Willow Sage Services

PARTICIPANT CONTACT INFORMATION
(PLEASE PRINT LEGIBLY)

TODAY'S DATE	
FULL LEGAL NAME	
ADDRESS	
CITY, STATE, ZIP	
PHONE	HOME PHONE: MOBILE PHONE:
EMAIL ADDRESS	
REPEAT EMAIL ADDRESS	
PREFERRED COMMUNICATION METHOD	[__] HOME PHONE [__] MOBILE PHONE [__] Email [__] TEXT MSG
	IS IT OK TO LEAVE VOICE MESSAGE ON HOME PHONE? [___] YES [___] NO
HOW DID YOU HEAR ABOUT US?	

PARTICIPANT INFORMATION (The following items apply to the participant, not to the parent/guardian)

PATIENT'S DATE OF BIRTH	/ /	PATIENT'S SOCIAL SECURITY NUMBER:	
ADMISSION STATUS:	[___] VOLUNTARY [___] COURT ORDERED		[___] MALE [___] FEMALE [___] IT'S COMPLICATED

MARITAL STATUS (PATIENT)	[___] Married [___] Divorced [___] Separated [___] Never Married [___] Other
PATIENT'S SCHOOL NAME	
PATIENT'S GRADE IN SCHOOL	| IEP? [___] YES [___] NO
NOTE: If your child has an IEP or "504 Plan," we will need a copy. Copies of School Psychological report, Positive Behavioral Support Plan, etc. would be helpful, as well.	
PATIENT'S EMPLOYER	
PATIENT'S EMPLOYER'S ADDRESS & PHONE	PHONE:
PATIENT'S ETHNICITY / NATIONAL ORIGIN	[___] Caucasian (White) [___] African American [___] Native American (Tribal) [___] Asian [___] Hispanic/Latino [___] Other:
PATIENT'S RELIGIOUS OR SPIRITUAL PREFERENCE:	

EMERGENCY / GUARDIAN INFORMATION

EMERGENCY CONTACT	PHONE:
PARENT / GUARDIAN NAME:	
PARENT / GUARDIAN DOB:	/ / PARENT / GUARDIAN SS #:
PARENTS' MARITAL STATUS	[___] Married [___] Divorced [___] Separated [___] Never Married [___] Other
NONCUSTODIAL PARENT	
MAILING ADDRESS	PHONE:
To provide services to children or adults with guardians, we must have current copies of custody orders, parenting plans, orders of protection, guardianship orders, powers of attorney or other documents bearing on legal custody, decision-making, etc.	

INSURANCE INFORMATION (NOTE: Medicaid is always considered Secondary insurance)

	Primary Insurance		Other or Secondary Insurance
COMPANY NAME		COMPANY NAME	
POLICY NUMBER		POLICY NUMBER	
EMPLOYER / GROUP		EMPLOYER / GROUP	
INSURED NAME		INSURED NAME	
DATE OF BIRTH		DATE OF BIRTH	
RELATION TO PATIENT		RELATION TO PATIENT	
SLIDING SCALE FEE			

CURRENT HEALTH CARE PROVIDERS (You will need a current well-child or physical within the last 12 months.)

PRIMARY CARE		LAST SEEN	
PSYCHIATRIST		LAST SEEN	
PSYCHOTHERAPIST		LAST SEEN	
CBRS/CM		LAST SEEN	
OTHER		LAST SEEN	

Is the <u>patient</u> currently being seen by another behavioral health clinician? (Psychiatrist, Counselor, Social Worker, Marriage and Family Therapist, PSR Agency, Developmental Disabilities Agency, etc.)	**If "Yes," name:**

PREVIOUS HEALTH CARE PROVIDERS

PRIMARY CARE		LAST SEEN	
PSYCHIATRIST		LAST SEEN	
PSYCHOTHERAPIST		LAST SEEN	
CBRS/CM		LAST SEEN	
OTHER		LAST SEEN	

MEDICATION ***(Use additional page if necessary. Please take information directly from pill bottles. Please include over-the-counter medications, as well supplements vitamins, and anything else used to effect health or behavior):***

Medication	Dose/Schedule	Purpose	Prescriber
_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____	_____ _____ _____ _____ _____

PARTICIPANT DESCRIPTION:

Reason for requesting services, what client and/or parent would like to get from services:	_____ _____
Age at onset: (what happened, when, impact)	_____ _____ _____
Current health problems/needs: (food or drug allergies, interfering symptoms, keeps appointments, other)	_____ _____

CHILDHOOD ANXIETY (Parents complete for children 12 and younger

Is your child more shy or anxious than other children her or his age?	YES	NO
Is your child more worried than other children her or his age?	YES	NO

Patient Health Questionnaire (PHQ-9) *(To be completed by or for all patients on intake)*				
Over the last two weeks has the patient been bothered by any of the following problems?				
	Not at all (0)	**Several days (1)**	**More than half the days (2)**	**Nearly every day (3)**
Little interest or pleasure in doing things				
Feeling down, depressed or hopeless				
Trouble falling asleep or sleeping too much				
Feeling tired or having little energy				
Poor appetite or overeating				
Feeling bad about yourself – or that you are a failure or have let yourself or your family down				
Trouble concentrating on things, such as reading the newspaper or watching television				
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				
Thoughts that you would be better off dead, or of hurting yourself in some way				
NOTE: If you checked off any problems above, 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 ____**				

Substance Use Screening Tool (To be completed by patients 10 and older)			
The following questions concern information about your potential involvement with alcohol and other drugs during the past 12 months. Carefully read each question and decide if your answer is "YES" or "NO". Please answer every question. If you cannot decide, then choose the response that is mostly right. When the word "drug" is used, it refers to the use of prescribed or over-the-counter drugs that are used more than the directions and any non-medical use of drugs. "Drugs" may include but are not limited to: cannabis (e.g., marijuana, hash), solvents (e.g., gas, paints), tranquilizers (e.g., Valium), barbiturates, cocaine, and stimulants (e.g., speed, meth), hallucinogens (e.g., LSD) or narcotics (e.g., Heroin, Oxycontin).			
Part A: During the PAST 12 MONTHS, did you?		**NO**	**YES**
1	Drink any alcohol (more than a few sips)? (Do not count sips of alcohol taken during family or religious events.)		
2	Smoke any marijuana or hashish?		
3	Use anything else to get high? ("anything else" includes illegal drugs, over the counter and prescription drugs, and things that you sniff or "huff")		
4	Have you ever used tobacco in any form (e.g., cigarettes, chew, cigars)?		
5	How often do you use tobacco in any form? [___] NEVER [___] OCCASIONALLY [___] DAILY		
Part B: CRAFFT		**NO**	**YES**
1	Have you ever ridden in a CAR driven by someone (including yourself) who was "high" or had been using alcohol or drugs?		
2	Do you ever use alcohol or drugs to RELAX, feel better about yourself, or fit in?		
3	Do you ever use alcohol or drugs while you are by yourself, or ALONE?		
4	Do you ever FORGET things you did while using alcohol or drugs?		
5	Do your FAMILY or FRIENDS ever tell you that you should cut down on your drinking or drug use?		
6	Have you ever gotten into TROUBLE while you were using alcohol or drugs?		

Aversive Childhood Experiences Scale (ACES) *(To be completed by or for <u>all</u> patients, regardless of age)*			
1	Did a parent or other adult in the household often or very often Swear at you, insult you, put you down, or humiliate you? or Act in a way that made you afraid that you might be physically hurt?	YES	NO
2	Did a parent or other adult in the household often or very often Push, grab, slap, or throw something at you? or Ever hit you so hard that you had marks or were injured?	YES	NO
3	Did an adult or person at least 5 years older than you ever Touch or fondle you or have you touch their body in a sexual way? or Attempt or actually have oral, anal, or vaginal intercourse with you?	YES	NO
4	Did you often or very often feel that No one in your family loved you or thought you were important or special? or Your family didn't look out for each other, feel close to each other, or support each other?	YES	NO
5	Did you often or very often feel that You didn't have enough to eat, had to wear dirty clothes, and had no one to protect you? or Your parents were too drunk or high to take care of you or take you to the doctor if you needed it?	YES	NO
6	Were your parents ever separated or divorced?	YES	NO
7	Was your mother or stepmother: Often or very often pushed, grabbed, slapped, or had something thrown at her? or Sometimes, often, or very often kicked, bitten, hit with a fist, or hit with something hard? or Ever repeatedly hit at least a few minutes or threatened with a gun or knife?	YES	NO
8	Did you live with anyone who was a problem drinker or alcoholic or who used street drugs?	YES	NO
9	Was a household member depressed or mentally ill, or did a household member attempt suicide?	YES	NO
10	Did a household member go to prison?	YES	NO

PTSD Checklist – Civilian Version (PCL-C) *(To be completed on intake by or for all patients)*					
In the past month, have you been bothered by... *(Please mark how often)*	**None**	**A little bit**	**Moderately**	**Quite a bit**	**Extremely**
Repeated disturbing *memories, thoughts or image*s of a stressful experience?					
Repeated disturbing *dreams* of a stressful experience?					
Suddenly *acting or feeling* as if a stressful experience *were happening again* (as if you were reliving it)?					
Feeling *very upset* when *something reminded you* of a stressful experience?					
Having *physical reactions* (e.g., heart pounding, trouble breathing, sweating) when *something reminded you* of a stressful experience?					
Avoiding *thinking about or talking about* a stressful experience or avoiding *having feelings* related to it?					
Avoiding *activities or situations* because *they reminded you* of a stressful experience?					
Trouble *remembering important parts* of a stressful experience?					
Loss of interest in activities that you used to enjoy?					
Feeling *distant or cut off* from other people?					
Feeling *emotionally numb* or being unable to have loving feelings for those close to you?					
Feeling as if your *future* somehow will be *cut short*?					
Trouble *falling or staying asleep*?					
Feeling *irritable* or having *angry outbursts*?					
Having *difficulty concentrating*					
Being *"superalert"* or watchful or on guard?					
Feeling *jumpy* or easily startled?					

Overall Treatment Goals Worksheet *(To be completed by or for all patients)*

INSTRUCTIONS: Please list the participant's goals, in his or her own words. Functional areas are listed only to suggest areas of concern. Number the goals in order of the importance assigned to them by the participant only after all goals have been written.

Priority	Functional Area	Goals: (In the participant, parent or guardian's own words)
Please number these in order of importance	Examples:	"I want to have more friends." "I want my daughter to worry less and have more fun." "I want my son to do his chores without throwing a fit." "I want to stay out of the hospital."
	Vocational/Educational	
	Social Relationships	
	Family	
	Basic Living Skills	
	Community/Legal Health/Medical	
	Housing (Adults)	
	Financial (Adults)	
	Health/Medical (Adults)	

CLIENT RIGHTS/HIPAA & PRIVACY/ACKNOWLEDGEMENT

THEORETICAL FRAMEWORK:

- Willow Sage Services subscribes to a diverse theoretical framework including cognitive behavior therapy, family systems therapy, solution-focused therapy, and behavior therapy. We believe that each family and case is different and needs to be addressed in this manner.

CONFIDENTIALITY:

- We strongly believe in doing everything we possibly can to safeguard the privacy and security of your health information and records. We follow the Health Information Portability and Accountability Act (HIPAA, 1996). HIPAA sets federal standards for the privacy and security of patient information for all healthcare providers, plans, insurance companies and anyone that they do business with. HIPAA gives you additional rights regarding control and use of your health information, meaning that you have more access and control than ever.
- No records regarding the treatment of the client will be released without prior written authorization. Some services offered by the Willow Sage Services are community based and it is likely that services will be performed in public settings as needed for the treatment of specific issues and strict confidentiality cannot be maintained in these settings and Willow Sage Services is harmless for these breaches of confidentiality.
- Exceptions: There are situations where healthcare providers may not have to follow these privacy rules. They include: emergency circumstances; identification of a body or the cause of death; public health needs; judicial and administrative proceedings; limited law enforcement activities; and activities related to national defense and security.

PATIENT RECOURSE IF PRIVACY PROTECTIONS ARE VIOLATED:

- If your privacy is violated, report the incident to our privacy officer immediately or to the Department of Health and Human Services, Office of Civil Rights, 200 Independence Avenue, S.W., Washington, D.C. 20201. You will not be discriminated or retaliated against in any way. There are also clear limits on all healthcare providers regarding how they disclose medical information, such as Providers must ensure that health information is not used for non-health purposes. Health information (covered by the privacy rules) generally may not be used for purposes not related to health care-such as disclosures to employers to make personnel decisions, or to financial institutions-without your explicit authorization. There are clear, strong protections against using health information for marketing. The privacy rules set new definitions, restrictions and limits on the use of patient information for certain marketing purposes. Providers must get your specific authorization before sending you any materials other than those related to treatment. Use only the minimum amount of information necessary. In general, uses or disclosures of information will be limited to the minimum necessary. This does not apply to disclosure of records for treatment purposes, because physicians, specialists and other providers may need access to the full record to provide quality care.

COURT TESTIMONY:

- Willow Sage employees will testify in court only in response to a subpoena. Such time is not reimbursable by Medicaid or other insurance and additional charges may accrue. Most CBRS specialists are not licensed professionals, and are unable to offer expert witness testimony. If they are called to testify in a custody dispute, child protection case, etc., they will describe what they have seen and heard (within the limits of the law), but will offer no opinions or interpretations. Most therapists are not qualified as "custody evaluators," and are ethically obligated to say as much if they are called upon to testify. Some therapists are qualified as "custody evaluators," but this service is not reimbursable by Medicaid or most insurance coverage. Additional charges WILL accrue for any such evaluation. **BENEFITS AND RISKS:**

- The benefits of treatment outweigh the risks. The benefits include but are not limited to increased communication skills, increase independence, increase level of functioning, increased ability to utilize coping skills, and increase social interaction skills. While the risks might include but are not limited to, increased dependence on others, decomposition of symptoms, and frequency and severity of symptoms increases.

CRISIS CALLS/TIMES

- If you are in a crisis and need emergency services, please call our crisis phone at 208-258-6799, if it is a medical emergency please call 911. Our on-call staff will make every effort to assist you. OR CALL OPTUM'S 24 HOUR CRISIS LINE AT 1-855-202-0973 **YOUR RESPONSIBILITIES:**

It is your responsibility to update your client information if you move, change your phone number or change your family doctor. It is important to keep this information up to date so please notify us of any changes within 3 days or as soon as possible.

APPOINTMENTS:

Arrive 10 minutes prior to my scheduled appointment to begin the check-in process, which includes updating any changes in my demographics, providing copies of current insurance cards, etc.

It is your responsibility to keep your appointments and to be on time. If you are unable to keep an appointment please contact your worker as soon as possible. If you are going to be out of town for a few days please let your worker know when you are leaving and when you will be back to reschedule your appointments. If you have any questions, please contact our office.

CANCELLATIONS / RESCHEDULE: Contact the office *at least 24 hours in advance* if unable to keep my scheduled appointment, or as soon as is practically possible in the event of an emergency.

NO SHOWS: Failure to call in may result in a $10.00 to $25.00 charge that I am personally responsible to pay; due from me and not my insurance carrier. Willow Sage Services may discharge client from care and terminate professional relationship if there are three (3) missed appointments without satisfactory cause or failure to contact the office in advance.

MEDICATION AND FOOD ALLERGIES:

It is your responsibility to self-report any medication, food or other substance allergies immediately upon your knowledge to one of our staff members. We offer medication ,management, monitor medication and medication recalls. If you have been notified of a recall on a medication we have prescribed to you, please surrender it to the prescribing Doctor, Nurse Practitioner or PA immediately.

HISTORY AND PHYSICAL:

It is your responsibility to maintain your annual physical, well child check up and release of information for coordination of care between providers.

INFECTIONS DISEASES:

It is your responsibility to self-report infectious diseases immediately upon your knowledge to one of our staff members. This will be reported to the local health authorities. *Providers will provide services to members based on a comfort level for both the member and the Provider. If an appropriate accommodation cannot be made a referral will be made to another provider.*

YOUR RIGHTS:

INFORMED CONSENT:

- Receive information about services and providers and their rights and responsibilities.
- Informed Consent: Members and their families will be given information regarding their care options participation, medication education and benefits and risks. They will be educated in order to give informed consent for treatment and medication as well as coping with behavior health problems.
- Be treated with respect and recognition of his or her dignity and right to privacy.
- Participate with providers in making decisions about his or her care. Provider disputes should not interfere with the professional relationship between the provider and the member.A candid discussion of appropriate or medically necessary treatment options for the member's condition.Voice complaints or appeals about Optum for the services provided by Optum.Make recommendations regarding Optum's Members' rights and responsibilities policies.Care that is considerate and that respects his or her personal values and belief system.
- Personal privacy and confidentiality of information.
- Reasonable access to care regardless of race, religion, gender, sexual orientation, ethnicity, age, or disability.
- Individualized treatment, including: Member rights member rights and responsibilities .
- Adequate and humane services regardless of the source(s) of financial support.
- Provision of services within the least restrictive environment possible.
- An individualized treatment or program plan with periodic review of the treatment or program plan.
- An adequate number of competent, qualified and experienced professional clinicians to supervise and carry out the treatment or program plan.
- Participate in the consideration of ethical issues that may arise in the provision of care and services, including:Resolving conflict.Withholding resuscitative services.Foregoing or withdrawing life-sustaining treatment.Participating in investigational studies or clinical trials.
- Designate a surrogate decision-maker if he or she is incapable of understanding a proposed. treatment or procedure or is unable to communicate his or her wishes regarding care.
- Be informed, along with his or her family, of his or her Optum rights in a language they understand.
- Choose not to comply with recommended care, treatment, or procedures and be informed of the potential consequences of not complying with the treatment recommendations

CHOICE OF PROVIDER:

At any time you may request a FULL LIST OF AVAILABLE PROVIDERS and may change providers at your discretion. You are under no obligation to Willow Sage Services to continue services with us, if you choose otherwise.

HANDICAP ACCOMMODATIONS:

Members will be screened for needs of handicap accommodations. And will be informed of choices as to accommodations recommendations and client will be free to choose location of services to be provided.

EMERGENCY:

In the event that I or the named EMERGENCY CONTACT individual cannot be reached, I give my consent for the client to be treated medically in an emergency situation. I also allow Willow Sage Services to release any information that may be necessary to aid in providing accurate and quality care in the event that I may not be reached.

TRANSPORTATION:

I give my permission for Willow Sage Services, its owners, agents, and employees to transport my child to activities and treatment sessions as deemed necessary by the program employees.

CONSENT TO SERVICES

I give my permission for Willow Sage Services, to provide Mental Health Therapy, Counseling, CBRS, Case Management, Medication Management and any other mental health treatments as deemed medically necessary

DISCLOSURE AND CONSENT - ELECTRONIC TECHNOLOGY

As in all of modern life, electronic communication and technology have become integral parts of the practice of psychotherapy. The following outlines the ways in which we at Willow Sage Services utilize technology to assist our work. In all aspects of our psychotherapy practice, your welfare is our highest priority.

Third-Party (Insurance) billing and communication: If you choose to utilize third-party (insurance) coverage for psychotherapy, we will be required to convey demographic and clinical information to your payer (e.g., insurance company, Medicaid, Medicare). We utilize a "HIPAA compliant" online "electronic health record" system to maintain records and submit claims information. Some payers may require more detailed information regarding your diagnosis, progress and treatment goals. That information is submitted either via an online HIPAA compliant platform, fax, or as email attachments.

Email correspondence: Non-encrypted email is generally not considered to be a secure or private mode of communication. We make our email address known to you, and you may choose to correspond with us via email. Be aware, though, of the risk that someone may be able to access your email. Limit email communications to scheduling and other non-therapeutic communication. Our emails include a "Confidentiality Notice;" however, there is no way for us to enforce those restrictions and we cannot guarantee that your privacy will not be compromised when using email. If you have concerns about this, please limit your communication with your therapist to meetings, or to the "land-line" office telephones.

Text message: Our therapists are discouraged from giving patients their cell phone numbers, as this has been shown to be disruptive to the therapist – patient relationship. Like email, text messages are not considered to be secure. Office personnel may use outgoing text messages for the sole purpose of appointment reminders, but incoming text messages will not be acknowledged. Text messaging is not an acceptable way of cancelling or changing an appointment.

Social media: Psychotherapists operate under various codes of ethics that provide guidelines on appropriate behavior. These do not prohibit therapists from engaging with patients via social media, but they do strongly recommend against such practices. Our therapists do not "friend" patients or their family members on social media such as Facebook, LinkedIn, etc. This is to safeguard your privacy, and to maintain the professional boundaries so important to our work together.

Online / distance therapy: Online or distance therapy calls for specialized training and use of a "HIPAA compliant" technology platform that provides for patient confidentiality and privacy. Except under very specific circumstances, our psychotherapists are not available for online therapy.

Breaches: In order to comply with HIPAA and other privacy laws and regulations, electronic platforms and services must have a plan to inform consumers in the event of a data breach. If we become aware of a data breath that may have compromised your information, we will promptly inform you.

Storage: Just as your paper records are kept in a locked cabinet, we maintain a password protected Electronic Health Record system to make every effort to avoid theft or violations of your privacy.

INFORMED CONSENT

I have received a copy of CLIENT RIGHTS/HIPAA & PRIVACY/ACKNOWLEDGEMENT and DISCLOSURE AND CONSENT - ELECTRONIC TECHNOLOGY.

I have read and I understand the provided information. I have had the opportunity to ask questions and my questions have been answered to my satisfaction. I understand that my participation is voluntary and that I am free to withdraw at any time, without giving a reason and without cost. I understand that I may be given a copy of this consent form and that at any time. I have been offered and may ask at any time for and receive a new copy of the CLIENT RIGHTS/HIPAA & PRIVACY/ACKNOWLEDGEMENT and DISCLOSURE AND CONSENT - ELECTRONIC TECHNOLOGY.

By signing this I give my informed consent for Willow Sage Services to provide the necessary treatment and services. I acknowledge that I have been offered education about prognosis and outcome as well as discussed the risks of not participating in treatment.

Participant's Signature: _____ Date: _____

Patient / Guardian Signature: _____ Date: _____

PATIENT FINANCIAL RESPONSIBILITY FORM

1. INDIVIDUAL'S FINANCIAL RESPONSIBILITY I understand that I am financially responsible for my health insurance deductible, coinsurance or non-covered service. Co-payments are due at time of service. If my plan requires a referral, I must obtain it prior to my visit. In the event that my health plan determines a service to be "not payable", I will be responsible for the complete charge and agree to pay the costs of all services provided. If I am uninsured, I agree to pay for the medical services rendered to me at time of service.

2. INSURANCE AUTHORIZATION FOR ASSIGNMENT OF BENEFITS I hereby authorize and direct payment of my medical benefits to (Willow Sage Services) on my behalf for any services furnished to me by the providers.

3. AUTHORIZATION TO RELEASE **MEDICAL** RECORDS I hereby authorize (Willow sage Services) to release **private health information necessary to obtain payment** to my insurer, governmental agencies, or any other entity financially responsible for my medical care,.

Signature of Patient, Authorized Representative or Responsible Party Date

Print Name of Patient, Authorized Representative or Responsible Party Relationship to Patient

Social Security Number of Responsible Party Birthdate