

# Bearden Behavioral Health New Patient Form

Full Name First: \_\_\_\_\_ Last: \_\_\_\_\_ Middle: \_\_\_\_\_

DOB: \_\_\_\_\_ SSN: \_\_\_\_\_ Male or Female \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Permanent Address: \_\_\_\_\_

Marital Status: \_\_\_\_\_

Phone #: \_\_\_\_\_ Alternate Phone #: \_\_\_\_\_

Email Address: \_\_\_\_\_ Employer: \_\_\_\_\_

Do you have access to a computer? Yes / No

May we contact you at the above phone numbers and email address?  Yes  No

May we leave a voice mail message at the above phone numbers?  Yes  No

May we leave a message with anyone besides you at the above numbers?  Yes  No

If yes, please list the name(s) of the individuals we may leave a message with:

## Emergency Contact: Please list who we may contact in case of emergency

Name: \_\_\_\_\_ Phone: \_\_\_\_\_

Relationship: \_\_\_\_\_ Address: \_\_\_\_\_

If under 18, legal guardian(s): \_\_\_\_\_

(If client is in custody of DCS- DCS is the emergency contact)

Self-Pay?  Yes  No

Self-Pay: \$150 for initial evaluation

Self-Pay: (Nurse Practitioner)

(Therapist) \$125 per follow-up session

\$185 for initial evaluation

Insurance?  Yes  No

\$85 for 30 min. follow-up

\$45 for 15 min. follow-up

Primary Insurance Company: \_\_\_\_\_

Insured/Policy Holder's Name, First: \_\_\_\_\_ Last: \_\_\_\_\_ Middle: \_\_\_\_\_

Insured/Policy Holder's DOB: \_\_\_\_\_ Insured/Policy Holder's SSN: \_\_\_\_\_

Insured/Policy Holder's Phone Number \_\_\_\_\_

ID / Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

Secondary Insurance Company: \_\_\_\_\_

Insured/Policy Holder's Name: \_\_\_\_\_

Insured/Policy Holder's DOB: \_\_\_\_\_ Insured/Policy Holder's SSN: \_\_\_\_\_

ID / Policy Number: \_\_\_\_\_ Group Number: \_\_\_\_\_

**BEARDEN BEHAVIORAL HEALTH NOTICE OF FINANCIAL INFORMATION:**

Appointments with each clinician of Bearden Behavioral Health are set by mutual agreement between the clinician and the client. Except for the Initial Evaluation, sessions last 45-50 minutes. **Clients must call to inform the office of appointment cancellations at least 24 hours in advance in order to avoid charges for missed sessions.**

Insurance co-pays/coinsurance/deductibles are due at the beginning of each session. All fees and copays **must** be paid at the time of the appointment. Should your insurance claim be denied, you are responsible for payment of your treatment including all deductibles and in- network and out-of-network co-insurances. **Payments for sessions should be made by cash or credit card (Visa, Discover, and MasterCard are accepted). Personal Checks will not be accepted.**

Any amount owed by a client will be sent a statement at the end of each month. Should payment or payment arrangements not be made within thirty (30) days of invoice date, all unpaid balances will be sent to a collection agency for non-payment. At this time, you understand and agree that the money owed to Bearden Behavioral Health will be collected by the collection agency plus a forty (40) percent collection fee.

Bearden Behavioral Health & our providers will complete forms, provide specialized records for clients to obtain or maintain disability income, work or school leave, FMLA, or for court or legal cases based on their individual clinical discretion. Bearden Behavioral Health and associates will not bill disability/worker's compensation insurance companies or client's attorneys, or get involved in disability or legal/court cases. Should any provider at Bearden Behavioral Health be subpoenaed or required to participate in any sort of legal matters (such as correspondence, consultations with attorneys, expert opinions, or creation of any documents which will be used for legal purposes), the client (not the insurance company) will be billed at a rate of \$350 per hour and a NON-REFUNDABLE minimum of two hours fee must be deposited one week prior to services. This is a per scheduled date fee and will be billed for each date the provider has to block their schedule for legal services. Any non-legal document preparation which provider agrees to complete will be billed at the rate of \$150 per document.

Medical Records will be provided when requested at a rate of \$20 for the first 5 pages and \$.50 per page after the first 5. If you request the records to be mailed you will also be responsible for postage. Please allow up to 30days for delivery.

Bearden Behavioral Health has no form of a sliding fee payment system. If you have a financial agreement prior to 01/01/18, it will be void effective 01/01/18.

**Bearden Behavioral Health & our providers are not able to accept some insurance plans; these include but are not limited to TennCare products.**

**If client is using health insurance to pay for sessions:**

I authorize the release of any medical or other information necessary to process insurance claims.

I authorize payment of medical benefits to the treatment professional for services provided to me.

\_\_\_\_\_  
Signature of Client or Parent/Guardian

\_\_\_\_\_  
Date

I acknowledge that I have read this notice of Office Information offered by Bearden Behavioral Health and Associates. I acknowledge that I may have a copy of this information sheet at any time upon request.

\_\_\_\_\_  
Printed Name of Client

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date

### ***Treatment Consent for Psychiatric Services at Bearden Behavioral Health***

**INITIAL EVALUATION & SESSIONS** Our providers generally conduct a thorough psychiatric evaluation during the initial session – which is typically scheduled for 60 minutes. This assessment focuses on determining the best treatment plan possible and is specific to each individual patient. It is extremely important for this initial assessment to be as comprehensive as possible. Therefore, please bring completed patient forms (under 'Forms' section of Bearden Behavioral Health website) to this appointment and make sure to provide information about previous providers, past psychiatric treatment, and medications you are currently taking as well as medications that you may have tried in the past. In some situations, extra sessions are needed to complete an appropriate evaluation. Additionally, collateral information (i.e., school reports, family reports, etc.) are often necessary for children and adolescents – and helpful for adult patients as well. These issues will be discussed during the initial session. Please remember that a comprehensive assessment is necessary regardless of the treatment modality (i.e., psychotherapy, psychiatric medications, or both) as it allows us to provide the best possible care. Additionally, we will mutually determine if the evaluating provider is the best fit for your individualized care.

**PRACTICE STATUS** Bearden Behavioral Health, is an integrated clinic of mental health providers. At any time, there may be several psychiatrists, psychologists, therapists, social workers, and other mental health professionals that work in this office suite. There also are other independent providers who sublease office space within the suite. While we share space and often provide collaborative care, each provider is responsible for providing care up to professional standards. All records are stored using an industry leading electronic health record called Therapy Notes. Your records should only be accessed by your current provider as well as covering providers. The office assistants also may, at times, have access to your record. Please note that it is our policy to always protect this information in accordance with all legal and ethical standards. Additionally, your provider here at Bearden Behavioral Health practices within a network of other professional colleagues (i.e., primary care doctors, other specialty physicians, psychologists, social workers, therapists, nutritionists, etc.) that we use as referrals for multidisciplinary care. If a referral is necessary, this will be discussed in session and your provider will work to collaborate with these professionals and coordinate your care. Please note, however, that although we attempt to identify top quality professionals with very high standards of care, we cannot be responsible for the services/treatment that they provide. It is always your responsibility to determine if a professional referral is acceptable, and alternative options will be considered.

**PSYCHOTHERAPY** is both a way of understanding human behavior and of helping people with their emotional difficulties and personal problems. Psychotherapy typically starts with an assessment of problematic symptoms and maladaptive behaviors that often intrude into a person's social life, personal relationships, school or work activities, and physical health. Specific psychotherapeutic strategies may be employed to alleviate specific problems causing distress such as depression, anxiety or relationship problems. Self-knowledge is seen as an important key to changing attitudes and behavior. Psychotherapy may involve the development of insight as to how our physical health may be compromised in many ways by emotional and relationship issues. Therapy is designed to help clients of all ages understand how their feelings and thoughts affect the ways they act, react, and relate to others. Whether or not therapy works depends a great deal on the client's willingness and ability to experience all relationships deeply, especially the therapeutic relationship. Each client has a unique opportunity to view themselves more accurately, and to make connections between past and current conflicts that illuminate the way one relates to one's self and to others. Clients are encouraged to talk about thoughts and feelings that arise in therapy, especially feelings toward the therapist. These feelings are important because elements of one's history of important affections and hostilities toward parents and siblings or significant others are often shifted onto the therapist and the process of therapy. Psychotherapy can be relatively short term (8 to 16 weeks) when the focus is limited to resolve specific symptoms or problem areas, or longer term if the treatment focus targets more pervasive or long-standing difficulties. When the client feels she or he has accomplished the desired goals, then a termination date can be set. Psychotherapy aims to help people experience life more deeply, enjoy more satisfying relationships, resolve personal conflicts, and better integrate all the parts of their personalities. Initials \_\_\_\_\_

**MEDICATION MANAGEMENT** Psychiatric medications can be used in conjunction with psychotherapy to treat many conditions. It is important to find the best combination of medications and therapy for each individual case. Our providers can provide an integrated approach as they are trained to administer both psychiatric medications and psychotherapy. However, in some situations, it may be appropriate to consider merely managing your psychiatric medications and sharing the psychotherapy with an alternative provider. Often called the 'split treatment' model, this should be discussed in order to determine if it would be a viable option for you. We can help find the best provider for you whether at Bearden Behavioral Health or another provider in the community. In situations that warrant the use of medications, it is imperative for you to

understand the target symptoms and likely outcomes. Additionally, since all medications have the potential for side effects, your provider will always discuss the risks, benefits, side effects, government warnings, and alternative treatments (which always includes not using medications) with you. Initials \_\_\_\_\_

**PROFESSIONAL RECORDS** Both law and professional standards protect mental health records. Although you are entitled to review a copy, these records can be misinterpreted given their professional nature. In rare cases when it is deemed potentially damaging to provide you with the full records directly, they are available to an appropriate mental health professional of your choice. Alternatively, we can review them together and/or treatment summaries can be provided. Please note that professional fees will be charged for any preparation time required to comply with such requests.

**CONFIDENTIALITY** is a cornerstone of mental health treatment and is protected by the law. Aside from emergency situations, information can only be released about your care with your written permission. If insurance reimbursement is pursued, insurance companies also often require information about diagnosis, treatment, and other important information (as described above) as a condition of your insurance coverage. Several exceptions to confidentiality do exist that actually require disclosure by law: (1) danger to self – if there is threat to harm yourself, we are required to seek hospitalization for the client, or to contact family members or others who can help provide protection; (2) danger to others – if there is threat of serious bodily harm to others, we are required to take protective actions, which may include notifying the potential victim, notifying the police, or seeking appropriate hospitalization; (3) suspicion of child, elder, or dependent abuse – if there is an indication of abuse to a child, an elderly person, or a disabled person; even if it is about a party other than yourself, we must file a report with the appropriate state agency; (4) certain judicial proceedings – if you are involved in judicial proceedings, you have the right to prevent us from providing any information about your treatment. However, in some circumstances in which your emotional condition is an important element, a judge may require testimony through a court order. Although these situations can be rare, we will make every effort to discuss the proceedings accordingly. We also reserve the right to consult with other professionals when appropriate. In these circumstances, your identity will not be revealed and only important clinical information will be discussed. Please note that such consultants are also legally bound to keep this information confidential.

**EMERGENCIES:**

You may telephone or arrange for telepsych services with your therapist in an emergency. Your therapist is not always immediately available by phone and may not be available in the evening. If unavailable, your call will be returned as soon as possible. If your therapist is unavailable, or you have an emergency, you should call 911; telephone a crisis line; or proceed to a psychiatric emergency facility. **For emergencies/crisis team services call mobile crisis at 865-539-2409.**

**ARBITRATION/MEDIATION:**

I agree to address any grievances I may have directly with my therapist immediately. If we cannot settle the matter between us, then a jointly agreed-upon outside consultation will be sought. If not, an arbitration process will be initiated, which will be considered as a complete resolution and legally binding decision under state law. By signing this contract you are agreeing to have any issue of medical or psychological malpractice decided by neutral arbitration and you are giving up your right to a jury or court trial. It is understood that any dispute as to medical malpractice, that is as to whether any medical series rendered under this contract were unnecessary or unauthorized or were improperly rendered, will be determined by submission to arbitration as provided by Tennessee law and in accordance with the rules of the American Arbitration Association, and not by lawsuit or resort to court process except as Tennessee law provides for judicial review or arbitration proceedings. Both parties to this contract, by entering into it, are giving up their constitutional right to have any such dispute decided in a court of law before a jury, and instead are accepting the use of arbitration. Any arbitration process will be considered as a complete resolution and legally binding decision. The client will be responsible for the costs of this process. In agreeing to treatment, you are consenting to the above identified grievance procedures

I understand that I may end mental health services with Bearden Behavioral Health at any time of my choosing.

Your signature below indicates that you have read the Treatment Consent Form which contains information on psychiatric services, sessions, professional records, confidentiality, and practice status, and you agree to abide by its terms during our professional relationship.

Name of patient (print): \_\_\_\_\_ Signature of patient: \_\_\_\_\_

Name of legal guardian (print): \_\_\_\_\_

\*(Only if patient is under 18 or a Dependent Adult)

Signature of patient or guardian:

Date: \_\_\_\_\_

**BEARDEN BEHAVIORAL HEALTH AND ASSOCIATES**  
**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 IT CAREFULLY**

This office is required by applicable federal and state law to maintain the privacy of your health information. We are also required to give you this Notice about the privacy practices, legal obligations, and your rights concerning your health information ("Protected Health Information" or "PHI." This office will follow the privacy practices that are described in this Notice (which may be amended from time to time).

This office has a copy of the Notice of Privacy Practices which is available for viewing and will be given to you upon request.

I acknowledge that I have been made aware of the Notice of Privacy Practices offered by Bearden Behavioral Health.

I acknowledge that I may have a copy of the Notice at any time upon request.

\_\_\_\_\_  
Name of Client

\_\_\_\_\_  
Signature of Client

\_\_\_\_\_  
Date



## Credit Card Pre-Authorization Form

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Patient DOB: \_\_\_\_\_

Patient Address: \_\_\_\_\_

The undersigned Patient/Cardholder hereby authorizes Bearden Behavioral Health, to obtain payment of fees for services from the Patient/Cardholder's Credit Card account identified below. Bearden Behavioral Health may charge the account for missed appointments (*minimum of 24 hours cancellation notice is required*), without requirement of the Patient/Cardholder's signature for each payment. A receipt of the transaction will be mailed to the address provided by the Patient/Cardholder above.

**By signing this form, the Patient/Cardholder acknowledges and agrees as follows:**

- *This signed form is confidential and will be kept on file at Bearden Behavioral Health.*
- *The Patient/Cardholder authorizes Bearden Behavioral Health to automatically charge the below-referenced Credit Card any remaining balance on the above-named patient's account (including copays, co-insurances, deductibles or missed appointment fees).*
- *The Patient/Cardholder certifies, warrants and represents that the Cardholder named above agrees to pay the credit charge(s) in accordance with the agreement described above.*
- *Credit Card payments will appear on your statement as Bearden Behavioral Health.*
- *If the Patient/Cardholder fails to dispute a charge within 30 days from the time the Credit Card is charged, the Patient/Cardholder agrees that the charges are valid and agrees not to dispute said charges.*
- *This authorization will remain valid for 12 months and will automatically renew on an annual basis, unless revoked in writing with 30 day notice of revocation.*
- *This authorization serves as agreement for receipts to be noted "signature on file" when charged.*

PLEASE CIRCLE ONE:    Visa    MasterCard    Discover

Name on Card: \_\_\_\_\_

Credit Card #: \_\_\_\_\_

CVV Number: (3-digits on back of card): \_\_\_\_\_

Expiration Date: (Month/Year): \_\_\_\_\_

Billing address for Card: \_\_\_\_\_

Printed Name of Authorized Signer: \_\_\_\_\_

Patient/Cardholder Authorized Signature: \_\_\_\_\_



## MISSED APPOINTMENT POLICY

In an effort to provide all of our patients with quality care in a timely manner, Bearden Behavioral Health has implemented a missed appointment policy.

Failure to show for a scheduled appointment, or **notify our office of cancellation at least 24 hours prior to your appointment time**, will result in a \$50 missed appointment fee. This fee will be directly charged to a credit card that we will keep on file. We will send you a receipt notifying you immediately of the missed appointment charge. If you decline to provide a credit card upfront and incur a \$50 missed appointment fee, we will mail you an invoice with a 10% surcharge resulting in a \$55 charge. All remaining appointments will be cancelled and you will not be rescheduled until the \$55 fee has been paid in full or payment arrangements have been made. **\*Please fill out the attached Credit Card Authorization Form.**

Our missed appointment policy enables us to better utilize available appointment time for all of our patients who are in need of care. Thank you for your consideration of this policy. We are honored that you have chosen Bearden Behavioral Health as your provider.

In order to be respectful of the needs of other patients, please be courteous and call our office if you are unable to keep your scheduled appointment. This will allow us to reallocate this appointment time to another patient in need of care. Please provide us with a minimum of 24 hours' notice should you need to cancel or reschedule. To cancel or reschedule an appointment please call our office at (865) 212-6600. We understand that occasionally we are busy and you are connected to our voicemail. **If you are trying to cancel by phone and reach our voicemail, please leave your full name and the time of your appointment in order to cancel. Please note if you do reach our voicemail and you choose not to leave a message and fail to notify us of cancellation, this will also result in a missed appointment charge.**

### Financial Statement:

Any amount owed by a client at the end of the month will be sent in an invoice at the end of the month. Should payment or payment arrangements not be made within **30 days** of the invoice date, any unpaid balance will be sent to a collection agency for non-payment. At this point, you understand and agree that the money owed to Bearden Behavioral Health will be collected by the collection agency plus a 40% collection fee.

- I accept this policy and will sign the credit card authorization form.  
 I accept this policy and decline to sign the credit card authorization form.

Patient Name \_\_\_\_\_ Date: \_\_\_\_\_

Guardian Name (if applicable): \_\_\_\_\_

Patient/Guardian Signature: \_\_\_\_\_



CONSENT FOR TRANSMISSION OF PROTECTED HEALTH INFORMATION BY NON-SECURE MEANS

I, \_\_\_\_\_ AUTHORIZE: **Bearden Behavioral Health**  
(name of client)

TO TRANSMIT THE FOLLOWING PROTECTED HEALTH INFORMATION RELATED TO MY HEALTH RECORDS AND HEALTH CARE TREATMENT:

- Information related to the scheduling of appointments (this may include support staff for clinician)
- Information related to billing and payment (this may include support staff for clinician)
- Completed forms, including forms that may contain sensitive, confidential information (this may include support staff for clinician)
- Information of a therapeutic or clinical nature, including discussion of personal material relevant to my treatment
- My health record, in part or in whole, or summaries of material from my health record

BY THE FOLLOWING NON-SECURE MEDIA: Unsecured email.

Bearden Behavioral Health takes all security measures required to protect the confidentiality of our client's protected health information. However, Bearden Behavioral Health is unable to control outside email servers and is therefore unable to safeguard these transmissions completely. We must inform all clients who prefer to communicate with their clinician this way at any time, that there may be some level of risk that the information in the email could be read by a third party. Patient agrees to hold harmless Bearden Behavioral Health for any information loss due to a technical failure.

TERMINATION

This authorization will terminate 12 months after the last day patient received treatment in our office.

I have been informed of the risks, including but not limited to my confidentiality in treatment, of transmitting my protected health information by unsecured means.

I understand that:

I am not required to sign this agreement in order to receive treatment.

I may terminate this authorization at any time.

It is the providers discretion to determine if an email is to become part of my electronic medical record.

\_\_\_\_\_  
(Signature of client or legal guardian)

\_\_\_\_\_  
Date

\_\_\_\_\_  
(Witness Signature & Relationship to client)

\_\_\_\_\_  
Date



## BEARDEN BEHAVIORAL HEALTH ADULT HISTORY FORM

Full Name \_\_\_\_\_

Date: \_\_\_\_\_

DOB: \_\_\_\_\_

Sex: MALE FEMALE

Have you ever received mental health treatment?  Yes  No

If yes, where have you received treatment before? What Dates?

\_\_\_\_\_

\_\_\_\_\_

### Psychological Family History

	Mother	Father	Grandmother	Grandfather	Sibling(s)	Aunts/Uncles
Depression						
Anxiety						
Obsessive Compulsive Disorder						
Schizophrenia						
Bipolar Disorder						
ADHD						
Suicide Attempt						
Completed Suicide						
Substance Use						
Other Mental Health Disorder						

### Medical History

Physician's Name/Address/Phone: \_\_\_\_\_

\_\_\_\_\_

Do you have any allergies? \_\_\_\_\_

Are you currently taking any medications?

Name of Medication	Dosage	Frequency	Reason for Taking	Prescribed By

For Females: Date of Last Menstrual Period: \_\_\_\_\_

What medical conditions do you have?

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Substance Use History**

Do you have any substance use history? If yes:

Drug/Type	Age of first use (years)	Length of use (years)	Date of last use (month/year)	Amount of last usage	Frequency how much
Alcohol					
Methamphetamines*					
Amphetamines**					
Barbiturates***					
Crack/Cocaine					
Marijuana					
PCP ****					
Opiates *****					
Tobacco					
Other					

\*Methamphetamines – meth, crank, ice, crystal meth

\*\*Amphetamines (not including cocaine, crack, or methamphetamines) - stimulants, uppers, speed, Ritalin, diet aids, dexedrine, dexamyl, etc.

\*\*\*Barbiturates (and other depressants, including benzodiazepines) – sedatives, quaaludes, Valium, downers, tranquilizers, elavil, seconal, phenobarbital, etc.

\*\*\*\*Opiates – heroin, opium, demerol, pern, codeine, darvon, darvocet, diluadid, OxyContin, any other opiate except methadone

\*\*\*\*\*PCP – phencyclidine, angel dust

**Family History**

Are you currently married?

Yes  No

Do you have any children?

Yes  No

Who resides in the home? \_\_\_\_\_

**Education and Employment**

Are you currently in school? \_\_\_\_\_ If yes, please explain: \_\_\_\_\_

Highest Education Level: \_\_\_\_\_

Currently Employed? \_\_\_\_\_ If yes, occupation: \_\_\_\_\_

**For office use only:**

HT: \_\_\_\_\_

WT: \_\_\_\_\_

BP: \_\_\_\_\_

P: \_\_\_\_\_



Below is a list of phrases that describe certain feeling that people have. Rate the patients by finding the answer which best describes the extent to which he/she has these conditions. Select one of the five responses for each of the fourteen questions.

0 = Not present,                      1 = Mild,                      2 = Moderate,                      3 = Severe,                      4 = Very severe.

- |   |  |
|---|--|
| <p><b>1 Anxious mood</b>                      <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4<br/>Worries, anticipation of the worst, fearful anticipation, irritability.</p> <p><b>2 Tension</b>                              <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4<br/>Feelings of tension, fatigability, startle response, moved to tears easily, trembling, feelings of restlessness, inability to relax.</p> <p><b>3 Fears</b>                                  <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4<br/>Of dark, of strangers, of being left alone, of animals, of traffic, of crowds.</p> <p><b>4 Insomnia</b>                              <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4<br/>Difficulty in falling asleep, broken sleep, unsatisfying sleep and fatigue on waking, dreams, nightmares, night terrors.</p> <p><b>5 Intellectual</b>                            <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4<br/>Difficulty in concentration, poor memory.</p> <p><b>6 Depressed mood</b>                    <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4<br/>Loss of interest, lack of pleasure in hobbies, depression, early waking, diurnal swing.</p> <p><b>7 Somatic (muscular)</b>                <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4<br/>Pains and aches, twitching, stiffness, myoclonic jerks, grinding of teeth, unsteady voice, increased muscular tone.</p> | <p><b>8 Somatic (sensory)</b>                    <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4<br/>Tinnitus, blurring of vision, hot and cold flushes, feelings of weakness, pricking sensation.</p> <p><b>9 Cardiovascular symptoms</b>        <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4<br/>Tachycardia, palpitations, pain in chest, throbbing of vessels, fainting feelings, missing beat.</p> <p><b>10 Respiratory symptoms</b>            <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4<br/>Pressure or constriction in chest, choking feelings, sighing, dyspnea.</p> <p><b>11 Gastrointestinal symptoms</b>      <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4<br/>Difficulty in swallowing, wind abdominal pain, burning sensations, abdominal fullness, nausea, vomiting, borborygmi, looseness of bowels, loss of weight, constipation.</p> <p><b>12 Genitourinary symptoms</b>         <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4<br/>Frequency of micturition, urgency of micturition, amenorrhea, menorrhagia, development of frigidity, premature ejaculation, loss of libido, impotence.</p> <p><b>13 Autonomic symptoms</b>             <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4<br/>Dry mouth, flushing, pallor, tendency to sweat, giddiness, tension headache, raising of hair.</p> <p><b>14 Behavior at interview</b>            <input type="checkbox"/> 0 <input type="checkbox"/> 1 <input type="checkbox"/> 2 <input type="checkbox"/> 3 <input type="checkbox"/> 4<br/>Fidgeting, restlessness or pacing, tremor of hands, furrowed brow, strained face, sighing or rapid respiration, facial pallor, swallowing, etc.</p> |
|---|--|

# PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

Over the last 2 weeks, how often have you been bothered by any of the following problems?  
(Use "✓" to indicate your answer)

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

FOR OFFICE CODING   0   +      +      +       
=Total Score:     

If you checked off any problems, 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
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

## Mood Disorder Questionnaire

Patient Name \_\_\_\_\_ Date of Visit \_\_\_\_\_

Please answer each question to the best of your ability

1. Has there ever been a period of time when you were not your usual self and...	YES	NO
...you felt so good or so hyper that other people thought you were not your normal self or you were so hyper that you got into trouble?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so irritable that you shouted at people or started fights or arguments?	<input type="checkbox"/>	<input type="checkbox"/>
...you felt much more self-confident than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you got much less sleep than usual and found that you didn't really miss it?	<input type="checkbox"/>	<input type="checkbox"/>
...you were more talkative or spoke much faster than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...thoughts raced through your head or you couldn't slow your mind down?	<input type="checkbox"/>	<input type="checkbox"/>
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	<input type="checkbox"/>	<input type="checkbox"/>
...you had more energy than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more active or did many more things than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	<input type="checkbox"/>	<input type="checkbox"/>
...you were much more interested in sex than usual?	<input type="checkbox"/>	<input type="checkbox"/>
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	<input type="checkbox"/>	<input type="checkbox"/>
...spending money got you or your family in trouble?	<input type="checkbox"/>	<input type="checkbox"/>
<b>2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?</b>	<input type="checkbox"/>	<input type="checkbox"/>

**3. How much of a problem did any of these cause you - like being unable to work; having family, money or legal troubles; getting into arguments or fights?**

No problems     Minor problem     Moderate problem     Serious problem

**BEARDEN BEHAVIORAL HEALTH**  
**CLIENT ACKNOWLEDGMENT OF PARTICIPATION IN TREATMENT PLAN**

(Signature Page)

Client Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Clinician Name: \_\_\_\_\_

**I, the undersigned, have participated in planning the treatment for myself/my child  
(those children under 16 years of age)**

Electronic copies of this Client Acknowledgment of Participation in Treatment Plan or any amendments hereto shall be binding upon the parties, and electronic reproduction of signatures appearing herein or on any reproduction shall be deemed to be original signatures.

\_\_\_\_\_  
(Client Signature) \_\_\_\_\_  
Date

\_\_\_\_\_  
(Parent/Legal Guardian Signature) \_\_\_\_\_  
Date

Unwilling     Unable to participate in planning treatment due to

\_\_\_\_\_ \_\_\_\_\_  
Date

Participated but unwilling to sign due to \_\_\_\_\_

\_\_\_\_\_ \_\_\_\_\_  
Date

**Verbal Consent** participated by phone, but not physically present to sign.

Print Name of BBH Witness who received the verbal consent

\_\_\_\_\_ \_\_\_\_\_  
Date

Bearden Behavioral Health  
 CONSENT/REFUSAL FOR MEDICATION(S) – Adult

CLIENT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

By signing below, I acknowledge that the possible benefits and side effects or risks of taking:

\_\_\_\_\_  
 (Brand Name/Generic)

\_\_\_\_\_  
 (Brand Name/Generic)

\_\_\_\_\_  
 (Brand Name/Generic)

have been explained to me by: \_\_\_\_\_

These risks include any black box warning or major side effects including:

- Antipsychotic (Elevation of prolactin, EPS, TD, NMS, metabolic and cardiac effects, and suicidal ideations)
- Mood Stabilizers (Stevens-Johnson Syndrome, seizures, adverse effects on liver/blood/kidney/pancreatic function)
- Antidepressants SSRIs & TCAs (suicidal ideations, GI side effects, seizures)
- Sedatives or Benzodiazepines (addiction potential, drowsiness, driving precautions, memory loss)
- Stimulants (cardiac arrhythmias, GI side effects, headaches, seizures, Serotonin Syndrome)
- Risk of Priapism
- Potential for a severe interaction with illegal drug use or alcohol
- I understand the importance of avoiding pregnancy while taking the medication(s) and agree to contact the psychiatrist/nurse practitioner immediately should I become pregnant (applies to female patients only.)

I understand the reason (diagnosis) for taking this medication and I understand what may happen if I do not take this medication. I have discussed possible alternative treatments. I have received educational information about this medication. I understand these explanations and agree to take the medication as directed.

Client or Legal Guardian's Signature:	Relationship to Client:	Date:
Prescriber's Signature and Credentials:		Date:
Telephone Consent/Refusal by: Client or Legal Guardian's name:	Relationship to Client:	Date:

## Nurse Practitioner Service Agreement

As a part of your holistic treatment plan, when working with a nurse practitioner, you may engage with 2 types of billable services. The 2 main services that a Nurse Practitioner (NP) can provide and bill for are:

### 1.) Medication Management

Service Expectations for Medication Management include:

- Medical evaluation
- Medication monitoring routinely and as needed
- Client education pertaining to the medication to support the individual in making an informed decision for its use.
- The service provider must make a good faith attempt to coordinate care with the individual's primary medical provider

### 2.) Time Based Psychotherapy Services

Service Expectations for Time Based Psychotherapy include:

- Interactive therapy involving any current symptom complaints or psychosocial stressors.
- Examples of time based psychotherapy: patients working collaboratively with their NP to improve organizational skills to cope with ADHD, patients working on sleep hygiene measures to reduce anxiety & improve sleep quality, processing of feelings surrounding a recent or past traumatic experience, working on strategies to ground when stressed or triggered, discussing family dynamics, working on ways to communicate effectively with ones partner, friends, or family, non medicinal strategies for coping with nightmares, mindfulness work, creative imagery or safe place visualization.
- Examples of patients who do not need time based therapy services: patients who are stable, have no active psychiatric complaints, no active stressors, and are just coming in for medication maintenance refills.

When you come to see an NP at BBH you will always be billed for a Medication Management code as that is a crucial part of an NP's clinical training and expertise. Depending on the situation, your NP may or may not bill for a time based psychotherapy service. It depends on what is discussed in the session and for how long. Some NPs have more expertise and continuing education to provide therapy services than others. Those that do, will spend time on this service in most any session unless it is deemed that there is no need for therapy (such as in the example listed above). Other NPs may spend more time doing med management only. It totally depends on their areas of training/specialty.

*Please be advised that unless you tell us in advance that you want no therapy from your NP, you may be billed for medication management and psychotherapy if an NP sees both services as medically necessary and they possess the expertise to offer both services to you.*

If you ask for no therapy services to be provided, you will need to put this in writing and bring it to your NP for further discussion. All services rendered are ultimately up to the NP, not billing or front scheduling staff so we ask that you reserve these conversations for your scheduled session.

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I acknowledge receipt and understanding of all information listed above and consent to receive the above services with my Nurse Practitioner, should they be assessed to be medically beneficial to me during the course of my treatment:

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Witness Signature