CENTER FOR BEHAVIORAL HEALTH, LLC

All information on this form is strictly confidential

PATIENT INFORMATION

Patient's last name:			First:		M:
Social Security no.:	Birth date:	Sex: M ☐ F ☐	Marital status : S ☐ Marr☐ Div☐ Wid☐ Non-married committed relationship ☐		
Street address:			City:	State:	ZIP:
May we contact you through this method:			Occupation:		
Home phone no.: ( )		Y ☐ N☐			
Cell phone no: ( )		Y ☐ N☐	Employer:		
Email Address:		Y ☐ N☐	Work phone no: ( ) ☐ May we call/leave a message on this phone: Y ☐ N☐		
PCP:			**Referral Source:**		

IN CASE OF EMERGENCY

Name of local friend or relative:	Relationship to patient:	Contact phone no.: ( )

FINANCIAL RESPONSIBLE PARTY

Name of Financial Responsible Party:	Relationship to patient:	Contact phone no.: ( )

INSURANCE INFORMATION

PRIMARY Insurance Company Information

Primary Insurance Company Name:		Identification No:		Group No:
Patient's relationship to subscriber:	☐ Self	☐ ***Spouse***	☐ ***Child***	☐ ***Other***

IF SUBSCRIBER IS OTHER THAN PATIENT:

Subscriber Name:	Subscriber's S.S. no.:	Birth date:	Sex:	Relationship:

Assignment of Benefits. I authorize my insurance benefits be paid directly to Center for Behavioral Health, LLC. I understand that I am financially responsible for any balance.

Release of Information. I also authorize Center for Behavioral Health, LLC to release any information required to process my claims as allowed by Law.

The above information is true to the best of my knowledge.

Signature *Date*

CENTER FOR BEHAVIORAL HEALTH, LLC

PATIENT NAME: **DOB**

List the problems for which you wish to be seen today:	What are your goals for treatment?
•	•
•	•
•	•

PSYCHIATRIC HISTORY

Do you have a history of mental health problems or hospitalizations? Y ☐ N☐ (If no, skip to the next question)

Diagnosis:	Dates Treated:	By Whom:
Diagnosis:	Dates Treated:	By Whom:
Diagnosis:	Dates Treated:	By Whom:

Are you currently receiving professional counseling or any kind of psychotherapy? Y ☐ N☐ (If no, skip to the next question)

If yes, by whom: Phone:

Trauma History: *Do you have a history of trauma from childhood abuse, military combat, workplace trauma, domestic violence, rape, or medical trauma?* Y ☐ N☐

If yes, please explain:

Suicide Risk Assessment *Have you ever had feelings so bad that you have had thoughts that you didn't want to go on, or that you might want to kill yourself?* Y ☐ N☐ **(If no, please skip to next section)**

Is this unhappy feeling so strong you ever wish you were dead? Y ☐ N☐ *Have you planned a time for this?* Y ☐ N☐

Have you ever thought about how you would kill yourself ? Y ☐ N☐ *Is the method you would use readily available?* Y ☐ N☐

Have you ever tried to kill or harm yourself before? Y ☐ N☐ *Did things change because of these attempts?* Y ☐ N☐

Has anything happened recently to make you feel like this?	How often have you had these thoughts?
On a scale of 1 to 10, how strong is your desire to kill yourself?	What would it take to move you one point down the scale?
Is there anything that would stop you from killing yourself?	If you could look into the future, what do you feel you could look forward to?

Family History: *Has any one in your family been diagnosed with or treated for: check all that apply):*

☐ Anxiety	If so, which family member:	☐ Post-traumatic stress	If so, which family member:
☐ Alcohol abuse	If so, which family member:	☐ Schizophrenia	If so, which family member:
☐ Bipolar disorder	If so, which family member:	☐ Suicide	If so, which family member:
☐ Depression	If so, which family member:	☐ Substance abuse	If so, which family member:

Has any family member been treated with a psychiatric medication? Y ☐ N☐

If yes, what medications? How effective were they?

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PATIENT NAME: **DOB:**

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? Y ☐ N☐ (If no, skip to the next question)

What Substances:	
Where were you treated?	When?
How many alcoholic drinks do you consume each week?	*In the past three months, what is the largest amount of alcoholic drinks you have consumed in one day?*
Have you used any street drugs in the past 3 months? Y ☐ N☐ (If no, skip to the next question)	Which ones?

Have you ever felt you ought to cut down on your drinking or drug use?	Y ☐ N☐
Have people annoyed you by criticizing your drinking or drug use?	Y ☐ N☐
Have you ever felt bad or guilty about your drinking or drug use?	Y ☐ N☐
Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover?	Y ☐ N☐
Do you think you may have a problem with alcohol or drug use?	Y ☐ N☐

Check if you have ever tried the following:

☐ Methamphetamine	Last use:	☐ Methadone	Last use:	☐ Marijuana	Last use:
☐ Pain killers (not prescribed)	Last use:	☐ Cocaine	Last use:	☐ Alcohol	Last use:
☐ LSD /Hallucinogens	Last use:	☐ Ecstasy	Last use:	☐ Stimulants (pills)	Last use:
☐Tranquilizer/sleeping pills	Last use:	Other:		Date of Last use:	

MEDICAL HISTORY

Allergies:

Do you wear? (check all that apply):
☐ *Glasses* ☐ *Contact Lenses* ☐ *Hearing Aid(s)*

Are you ? (check all that apply):
☐ *Blind* ☐ *Deaf* ☐ *Hard of Hearing*

Name of your Primary Care Provider: ***Phone No:***

Date of Last Physical Exam:	*Have you ever had an EKG?* N☐ Y ☐ Date:
Current prescription medications and how often you take them: ***(if none, write none)***	*Current over-the-counter medications or supplements*

Current medical issues/concerns:

Do you have any significant ambulatory or sensory issues? (If so, please describe)

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PATIENT NAME: **DOB:**

Past medical hospitalizations/surgeries:

Dates:	Hospital:	Reason:
Dates:	Hospital:	Reason:
Dates:	Hospital:	Reason:

Advanced Directive *Do you have an Advanced Directive?*

☐ **Yes.** ***Please provide a copy for your chart*** ☐ **No** ***If you are interested in completing an Advanced Directive, please request a form from the Front Office.***

Tobacco History

Do you Smoke Cigarettes: Y ☐ N☐ How many per day on average? For how many years?

In the Past: : Y ☐ N☐ *When did you quit?*

Pipe, cigars, or chewing tobacco? Y ☐ N☐ How many per day on average? *In the Past: :* Y ☐ N☐

For Women Only:

Date of Last Period: Birth control method

Are you currently pregnant or do you think you might be pregnant? Y ☐ N☐ Are you planning to get pregnant in the near future? Y ☐ N☐

SOCIAL HISTORY

Education

Indicate highest grade completed: College: ☐ Yes: _____years ☐ No

Occupational training, technical or vocational school: ☐ Yes ☐ No

Marital History and Current Family:

How would you identify your sexual orientation: straight/heterosexual ☐ lesbian/gay/homosexual ☐ bisexual ☐ transexual ☐

Do you have concerns related to your sexual orientation? Y ☐ N☐

Are you currently dating, sexually active, or in a relationship(s)? Y ☐ N☐	*What is your significant other's occupation?*

Describe your relationship with your spouse or significant other:

Have you had any prior marriages? Y ☐ N☐	*If so, how many?*	*For how long?*

Do you have any children? Y ☐ N☐	*Ages:*

Describe your relationship with your children:

CENTER FOR BEHAVIORAL HEALTH, LLC

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

State and Federal laws require us to maintain the privacy of your health information and to inform you about our privacy practices by providing you with this Notice. We must follow the privacy practices as described below. It is our right to change our privacy practices provided law permits the changes. Before we make a significant change, this Notice will be amended to reflect the changes and we will make the new Notice available upon request. We reserve the right to make any changes in our privacy practices and the new terms of our Notice effective for all health information maintained, created and/or received by us before the date changes were made.

TYPICAL USES AND DISCLOSURES OF HEALTH INFORMATION

We will keep your health information confidential, using it only for the following purposes:

- **Treatment:** We may use your health information to provide you with our professional services. We have established "minimum necessary or need to know" standards that limit various staff members' access to your health information according to their primary job functions. Everyone on our staff is required to sign a confidentiality statement.
- **Disclosure:** We may disclose and/or share your healthcare information with other health care professionals who provide treatment and/or service to you. These professionals will have a privacy and confidentiality policy like this one. Health information about you may also be disclosed to your family, friends and/or other persons you choose to involve in your care, only if you agree that we may do so.
- **Payment:** We may use and disclose your health information to seek payment for services we provide to you. This disclosure involves our business office staff and may include insurance organizations or other businesses that may become involved in the process of mailing statements and/or collecting unpaid balances.
- **Emergencies:** We may use or disclose your health information to notify, or assist in the notification of a family member or anyone responsible for your care, in case of any emergency involving your care, your location, your general condition or death. If at all possible we will provide you with an opportunity to object to this use or disclosure. Under emergency conditions or if you are incapacitated we will use our professional judgment to disclose only that information directly relevant to your care. We will also use our professional judgment to make reasonable inferences of your best interest by allowing someone to pick up filled prescriptions, x-rays or other similar forms of health information and/or supplies unless you have advised us otherwise.
- **Healthcare Operations:** We will use and disclose your health information to keep our practice operable. Examples of personnel who may have access to this information include, but are not limited to, our medical records staff, outside health or management reviewers and individuals performing similar activities.
- **Required by Law**: We may use or disclose your health information when we are required to do so by law. (Court or administrative orders, subpoena, discovery request or other lawful process.) We will use and disclose your information when requested by national security, intelligence and other State and Federal officials and/or if you are an inmate or otherwise under the custody of law enforcement.
- **Abuse or Neglect:** We may disclose your health information to appropriate authorities if we reasonably believe that you are a possible victim of abuse, neglect, or domestic violence or the possible victim of other crimes. This information will be disclosed only to the extent necessary to prevent a serious threat to your health or safety or that of others.
- **Public Health Responsibilities:** We will disclose your health care information to report problems with products, reactions to medications, product recalls, disease/infection exposure and to prevent and control disease, injury and/or disability.
- **Marketing Health-Related Services:** We will not use your health information for marketing purposes unless we have your written authorization to do so.
- **National Security:** The health information of Armed Forces personnel may be disclosed to military authorities under certain circumstances. If the information is required for lawful intelligence, counterintelligence or other national security activities, we may disclose it to authorized federal officials.
- **Appointment Reminders:** We may use or disclose your health information to provide you with appointment reminders, including, but not limited to, voicemail messages, postcards or letters.

YOUR PRIVACY RIGHTS AS OUR PATIENT

- **Access:** Upon written request, you have the right to inspect and get copies of your health information (and that of an individual for whom you are a legal guardian.) There will be some limited exceptions. If you wish to examine your health information, you will need to complete and submit an appropriate request form. Contact the Office for a copy of the Request Form. You may also request access by sending us a letter to the address at the end of this Notice. Once approved, an appointment can be made to review your records. Copies, if requested, will be $ .75 for each page and the staff time charged will be $10.00 per hour including the time required to locate and copy your health information. If you want the copies mailed to you, postage will also be charged. If you prefer a summary or an explanation of your health information, we will provide it for a fee.
- **Amendment:** You have the right to amend your healthcare information, if you feel it is inaccurate or incomplete. Your request must be in writing and must include an explanation of why the information should be amended. Under certain circumstances, your request may be denied.
- **Non-routine Disclosures:** You have the right to receive a list of non-routine disclosures we have made of your health care information. (When we make a routine disclosure of your information to a professional for treatment and/or payment purposes, we do not keep a record of routine disclosures: therefore these are not available.) You have the right to a list of instances in which we, or our business associates, disclosed information for reasons *other than* treatment, payment or healthcare operations.
- **Restrictions:** You have the right to request that we place additional restrictions on our use or disclosure of your health information. We do not have to agree to these additional restrictions, but if we do, we will abide by our agreement. (Except in emergencies.) This request must be submitted in writing.

CENTER FOR BEHAVIORAL HEALTH, LLC

I (Printed Name)_____acknowledge that I received a copy of this NOTICE OF PRIVACY PRACTICES. I understand that I may request a copy of the Privacy Practices.

_____ _____
Signature Date

_____ _____ _____
Parent/Guardian Signature Printed Name Date

_____ _____ _____
Witness Printed Name Date

==========

APPOINTMENT REMINDER CONSENT

I Printed Name)_____

☐ give Center for Behavioral Health, LLC, PC and members of the staff working at the location my permission to notify me prior to an appointment to remind me of the appointment date and time.

I understand that this notification is a **courtesy** and any failure to reach me will not relieve me of any responsibility for any missed appointment charges.

I am fully aware that I am to provide a 48-hour notice prior to making changes to my appointment time. I understand that failure to provide that 48-hour notice will result in a $50 charge.

☐ **I prefer to receive an email confirmation at:** _____

☐ **I prefer to receive a text message confirmation at:** _____

☐ **I prefer to be called at:**_____.

The office may leave a message on (check all that apply):

□ Voicemail only □ Members sharing that phone number

□ do NOT give Center for Behavioral Health, LLC, PC and members of the staff working at the location my permission to call or email me prior to an appointment to remind me of the appointment date and time. I am fully aware that I am to provide a 48-hour notice prior to making changes to my appointment time. I understand that failure to provide that 48-hour notice will result in a $50 charge.

I understand that I may withdraw this consent at any time, either verbally or in writing except to the extent that action has been taken on reliance on it. This consent will last while I am being treated by Center for Behavioral Health, LLC, PC unless I withdraw my consent during treatment. This consent will expire one (1) year after I complete my treatment, unless notified by me.

_____ _____
Signature Date

_____ _____ _____
Parent/Guardian Signature Printed Name Date

_____ _____ _____
Witness Printed Name Date

CENTER FOR BEHAVIORAL HEALTH, LLC

Client Identified Recovery Issues

Date: Patient Name:

Do you have a problem with:			*Would you like help with this?*	
1. Cravings for alcohol?	☐ Yes	☐ No	☐ Yes	☐ No
2. Cravings for other drugs?	☐ Yes	☐ No	☐ Yes	☐ No
3. Improving your physical health?	☐ Yes	☐ No	☐ Yes	☐ No
4. Improving your eating habits?	☐ Yes	☐ No	☐ Yes	☐ No
5. Being able to speak clearly?	☐ Yes	☐ No	☐ Yes	☐ No
6. Your ability to sleep?	☐ Yes	☐ No	☐ Yes	☐ No
7. Learning how to relax?	☐ Yes	☐ No	☐ Yes	☐ No
8. Overcoming your dependence on alcohol	☐ Yes	☐ No	☐ Yes	☐ No
9. Overcoming your dependence on other drugs	☐ Yes	☐ No	☐ Yes	☐ No
10. Dealing with alcohol and/or drug abusing friends	☐ Yes	☐ No	☐ Yes	☐ No
11. Learning how to say "NO" to a drink when offered?	☐ Yes	☐ No	☐ Yes	☐ No
12. Avoiding a relapse?	☐ Yes	☐ No	☐ Yes	☐ No
13. Talking to non-alcoholics about your drinking?	☐ Yes	☐ No	☐ Yes	☐ No
14. Learning how to use 12-step recovery groups like Alcohol Anonymous?	☐ Yes	☐ No	☐ Yes	☐ No
15. Fitting in at 12-step recovery meetings like AA?	☐ Yes	☐ No	☐ Yes	☐ No
16. Finding a sponsor in the 12-step Program?	☐ Yes	☐ No	☐ Yes	☐ No
17. Being a parent?	☐ Yes	☐ No	☐ Yes	☐ No
18. Problem-solving with your children?	☐ Yes	☐ No	☐ Yes	☐ No
19. Obtaining greater satisfaction with your children?	☐ Yes	☐ No	☐ Yes	☐ No
20. Problem-solving with your parents?	☐ Yes	☐ No	☐ Yes	☐ No
21. Problem-solving with your spouse or significant other?	☐ Yes	☐ No	☐ Yes	☐ No
22. Expressing your feelings with your spouse?	☐ Yes	☐ No	☐ Yes	☐ No
23. Feeling comfortable in social settings?	☐ Yes	☐ No	☐ Yes	☐ No

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24. Having fun without alcohol or drugs?	☐ Yes	☐ No	☐ Yes	☐ No
25. Making friends?	☐ Yes	☐ No	☐ Yes	☐ No
26. Expressing your feelings to others?	☐ Yes	☐ No	☐ Yes	☐ No
27. Handling negative emotions?	☐ Yes	☐ No	☐ Yes	☐ No
28. Being less dependent on others?	☐ Yes	☐ No	☐ Yes	☐ No
29. Being more self-sufficient?	☐ Yes	☐ No	☐ Yes	☐ No
30. Handling your temper?	☐ Yes	☐ No	☐ Yes	☐ No
31. Dealing with your sexual expectations?	☐ Yes	☐ No	☐ Yes	☐ No
32. Dealing with depression?	☐ Yes	☐ No	☐ Yes	☐ No
33. Handling feelings of shame?	☐ Yes	☐ No	☐ Yes	☐ No
34. Handling feeling of guilt?	☐ Yes	☐ No	☐ Yes	☐ No
35. Dealing with thoughts of suicide?	☐ Yes	☐ No	☐ Yes	☐ No
36. Dealing with employment problems?	☐ Yes	☐ No	☐ Yes	☐ No
37. Getting ahead in your career?	☐ Yes	☐ No	☐ Yes	☐ No
38. Improving your educations skills	☐ Yes	☐ No	☐ Yes	☐ No
39. Spiritual beliefs?	☐ Yes	☐ No	☐ Yes	☐ No
40. Dealing with self-doubt?	☐ Yes	☐ No	☐ Yes	☐ No
41. Dealing with an alcohol/drug problem of one of your relatives?	☐ Yes	☐ No	☐ Yes	☐ No
42. Dealing with your family?	☐ Yes	☐ No	☐ Yes	☐ No
43. Dealing with physical abuse?	☐ Yes	☐ No	☐ Yes	☐ No
44. Dealing with sexual abuse?	☐ Yes	☐ No	☐ Yes	☐ No
45. Dealing with emotional abuse?	☐ Yes	☐ No	☐ Yes	☐ No
46. Other:	☐ Yes	☐ No	☐ Yes	☐ No

CENTER FOR BEHAVIORAL HEALTH, LLC

Treatment Input Form

Active participation and your direct involvement are vital in the development of your treatment plan. The purpose of this form is to collaborate with you to create a recovery-oriented treatment plan.

Name: DOB:

What I gained/stuck out most about myself and my addiction in previous treatment(s) was:

The high risk situations I am facing are

AREA 1

The first area that I want to work on is:

I hope to learn/achieve:

The steps I need to take are:

The timeframe to achieve these steps are

The people and the resources I need to accomplish this are (Consider information, time and cost.)

I will know that I have achieved my goal when:

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AREA 2

The second area that I want to work on is:

I hope to learn/achieve:

The steps I need to take are:

The timeframe to achieve these steps are

The people and the resources I need to accomplish this are (Consider information, time and cost.)

I will know that I have achieved my goal when:

AREA 3

The third area that I want to work on is:

I hope to learn/achieve:

The steps I need to take are:

The timeframe to achieve these steps are

The people and the resources I need to accomplish this are (Consider information, time and cost.)

I will know that I have achieved my goal when: