NEW PATIENT FORM

(Full Name) First: _____ Last: _____ Middle: _____

DOB: _____ SSN: _____ ☐ Male ☐ Female ☐ Transgender **(Birth Gender ☐ Male ☐ Female)**

Mailing Address: _____ _____ ____ _____
Street City State Zip

Permanent Address: _____ _____ ____ _____
Street City State Zip

Marital Status: _____

Phone #: _____ Alternate Phone #: _____

Email Address: _____ Employer: _____

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

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

(Name) First: _____ Last: _____ Relationship: _____

Address: _____ _____ ____ _____
Street City State Zip

Phone #: _____

If under 18, legal guardian(s) (Full Name) First: _____ Last: _____
(If client is in custody of DCS- DCS is the emergency contact)

Legal guardian(s) Address: _____ _____ _____ _____
Street City State Zip

Phone #: _____

Self-Pay? ☐ Yes ☐ No

Insurance: ☐ Yes ☐ No

Self-Pay: (Counseling)
$150 for Initial Evaluation
$125 per Follow-Up Session

Self-Pay: (Med Management)
$200 for initial evaluation
$125 for 30min. follow-up
$75 for 15min. 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: _____ Relationship:_____

ID / Policy Number: _____ Group Number: _____

Secondary Insurance Company: _____

Insured/Policy Holder's Name - First: _____ Last: _____ Middle: _____

Insured/Policy Holder's DOB: _____ Insured/Policy Holder's SSN: _____

ID / Policy Number: _____ Group Number: _____

EAP Info: What company is your EAP through? _____ Phone #: _____

EAP Auth#: _____ # of Visits Authorized: _____ Start Date: _____ End Date: _____

BEARDEN BEHAVIORAL HEALTH NOTICE OF FINANCIAL INFORMATION

Appointments with each clinician at Bearden Behavioral Health are set by mutual agreement between the clinician and the client. Except for the Initial Evaluation, sessions last 45-60 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 prior to the beginning of each session. All fees and copays **must** be paid prior to the appointment. Should your insurance claim be denied, you are responsible for payment of your treatment in full 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). We do not accept American Express. 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 the invoice date, all unpaid balances will be sent to a collection agency for non-payment. At this time, you understand and agree that amounts owed to Bearden Behavioral Health will be collected by the collection agency, and will include an additional 40% 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 30 days for delivery.

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

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. Please note the provider you are seeing may or may not currently be credentialed with your insurance company at the time of your session. The provider may currently be working under the supervision of the clinical director due to credentialing. Therefore your EOB may reflect the name of the clinical director for billing purposes. 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.

Name of patient (print): _____ **Signature of patient:** _____

Name of legal guardian (print): _____
*(Only if patient is under 18 or a Dependent Adult)

Signature of legal guardian: _____ **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.) is 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. ***INITIALS:*** _____

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 system 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. ***INITIALS:*** _____

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 will work 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 with 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. (Please refer to Bearden Behavioral Health Notice) ***INITIALS:*** _____

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. ***INITIALS:*** _____

EMERGENCIES:
You may telephone or arrange for TeleHealth 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, and 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 the **Mobile Crisis Hotline at 865-539-2409.** ***INITIALS:*** _____

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. ***INITIALS:*** _____

Name of patient (print): _____ **Signature of patient:** _____

Name of legal guardian (print): _____
*(Only if patient is under 18 or a Dependent Adult)

Signature of legal guardian: _____

Antidepressants Not Working?

Let NeuroStar TMS Help!

CAN YOU ANSWER YES TO THESE QUESTIONS?

- Depression symptoms have interfered with my daily life.
- I am not satisfied with the results I get from depression medication.
- I have had or worry about side effects from depression medications.
- I have switched medications for depression due to side effects.
- I am interested in a proven, non-drug therapy for depression.

IF SO, LET'S TALK ABOUT TMS THERAPY!

Neurostar TMS is the most effective and least invasive treatment for depression on the market today and we offer this treatment here at Bearden Behavioral Health! TMS is covered by most insurance carriers too!

If you would like to speak to someone about TMS, please sign your name here and add your phone number or email!

NAME:_____ EMAIL:_____

DATE:_____ PHONE:_____

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

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 misused appointment fee, we will mail you an invoice with a 10% surcharge resulting in a $55 charge. ***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.

Name of patient (print): _____ **Signature of patient:** _____

Name of legal guardian (print): _____
*(Only if patient is under 18 or a Dependent Adult)

Signature of legal guardian: _____ **Date:** _____

Credit Card
Pre-Authorization Form

Patient Name: _____ DOB: _____

Address: _____
Street

_____ _____ _____
City State Zip

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 CHECK ONE: ☐ Visa ☐ MasterCard ☐ Discover

Name on Card: _____

Credit Card #: _____

CVV # (3 digits on back of card: _____ Expiration Date (Month/Year): _____

Printed Name of Authorized Signer: _____

Patient/Cardholder Authorized Signature: _____

Name of legal guardian (print): _____
*(Only if patient is under 18 or a Dependent Adult)

Signature of legal guardian: _____ **Date:** _____

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

I, AUTHORIZE: **Bearden Behavioral Health and my Provider of Service**

Name of Client: _____ DOB: _____

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

- Information related to the scheduling of appointments.
- Information related to billing and payment (this may include support staff for clinician)
- Completed forms, including forms that may contain sensitive, confidential information.
- 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

Patient Information and Consent Form for TeleHealth

Introduction

TeleHealth is the delivery of psychological services using interactive audio and visual electronic systems where the clinician and the patient are not in the same physical location. The interactive electronic systems used in TeleHealth incorporate network and software security protocols (encryption) to protect the confidentiality of patient information and audio and visual data.

Potential Benefits of TeleHealth

• Increased accessibility to psychological care • Patient convenience

Potential Risks with TeleHealth

As with any healthcare service, there may be potential risks associated with the use of TeleHealth.

These risks include, but may not be limited to:

- Information transmitted may not be sufficient (e.g., poor resolution of video) to allow for appropriate psychological treatment by Clinical Staff of Bearden Behavioral Health (Provider).
- Clinical staff of Bearden Behavioral Health (Providers) may not be able to provide psychological treatment to me using interactive electronic equipment nor provide for or arrange for emergency care that I may require.
- Delays in psychological evaluation and treatment may occur due to deficiencies or failures of the equipment.
- Security protocols can fail, (although extremely unlikely) causing a breach of privacy of my confidential psychological information.
- A lack of access to all the information that might be available in a face to face visit but not in a TeleHealth session may result in errors in psychological judgment.
- Alternatives to the use of TeleHealth
- Traditional face to face sessions with a local provider.

Confidentiality Standards Required for TeleHealth:

- During a TeleHealth health session, both locations shall be considered a patient examination room regardless of a room's intended use.
- Both sites shall be appropriately chosen to provide audio and visual privacy.
- Rooms shall be designated private for the duration of the session with the Provider and no unauthorized access shall be permitted.
- Both sites shall take every precaution to ensure the privacy of the consult and the confidentiality of the patient. All persons in the exam room at both sites shall be identified to all participants prior to the consultation and the patient's permission shall be obtained for any visitors or clinicians to be present during the session.
- HIPAA confidentiality requirements apply the same for TeleHealth as for face-to-face consultations.

My Rights:

1.1 understand that the laws that protect the privacy and confidentiality of psychological information also apply to TeleHealth.

1. I understand that the video conferencing technology used by the clinical team of Bearden Behavioral Health is encrypted to prevent unauthorized access to my private psychological information.

2. I have the right to withhold or withdraw my consent to the use of TeleHealth during the course of my care at any time. I understand that my withdrawal of consent will not affect any future care or treatment.
3. I understand that Clinical Providers of Bearden Behavioral Health have the right to withhold or withdraw his/her consent for the use of TeleHealth during the course of my care at any time.
4. I understand that the all rules and regulations which apply to the practice of psychotherapy in the state of Tennessee also apply to TeleHealth.
5. I understand that the clinical staff of Bearden Behavioral Health will not record any of our TeleHealth sessions without my prior written consent.

My Responsibilities

6. I will not record any TeleHealth sessions without prior written consent from my mental health provider at Bearden Behavioral Health.
7. I will inform my treatment provider at Bearden Behavioral health if any other person can hear or see any part of our session before the session begins. My mental health provider at Bearden Behavioral Health will inform me if any other person can hear or see any part of our session before the session begins.
8. I understand that third-parties may be required to join in the meeting with my provider and me to provide technical support. I understand that I may be asked to interact with the technical support person on camera in order to fix the problem. I understand that if I decline this request and my equipment is rendered unusable for video conferencing, I may forfeit my option to use TeleHealth.
9. I understand that I, not my treatment provider at Bearden Behavioral Health, am responsible for the configuration of equipment on my computer which is used for TeleHealth. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins. I understand that I may need to contact a designated third party (Doxy.me) for technical support to determine my computer's readiness for TeleHealth prior to beginning TeleHealth sessions with my Provider.
10. I understand that I must be a resident of the state of Tennessee to be eligible for TeleHealth services from my treatment provider at Bearden Behavioral Health.

Patient Consent To The Use of TeleHealth

I have read and understand the information provided above regarding TeleHealth, have discussed it with my treatment provider at Bearden Behavioral Health and all of my questions have been answered to my satisfaction.

I hereby give my informed consent for the use of TeleHealth in my psychological care and authorize my treatment provider at Bearden Behavioral Health, to use TeleHealth in the course of my diagnosis and treatment.

Patients Name: _____ Date: _____

Signature of Patient: _____

ADULT HISTORY FORM

(Full Name) First: _____ Last: _____ Middle: _____

DOB: _____ ☐ Male ☐ Female ☐ Transgender **(Birth Gender ☐ Male ☐ Female)**

Pharmacy/Location: _____ Pharmacy Ph#: _____

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	☐	☐	☐	☐	☐	☐

Physician's Name / Address / Phone: _____

_____

Are you currently taking any medications?

Name of Medication	Dosage	Frequency	Reason for Taking	Prescribed by:

Do you have any drug or other allergies? _____

For Females - Date of Last Menstrual Period: _____

What medical conditions do you have?

_____

_____

Substance Use History

Do you have any substance use history? ☐ YES ☐ NO (if 'YES' complete below)

Are you currently being prescribed Suboxone? ☐ YES ☐ NO

Drug Type	Age of first use	Length of use (years)	Date of last use (month/year)	Amount of last usage	Frequency / How much?
Alcohol					
Methamphetamines *					
Amphetamines **					
Barbiturates/Benzodiazepines ***					
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, and 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? ☐ YES ☐ NO If yes, please explain: _____

Highest Education Level: _____

Currently Employed? ☐ YES ☐ NO If yes, occupation: _____

*** For office use only:**

HT: _____

WT: _____

BP: _____

P: _____

GAD-7

Anxiety

Patient Name: _____ Date of Visit: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	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 sleep or control worry	☐ 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

Column Totals _____ + _____ + _____ + _____ =

Total Score: _____

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

Scoring GAD-7 Anxiety Severity

This is calculated by assigning scores of 0, 1, 2, and 3 to the response categories, respectively, of “not at all,” “several days,” “more than half the days,” and “nearly every day.” GAD-7 total score for the seven items ranges from 0 to 21.

0-4: minimal anxiety

5-9: mild anxiety

10-14: moderate anxiety

15-21: severe anxiety

PATIENT HEALTH QUESTIONNAIRE - 9

(PHQ - 9)

Patient Name: _____ Date of Visit: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	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

Column Totals _____ + _____ + _____ + _____ =

Total Score: _____

If you checked any problems, how difficult have they 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
☐	☐	☐	☐

MOOD DISORDER QUESTIONNAIRE

Patient Name: _____ Date of Visit: _____

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?	☐	☐
...you were so irritable that you shouted at people or started fights or arguments?	☐	☐
...you felt much more self-confident than usual?	☐	☐
...you got much less sleep than usual and found that you didn't really miss it?	☐	☐
...you were more talkative or spoke much faster than usual?	☐	☐
...thoughts raced through your head or you couldn't slow your mind down?	☐	☐
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	☐	☐
...you had more energy than usual?	☐	☐
...you were much more active or did many more things than usual?	☐	☐
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	☐	☐
...you were much more interested in sex than usual?	☐	☐
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	☐	☐
...spending money got you or your family in trouble?	☐	☐

2. If you checked 'YES' to more than one of the above, have several of these ever happened during the same period of time?	☐	☐

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 ☐

CLIENT ACKNOWLEDGEMENT
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 Acknowledgement 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