RIVER'S BEND, P.C.

CLIENT FACE SHEET

RE-ADMISSION ☐ YES ☐ NO CASE # _____

CLIENT NAME _____ CITY _____ STATE _____ ZIP_____

ADDRESS _____

HOME PHONE _____WORK PHONE _____CELL PHONE _____

I AUTHORIZE THE OFFICE TO CONTACT ME AT: ☐ HOME ☐ WORK ☐ CELL

BIRTHDATE _____ AGE _____ SEX ☐ M ☐ F SS#_____

EMPLOYER _____ REFERRED BY _____

PARENT/GUARDIAN _____

ADDRESS (IF DIFFERENT THAN CLIENT)

_____

INSURANCE INFORMATION

INSURANCE COMPANY _____ PHONE _____

NAME OF INSURED/POLICY HOLDER _____

POLICY NUMBER _____ INSURED'S SS# _____

DATE OF BIRTH OF POLICY HOLDER _____ GROUP # _____

INSURED'S EMPLOYER _____

EMERGENCY CONTACT

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY _____

RELATIONSHIP _____ CONTACT'S PHONE #(s) _____

CONTACT'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

SIGNATURE BELOW AUTHORIZES THE CLINIC TO CONTACT THE ABOVE-NAMED PERSON IN CASE OF EMERGENCY

_____ _____

CLIENT SIGNATURE DATE SIGNATURE (PARENT/GUARDIAN) DATE

For office use only:

RIVER'S BEND, P.C.

CONSENT TO TREATMENT STATEMENT

CLIENT NAME _____ CASE # _____

I, _____ the undersigned hereby attest that I have voluntarily entered into treatment with the staff of River's Bend, P.C. Further, I consent to have treatment provided by a Psychiatrist, Psychologist, or Social Worker under the supervision of the Psychiatric Director. I understand that therapy may be discontinued at any time by either party; however, we recommend that this decision be discussed with your psychotherapist and made as a joint decision whenever possible. This cooperation will facilitate better discharge planning and re-entry into the program should it be needed again at a later date.

CLINIC POLICY

Cancellation of appointment: You may cancel your appointment by calling our regular number (24 hours a day). BUT YOU MUST CANCEL AT LEAST 24 HOURS IN ADVANCE! If you do not cancel or keep your appointment, YOU, NOT YOUR INSURANCE COMPANY, WILL BE CHARGED FOR THE SESSION. All psychiatric appointment s require at least 72 hours for cancellation. Payment for services is expected at the time services are rendered, unless other arrangements have been made with the treating professional. I, the undersigned, agree and acknowledge that responsibility for full payment for services rendered, including any deductibles and/or co-payments is mine. If payment is delinquent and no responses or arrangement is made, your account may be handled by our Collections Department or Agency.

RECIPIENT'S RIGHTS

I certify that I have received the "Know Your Rights" pamphlet available at River's Bend and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information about my rights from my Program Rights Advisor, Kristi Hopkins.

NON-VOLUNTARY DISCHARGE FROM TREATMENT

A client may be terminated from the program non-voluntarily by the therapist: (A) If the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal activity at the clinic. (B) If the client refuses to comply with stipulated program and case protocol or refuses to comply with treatment recommendations. The client will be notified of a non-voluntary discharge by client's therapist but this is seen as a last resort when other less drastic measures have proven ineffective. The client may appeal this decision with the program director, or request to re-apply for services at a later date.

CLIENT NOTICE OF CONFIDENTIALITY

The confidentiality of patient records maintained by the program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless: (1) The patient consents in writing; (2) The disclosure is allowed by a court order, or; (3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse, neglect, or adult abuse from being reported under State law to appropriate State or local authorities.

My signature below indicates that I have been given a copy of my rights regarding confidentiality.

PAYMENTS

I hereby authorize billings to my primary insurance company for services rendered to me by RIVER'S BEND, P.C. I authorize payments by my insurance company to be made directly to RIVER'S BEND, P.C. and understand that I am liable for payments of all fees. Further, I understand that should the insurance information provided not cover these services, I am responsible for all costs incurred. All checks shall be made payable to: RIVER'S BEND, P.C. I authorize release of pertinent information to my insurance company for purposes of billing and payment.

_____ _____

SIGNATURE OF CLIENT/LEGAL GUARDIAN* DATE

_____ _____

WITNESS DATE

*In case a client is under 18 years of age, a legally responsible person acting on his/her behalf.

RIVER'S BEND, P.C.

Acknowledgement of Reviewing the Psychotherapist-Patient Services Agreement

HIPAA

CLIENT NAME _____ CASE # _____

River's Bend, P.C. has provided the Psychotherapist-Patient Services agreement and I acknowledge understanding of same.

Client Name (printed)_____

Client and/or Guardian Signature_____

Client Date of Birth_____

If guardian, please complete your relation to client_____

Guardian Date of Birth_____ Case #_____

PLEASE NOTE: If you desire an explanation of the HIPAA guidelines or a copy of the notice, please ask your clinician for a copy.

RIVER'S BEND, P.C.

MEDICATION FORMULARY

Client Name:_____ Case #_____ Date:_____

Person Completing Form:_____

Medication at Intake (please include vitamins and herbal supplements)	Date	Dosage/Frequency	Provide prescribing physician or if medication is over the counter and reason for medication.

Please list any known allergies:

_____

_____

Review questions or concern by medical staff:

_____

_____

_____

_____

Reviewed by:_____ Date:_____

(Medical Director / Consulting Psychiatrist)

RIVER'S BEND, P.C.

AUTHORIZATION FOR PROVIDER/PRIMARY CARE PHYSICIAN COMMUNICATION

CLIENT NAME _____ CASE # _____

CLIENT'S DATE OF BIRTH:_____

To Be Completed by Client: **Insurance Company**_____

I, _____ authorize/do not authorize _____
(please print) **(Provider's Name)**

my behavioral health provider and _____
(PCP Name) **(PCP address and phone number)**

to exchange information regarding my mental health/chemical dependency treatment and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health or chemical dependency care and/or treatment such as diagnosis and treatment plan. I understand this authorization shall remain in effect for one year from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider if I choose to change my Primary Care Physician.

PLEASE CHOOSE THE FOLLOWING:

X _____ _____
I Authorize Communication with my PCP Date
(Client or Guardian Signature)

X _____ _____
I Do Not Authorize Communication with my PCP Date
(Client or Guardian Signature)

X _____ _____
Witness Date

To Be Completed by Provider:

_____ **River's Bend, P.C. 800 Stephenson Suite 250 Troy, MI 48083 (248) 585-3239**
Provider's Name Facility Name Address City/State Phone

DSM IV Diagnostic Code & Name_____

Treatment Plan: Type:_____ Frequency:_____ Est. length of Tx:_____

Medication Prescribed:_____

Comment:_____

_____

☐ Conclusion of mental health/chemical dependency treatment
☐ Date of last session_____ Treatment completed? ☐ Yes ☐ No
☐ Notification of prescription or change in medications (see comments)
☐ Other_____

_____
Print Provider Name Signature/Credentials Phone number

A COPY OF THIS FORM MUST BE SENT TO THE PCP, RETAINING THE ORIGINAL IN THE CLIENT'S CHART.

_____ _____ ☐ Mail ☐ Fax
Date Sent Sent by (initials)

RIVER'S BEND, P.C.

REQUEST FOR TREATMENT

CLIENT NAME _____ CASE # _____

I acknowledge that I am voluntarily authorizing treatment for myself, or for my dependent, _____ at River's Bend, P.C. I have been informed of the purposes of treatment, the services which may be provided, and any attendant benefits, risks, and/or consequences.

I accept this as full notification that if I fail to schedule my/dependent's medication review appointment in a timely manner and/or cancel the appointment, there will be a $25.00 office charge if a medication refill is required.

_____
Initial

I agree that the fee per appointment will be $_____

The fees will be paid (check appropriate statement):

_____ By direct billing to _____ insurance company, plus a co-payment of $_____ or _____ % paid by me.

_____ By me in full

_____ By another arrangement (please state)_____

I understand that it is the policy of River's Bend P.C. that payment is due at the time of my appointment.

I understand that I am responsible for all charges not paid by my insurance company. I also understand that I will be charged the regular clinic fee for appointment not cancelled at least 24 hours in advance. All psychiatric appointments must be canceled at least 72 hours in advance. Accounts which are not direct insurance payments to the clinic and which are delinquent over thirty (30) days may be subject to collection.

I also understand that although the staff at River's Bend, P.C. will attempt to determine the status of my insurance benefits, I am ultimately responsible for knowing what they are, knowing when my benefits are exhausted, and for making the staff aware of any changes in my benefits.

I further state that I have informed River's Bend, P.C. of every medical insurance I have and accept full responsibility for any charges that may arise from my non-disclosure.

I authorize River's Bend, P.C. to release any information necessary to process claims to my insurance company.

I authorize payment of medical benefits to River's Bend, P.C.

I authorize River's Bend, P.C. to acknowledge the party that referred me here (_____ Authorization denied)

I have read this information, understand, and agree to the conditions specified above.

_____

Client's Signature (or Parent/Legal Guardian) Date

_____

Witness Signature Date

RIVER'S BEND, P.C.

PERSONAL HISTORY FORM

CLIENT NAME _____ CASE # _____

ADDRESS _____

CITY _____ STATE _____ ZIP_____

Phone number to best contact you : _____DOB _____

WHY ARE YOU REQUESTING TREATMENT? WHAT DO YOU SEE AS THE MAIN PROBLEM?

_____

FAMILY INFORMATION

Relationship	Name	Sex	Age	Lives with you	Conflict with
Client					
Mother					
Father					
Spouse					
Children					
Siblings					
Others					

MARITAL STATUS

☐ Single ☐ Married – length of time _____ ☐ Divorced – length of time _____

☐ Separated - length of time _____ ☐ Widowed – length of time _____

☐ Living with _____

Other marital information: Total marriages_____ Divorce in progress _____

Assessment of current relationship ☐ Good ☐ Fair ☐ Poor

Has anyone in your family ever been diagnosed with a mental illness? ☐ Yes ☐ No

Please explain _____

Has a family member or close friend of yours ever attempted or committed suicide? ☐ Yes ☐ No

Please explain_____

CLIENT NAME _____ CASE # _____

Have you experienced any of the following?

Current	Past	No		Current	Past	No	
☐	☐	☐	Severe childhood illnesses	☐	☐	☐	Sexual Abuse
☐	☐	☐	Death in the family	☐	☐	☐	Trauma from crime
☐	☐	☐	Severe injury	☐	☐	☐	Emotional difficulty due to divorce
☐	☐	☐	Problems in school	☐	☐	☐	Sibling conflicts
☐	☐	☐	Physical Abuse	☐	☐	☐	Parenting problems
☐	☐	☐	Emotional Abuse	☐	☐	☐	Physical/Domestic violence

SOCIAL INFORMATION

How do you relate to other people ☐ easily ☐ shy ☐ leader ☐ follower ☐ extrovert

Who do you socialize with? _____

SEXUAL HISTORY

Age of first sexual encounter? _____

What is your sexual preference/orientation? _____

CULTURAL/ETHNIC INFORMATION

What cultural or ethnic group do you come from? Do you closely identify with this group and if so, do you see this as a strength?_____

Do you have any concerns how your culture or ethnicity may affect your therapy? ☐ Yes ☐ No

SPIRITUAL/RELIGIOUS INFORMATION

Do you consider yourself a spiritual person? ☐ Yes ☐ No
Were you raised any particular religion? ☐ Yes ☐ No
Do you practice a formal religion now? ☐ Yes ☐ No
If so, what religion do you currently practice?_____

MILITARY EXPERIENCE ☐ Yes ☐ No

Branch_____ Type of discharge _____
Combat experience ☐ Yes ☐ No Rank at discharge _____
Date enlisted _____
Discharge date _____

CLIENT NAME _____ CASE # _____

LEGAL INFORMATION

Current status

Are you involved in any active cases? (traffic, civil, criminal) ☐ Yes ☐ No

If yes, describe and indicate the court and hearing date/trial dates and charges:

_____

Are you presently on probation or parole? ☐ Yes ☐ No

If yes, please describe _____

Past history

Yes	No		Yes	No	
☐	☐	Traffic violations (other than parking)	☐	☐	Civil Involvement
☐	☐	Criminal involvement	☐	☐	DUIL, etc.

If yes to any of the above, complete the following:

CHARGES	DATE	WHERE (city)	RESULTS

EDUCATIONAL

☐ High school diploma ☐ GED

☐ Currently enrolled: Where _____ Highest grade completed _____

☐ College ☐ Vocational training

Special circumstances (e.g. learning disabilities, gifted program, special ed., etc.): _____

EMPLOYMENT/VOCATIONAL

Are you currently employed? ☐ Yes ☐ No

Beginning with most recent job, give employment history, include homemaker experience

Employer	Dates	Job Description	Salary

Total year income: $_____ Total family income: $_____

Special circumstances (laid off, self-employed, suspended, disabled, retired, etc.):

_____

CLIENT NAME _____ CASE # _____

LEISURE/RECREATIONAL

Has your activity level changed in the last 6 months? ☐ Yes ☐ No

If yes, please describe _____

Which of the following activities do you participate in on a regular basis?

Daily	Weekly	Monthly		Daily	Weekly	Monthly	
☐	☐	☐	Arts &Crafts	☐	☐	☐	Books/Films
☐	☐	☐	Music	☐	☐	☐	Physical Fitness
☐	☐	☐	Outdoor activity	☐	☐	☐	Sports
☐	☐	☐	Church activity	☐	☐	☐	Other _____

Do you or any family member have a gambling problem? ☐ Yes ☐ No
Do you ever gamble more than you intended? ☐ Yes ☐ No
If yes, please describe _____

COUNSELING/PRIOR TREATMENT HISTORY

Type of Treatment	Yes	No	Dates	# of times	Where	Outcomes
Counseling/Psychiatric Treatment						
Alcohol/Drug treatment						
Hospitalizations						
Self-help groups: AA, Al-Anon, ACOA Overeaters, Other(s) _____						

Have you ever experienced any suicidal thoughts? ☐ Yes ☐ No ☐ Current ☐ Past
If yes, please describe; and if they are current, please provide some details:

_____

Have you ever attempted suicide? ☐ Yes ☐ No
If yes, list how many times, the most recent date, and the method(s) used:

_____

Have you experienced any homicidal thoughts? ☐ Yes ☐ No ☐ Current ☐ Past
If yes, please describe; and if they are current, please provide some details:

_____

Have you ever acted on these thoughts? ☐ Yes ☐ No
If yes, list how many times, the most recent date, and the method(s) used:

_____

Have you ever assaulted anyone? ☐ Yes ☐ No
If yes, list how many times, and include the dates and how the assault(s) happened:

_____

CLIENT NAME _____ CASE # _____

ADDICTIVE OR CHEMICAL USE HISTORY

Substance	Method	Frequency	Age of first use	Age of last use	Used in 48 hours	Used in 30 days
Alcohol						
Barbiturates						
Valium/Librium						
Cocaine/Crack						
Heroin/Opiates						
Marijuana						
PCP/LSD/Mesc.						
Inhalants						
Caffeine						
Nicotine						
Over the counter						
Prescription drugs						
Other drugs						
Addictive gambling						

SUBSTANCE OF PREFERENCE:

1._____ 2._____

3._____ 4._____

SUBSTANCE ABUSE QUESTIONS:

Describe when and where you typically use:_____

Describe any changes in your use pattern:_____

Describe how your use has affected your family or friends, include their perception of your use:

_____

Do you use to build up your confidence?_____

What is your perception of your use:_____

Have you ever lived with someone who has an alcohol/substance abuse problem? ☐ Yes ☐ No

Describe who or what has helped you:_____

Do you have members or close friends with an alcohol or drug problem? ☐ Yes ☐ No

Have you had withdrawal symptoms when trying to stop drinking or using drugs?_____

Have you had any adverse reactions or overdose to drugs/alcohol (describe)_____

Does your temperament change when you drink (describe)_____

Has alcohol/drugs created a problem for your job?_____

CLIENT NAME _____ CASE # _____

PHYSICAL AND MEDICAL HISTORY

Date last seen by your physician _____
Reason for seeing your physician _____
Your current physician:
Name:_____
Address:_____
Phone:_____

PHYSICAL HEALTH CHECKLIST (check all that apply):

- ☐ AIDS/HIV
- ☐ Alcoholism/drugs
- ☐ Allergies
- ☐ Anemia
- ☐ Asthma/coughing
- ☐ Bone/joint problems
- ☐ Bowel problems
- ☐ Cancer
- ☐ Chest pain
- ☐ Chronic pain
- ☐ Cirrhosis/liver disease
- ☐ Diabetes
- ☐ Eating problems
- ☐ Epilepsy
- ☐ Fainting
- ☐ Fibromyalgia/muscle pain
- ☐ Frequent urination
- ☐ Glaucoma
- ☐ Headaches
- ☐ Head injury
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Hypertension
- ☐ Kidney problems
- ☐ Lung disease
- ☐ Menstrual pain
- ☐ Neurological problems
- ☐ Oral health/dental
- ☐ Sexually transmitted disease
- ☐ Sore throat
- ☐ Stomach problems
- ☐ Stroke
- ☐ Thyroid problem
- ☐ Tuberculosis
- ☐ VD

How would you describe your health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor
Have you ever had any seizures? ☐ Yes ☐ No

Please list any past or present illnesses or medical conditions (type of illness or condition)		Are you currently being treated? YES	NO

Please list your current medications on the <u>Medication Formulary</u> included in your intake paperwork

ALLERGIES/DRUG SENSITIVITIES

- ☐ None
- ☐ Food (specify) _____
- ☐ Medicine (specify) _____
- ☐ Other (specify) _____

PREGNANCY HISTORY

- ☐ Not pertinent
- ☐ Currently pregnant (if yes, expected delivery date: _____)

Receiving any pre-natal healthcare? ☐ No ☐ Yes (if yes, indicate provider: _____)
Any significant pregnancy history? ☐ No ☐ Yes (if yes, explain: _____)

CLIENT NAME _____ CASE # _____

NUTRITIONAL ASSESSMENT: Please describe your eating pattern (please check those that apply):

☐ Two or three well-balanced meals/day ☐ One or two meals/day plus snacking
☐ Several small meals during the day ☐ Poor eating habits (lots of snacks, little nutrition)
☐ Makes self throw up to lose weight ☐ Other: _____

Recent weight gain or loss? ■ gain ☐ loss Amount gained or lost _____
During what time period was the weight gain or loss _____
If weight lost, was this a result of purposeful dieting? ☐ Yes ■ No

PAIN ASSESSMENT

Are you experiencing any physical pain? ☐ Yes ■ No
If yes, describe location and type of pain (e.g. sharp, dull, throbbing) _____
If not experiencing physical pain, stop here.

Does the pain interfere with your activities of daily living and/or social activities? ☐ Yes ☐ No
If yes, how: _____
Are you taking any prescribed, non-prescribed or over the counter medication for pain relief? ☐ Yes ☐ No
If yes, please list the medications: _____
Other pain relief measures you are using: _____

OTHER ITEMS OR ISSUES WE SHOULD KNOW ABOUT YOU? _____
_____
_____

CLIENT SIGNATURE _____ **Date** _____

(STAFF USE ONLY)
THERAPIST SECTION:
NUTRITIONAL SCREENING FOLLOW UP (A gain or loss of greater than 10 lbs in 2 weeks if not a result of dieting should be referred for follow-up)

Client appears to have a nutritional pattern that requires further evaluation	☐ Yes	☐ No
Client currently being seen for eating disorder or nutritional problems	☐ Yes	☐ No
Client/Legal Guardian referred to PCP for follow-up	☐ Yes	☐ No

PAIN SCREENING FOLLOW-UP:

☐ Client currently receiving care for pain management
☐ Referred to PCP
☐ Other _____
Therapist questions or comment: _____

Therapist's signature _____ **Date** _____

PHYSICIAN SECTION

Physical exam ☐ is required ☐ is not required ☐ is recommended

MD/DO comment: _____

Physician signature _____ **Date** _____
CERTIFIES DIAGNOSIS, CASE ASSIGNMENT, AND LEVEL OF CARE