks of using email and choose to proceed.

_____I understand this authorization applies only to emails I send to CCH&WC.

_____I understand I may revoke this authorization at any time by submitting a written request.

_____I understand CCH&WC encourages encryption of any email containing PHI.

_____I will notify CCH&WC immediately of any changes to my email address.

_____I will NOT use email for urgent or time-sensitive matters and will call CCH&WC instead.

_____I agree to hold CCH&WC harmless for any unauthorized use, disclosure, or access of my protected health information that may occur during, or as a result of, electronic transmission.

Duration of Authorization

This authorization remains in effect until revoked in writing. Revocation does not apply to information already received by CCH&WC prior to the revocation.

By signing below, I acknowledge that I have read and understand this authorization and the associated risks. I voluntarily consent to the disclosure of my health information as described above.

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

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