# BEHAVIORAL HEALTHCARE INCORPORATED

**804 Levee Street, Hoquiam, WA 98550 Ph. 360-532-0060**
**1226 Carpenter Road SE, Ste B3, Lacey, WA 98503 Ph. 360-491-2232**
**2451 NE Kresky Avenue, Ste E, Chehalis, WA 98532 Ph. 360-532-0060**

## MEDICATION MANAGEMENT INTAKE FORM

The following information is needed for a proper assessment. Please clearly print your response to each question. Case records are strictly confidential.

**SECTION I:**

Date______________ Name_________________________________ Social Security #__________________

Address___________________________City_________________Zip______ Date of Birth_______________

Mailing Address: ___________________________ City __________________ Zip ___________

Home Phone_______________Work Phone______________ Name of Physician________________________

Age____ Sex: ___M ___F Single____ Married____Separated____Divorced____Widowed_____

Number of children____ Total # in household____ Height______ Weight______Years of Education____

Your occupation_______________________________ Place of Employment___________________________

Emergency Contact___________________________________ Phone Number_________________________

If you are a student, where do you attend school?________________________________________________

If you are 16 years or younger, name of parent/guardian __________________________________________

Person responsible for payment: ______________________________________________________________

**Who referred you to our clinic: ______________________________________________________________**

**What symptoms are causing you to seek medication management**?

__________________________________________________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

**SECTION II: Medical History**

Family Health History

| | Age: | Gender: | Mental Health Diagnosis, Symptoms Substance Abuse, Mood, Sleeping | Age Died: | Cause of Death: |
|---|---|---|---|---|---|
| Father | ____ | ______ | ____________________________ | _____ | ______________________ |
| Mother | ____ | ______ | ____________________________ | _____ | ______________________ |
| Siblings 1) | ____ | ______ | ____________________________ | _____ | ______________________ |
| 2) | ____ | ______ | ____________________________ | _____ | ______________________ |
| 3) | ____ | ______ | ____________________________ | _____ | ______________________ |
| 4) | ____ | ______ | ____________________________ | _____ | ______________________ |
| 5) | ____ | ______ | ____________________________ | _____ | ______________________ |
| Children 1) | ____ | ______ | ____________________________ | _____ | ______________________ |
| 2) | ____ | ______ | ____________________________ | _____ | ______________________ |
| 3) | ____ | ______ | ____________________________ | _____ | ______________________ |

Previous medical history <u>other than reason for being here</u>. Include significant illnesses, hospitalizations and injuries.

| Problem & Treatment | Where | Physician | Dates |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

Do you currently have an outpatient mental health provider/counselor? ____ No, ____ Yes, if yes who and how long have you seen them: _________________________________

Have you ever been admitted for an inpatient stay for a mental health condition: ____ No, ____ Yes, please describe below

| Where | Diagnosis | Dates | Results |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**SECTION III: Medications**

**Please list all medications you are now taking or have taken in the <u>past three months.</u>**

| Medication: | Strength: | Average in 24 hrs.: | Maximum in 24 hrs: | M.D. prescribing | How many months? | Benefit Yes/No |
|---|---|---|---|---|---|---|
| | | | | | | |
| | | | | | | |
| | | | | | | |
| | | | | | | |

- *Check here if additional pages attached for medication list*

*Medications to which you are allergic: ________________________________________________

Please check medications you have taken in the past and list any side effects or reactions:

___ Depakote/Valproate Acid _________________________________________________________

___ Lamictal/Lamotrigine ___________________________________________

___ Lithium ______________________________________________________

___ Tegretol/Carbamazepine ________________________________________

___Trileptal/Oxcarbazepine _________________________________________

___ Celexa/Citalopram _____________________________________________

___Cymbalta/Desvenlafaxine ________________________________________

___ Effexor/ Venlafaxine ____________________________________________

___ Elavil/ Amitriptyline ____________________________________________

___ Lexapro/ Escitalopram __________________________________________

___ Luvox/Fluvoxamine ____________________________________________

___ Pamelor/Nortriptyline ___________________________________________

___Paxil/ Paroxetine _______________________________________________

___ Prozac/ Fluoxetine ___________________________________________
___ Sinequan/ Doxepin ___________________________________________
___ Wellbutrin/Buproprion ________________________________________
___ Zoloft/ Sertraline _____________________________________________
___ Abilify/Ariprizole _____________________________________________
___ Geodon/Ziprasidone __________________________________________
___ Haldol/Haloperidol ___________________________________________
___ Invega/ Paliperidone __________________________________________
___ Latuda/ Lurasidone ___________________________________________
___ Prolixin/Fluphenazine _________________________________________
___ Risperdal/Risperidone _________________________________________
___ Saphris/ Asenopine ___________________________________________
___ Seroquel/ Quetiapine __________________________________________
___ Thorazine/Chlorpromazine ______________________________________
___ Zyprexa/Olanzapine ___________________________________________
___ Ambien/Zolpidem _____________________________________________
___ Benadryl/Diphenhydramine ______________________________________
___ Lunesta/Eszopiclone ___________________________________________
___ Remeron/Mirtazapine __________________________________________
___ Sonata/Zaleplon ______________________________________________
___ Trazodone _________________________________________________
___ Ativan/ Lorazepam ____________________________________________
___ Buspar/Buspirone _____________________________________________
___ Klonopin/Clonazepam __________________________________________
___ Valium/Diazepam _____________________________________________
___ Vistaril/Hydroxyzine ___________________________________________
___ Xanax/Alprazolam _____________________________________________
___ Adderall _____________________________________________________
___ Ritalin/ Methylphenidate _________________________________________
___ Vyvanse/ Lisdexamfetamine________________________________________
___ Strattera/ Atomoxetine___________________________________________
___ Topamax/Topiramate ____________________________________________
___ Prazosin________________________________________________________

**Which substances have you used, please mark all that apply:**

| Substance | Start | Last Use | How much per day? |
|---|---|---|---|
| Amphetamine/Methamphetamine | | | |
| Marijuana | | | |
| Crack/Cocaine | | | |
| Pain Pills | | | |
| Tranquilizers | | | |
| Heroin | | | |
| Alcohol | | | |
| LSD | | | |
| Mushrooms | | | |
| Ecstacy | | | |
| Other prescription medications | | | |
| Other Drugs | | | |

**SECTION IV: Spouse/Relationship Information**

Date of 1st marriage______ Date Divorced______ # of children____ Age(M/F)___ ___ ___ ___

Date of 2nd marriage______ Date Divorced______ # of children____ Age(M/F)___ ___ ___ ___

Date of 3rd marriage______ Date Divorced______ # of children____ Age(M/F)___ ___ ___ ___

Date of 4th marriage______ Date Divorced______ # of children____ Age(M/F)___ ___ ___ ___

Married or living with a spouse or mate? Yes____ No____ Name________________________

Age_____ Occupation_____________________ Place of Employment_____________________

**SECTION V: History**

Where are you from: ______________________________________

What states have you lived in, how long did you live in each state and why did you move:

________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________
________________________________________________________________________________

**Sleep Study:**

Do you snore loudly (louder than talking or loud enough to be heard through closed doors)?
Yes____ No____

Do you often feel tired, fatigued, or sleepy during the daytime?
Yes____ No____

Has anyone observed you stop breathing during your sleep?
Yes____ No____

Do you have or are you being treated for high blood pressure?
Yes____ No___

# BEHAVIORAL HEALTH MEDICATION MANAGEMENT PATIENT AGREEMENT

I, ______________________________, understand and voluntarily agree to the following (initial each statement after reviewing):

___ I will keep, and be on time for, all my scheduled appointments with Behavioral Healthcare.

___ I will participate in all other types of treatment that I am asked to participate in.

___ I will keep my prescribed medication safe, secure and out of the reach of children. If the medicine is lost or stolen I understand that it will not be replaced until my next appointment and may not be replaced at all.

___ I will take my medications as instructed and not change the way I take it without first talking to my provider or another member of their treatment team.

___ I will treat the staff at the office respectfully at all times. I understand that if I am disrespectful to staff or disrupt the care of other patients my treatment will be stopped.

___ I will inform my provider of all medications that I take and let them know right away if I have a prescription for a new medication.

___ I will not get any opioid pain medications or other medications that can be addictive such as benzodiazepines (Klonopin, Xanax, Valium) or stimulants (Ritalin, Amphetamine) without telling a member of the treatment team before I fill that prescription. I understand that the only exception to this is if I need pain medicine for an emergency at night or on the weekends.

___ I will not use illegal drugs such as heroin, cocaine or amphetamines. I understand that if I do, my treatment may be stopped.

___ I will come in for drug testing and counting of my pills within 24 hours of being called. I understand that I must make sure the office has current contact information in order to reach me, and that any missed tests will considered positive for drugs.

___ I will keep up to date with any bills from the office and tell my provider, or a member of the treatment team, immediately if I lose my insurance or can't pay for treatment anymore.

___ I understand that if my provider feels my medication is hurting me more than helping me that my medication may be stopped or changed by them in a safe manner.

___ I understand that I may lose my right to treatment in this office if I break any part of this agreement.

## Medication Management Statement

We here at Behavioral Healthcare Inc., are making a commitment to work with you in your efforts to get better. To help you in this work, we agree that:

- We will help you schedule regular appointments for medication refills. If we have to cancel or change your appointments for any reason, we will make sure you have enough medication to last until your next appointment.
- We will make sure that this treatment is as safe as possible. We will respond to messages or concerns to ensure you are not having bad side effects.
- We will keep track of your prescriptions and test for drug use, as needed, to help you feel like you are being monitored well.
- We will help connect you with other forms of treatment to help you with your condition.
- We will help set treatment goals and monitor your progress toward achieving those goals.
- We will work with any other doctors or providers you are seeing so that they can treat you safely and effectively.
- We will work with your medical insurance providers to make sure you do not go without medicine because of paperwork or other things they may ask for.
- If you become addicted to these medications, we will help you get treatment and get off of the medications that are causing your problems safely, without getting sick.

| ____________________ | ____________________ | ____________________ |
|---|---|---|
| Patient Signature | Patient Printed Name | Date |
| ____________________ | ____________________ | ____________________ |
| Provider Signature | Provider Printed Name | Date |

# BEHAVIORAL HEALTHCARE INC.

## OFFICE POLICY STATEMENT

Updated November 2022

### TREATING PROVIDERS:

This information is provided to explain the format and procedures involved in your treatment at Behavioral Healthcare Inc. You will be working with a Licensed Psychologist, Licensed Marriage & Family Therapist, Licensed Mental Health Counselor, Licensed Clinical Social Worker or a Licensed Psychiatric Nurse Practitioner. In order to practice in the mental health field in the State of Washington these practitioners have passed all state educational requirements and maintain active licensures with the Department of Health.

### PATIENT RESPONSIBILITY & RIGHTS:

As a participant, it will be your responsibility to make the choice to engage in treatment here and to participate actively, which may include homework and practice of new skills. It is our responsibility to teach you the skills as effectively as we can. You have the right, at any time, to question us, request changes, discontinue treatment or be referred to another therapist. In the event that you feel dissatisfied, please let the therapist know immediately. If the problem is not properly addressed, you have the right to contact the following organization with your grievance:

Department of Health
Examining Board of Psychology
P.O. Box 47868
Olympia, WA 98504-7868

### INSURANCE:

- We base our fees on the most current Professional Services Fee Schedule published by the Washington State Department of Labor and Industries (L&I). The allowable amount for your services is based on the contractual agreement we have with your insurance company. These rates can vary depending on the insurance company and provider type. Not all providers in our group are covered under the same insurance plans, if your coverages changes or you change providers we recommend discussing with staff or checking with your insurance carrier regarding your coverage.
- We make every effort to obtain your insurance information prior to your appointment and attempt to get a quote of your insurance benefits. This is a courtesy and only a quote. Based off this quote we will attempt to inform you of any applicable copays, deductibles and/or coinsurance costs that we anticipate. All payments are due at time of service. Behavioral Healthcare Inc. will submit a claim to your insurance company for processing. Once the claim finalizes your insurance will send us a remittance with their final determination, if it differs from the original quote we will inform you. You are responsible for any cost shares as outlined in your insurance plan. If

you have concerns ahead of time we recommend contacting your insurance carrier and inquiring about your outpatient mental health benefits in an office setting.

- We do offer a private pay rate for those without insurance, this rate does vary depending on the provider and service type. At this time we are not offering a sliding fee scale.
- Our office has opted out of participation of all Employee Assistance Programs (EAP) and therefore they cannot be utilized for services with our clinic.
- We are not contracted with any of the Washington State Apple Health or Medicaid plans and therefore are unable to bill to them for any services.
- All payments are due at time of service. We do accept credit, debit, cash, check and HSA cards. We are not offered by Care Credit.
- Auto Accident Claims (Personal Injury Protection-PIP) for claims related to an auto accident where PIP coverage is available we will attempt to bill your PIP claim, if for any reason the auto insurance denies the balance will be immediately due to you. We do not wait for auto insurance settlements, although if you have a private insurance we are contracted with we are willing to attempt to bill them as an alternative.
- It is your responsibility as the client to keep us updated with your current medical insurance information. We do request that you contact us immediately for any insurance changes to your account so that your information can be updated. You understand that at any time if you become ineligible under the terms of your insurance/subscriber agreement or your insurance denies your treatment that you are liable for the cost of all services rendered. You further understand that it is your responsibility to check eligibility and coverages issues with your insurance carrier if you have concerns. Behavioral Healthcare Inc. cannot guarantee eligibility and coverage for insurance plans.

**FEES:**

- Scheduled sessions are for your time and work with your provider. A minimum of 24 hours cancellation notice is required so we can offer the time to someone on the waiting list. A no-show or same-day cancellation with less than 24 hours' notice may incur a charge of $50.00, payable prior to your next visit.
- Requests to your provider to fill out paperwork or write letters may be subject to a paperwork fee of $50.00

**REMINDERS:**

Behavioral Healthcare Inc. does a courtesy reminder the day before your scheduled appointment to the number we have on file. We do only reach out to the primary number on file. If a voicemail is reached and available, a voicemail is left with the information for your upcoming appointment. If you prefer not to receive a reminder, please let staff know and they can update your account. Of note, reminder are a courtesy offered to our patients. It is still ultimately up to the patient to remember and keep their appointments on time.

**CONFIDENTIALITY:**

- The activities and issues involved in treatment are confidential. Even the fact that you are attending treatment at our clinic will be unavailable to others without your written consent. There are some specific, legally defined exceptions to this protection of information.
- If we are informed that you are planning to physically harm yourself or another person, or physically and/or sexually abusing a minor, elderly or developmentally disabled person; or are unable to meet your basic survival needs, we are required by law to report this information to the appropriate authorities. In cases of child abuse, where the abuser still has access to children, a report must be made to Child Protective Services. Also, according to state law, we must comply with a court order to release records signed by a Judge. For consultation or referral purposes, the therapists within our office may occasionally share clinical information. When working with our nurse practitioners they may share information with other your prescribing provider under continuity of care. All other information is kept strictly confidential and your consent is required to make information available to others.
- In the case of treatment being provided to a minor under the age of 13, where the parents are divorced, and there is joint-custody a release of information form must be signed to validate both parties to agreeable to therapy. In the case where one parent or guardian has sole custody, documentation must be provided to validate this.
- Per Washington State Law adolescents age thirteen and above have full mental health privileges in Washington State. Once treatment is initiated a signed Release of Information will be required for access to anything related to their care to include treatment, billing and scheduling. This release is required to discuss information with parents as well, even though they are under the age of eighteen we are legally bound to have the underage patient's written consent.
- An important aspect of confidentiality in couple's/family therapy involves information shared by each member of the couple/family. Secrets kept between one member of a couple and the therapist can be damaging to the therapy and to the well-being of the couple/family. While you may meet with your therapist individually at times, we consider what each of you tells us to belong to you as a couple/all of you as a family. This does not mean that you will not have privacy in individual meetings, but it does mean that if you disclose something to your therapist that could be damaging to your partner/family member of therapy if not shared, we will talk with you and help you share such information with your partner/family member directly.
- If being seen by more than one provider in our practice, or transferring to another provider within our practice, we are considered one entity and your PHI may be shared between the treating professionals in order to facilitate the coordination of your care.

**COURT/MANDATORY:**

As an office policy we do not participate in court or mandated treatment. By initiating treatment with our clinic you are agreeing that you are not requesting any treatment that is court related or mandatory and that if at any point this changes you realize that, at provider discretion, your services could be terminated at our clinic.

# BEHAVIORAL HEALTHCARE INCORPORATED

## Consent to Treatment and Agreement to Pay for Professional Services

I request that Behavioral Healthcare Incorporated (BHC) provide professional services to me or to a member of my family and I agree to pay the therapist's fee for these services.

I agree that this financial relationship with BHC will continue as long as the therapist provides services or until I inform him or her in person or by certified mail that I wish to end it. I agree to meet with this therapist at least once before stopping therapy. I agree to pay for services provided to me up until the time I end the relationship.

I agree that I am responsible for the charges for services provided by this therapist to me, although other persons or insurance companies may make payments on my account.

I have also read this therapist's "Office Policy Statement" brochure and agree to act according to everything stated there, as shown by my signature below.

_____________________________________________ __________________
Signature of client (or person acting for client) Date

_____________________________________________
Printed name

I, the therapist, have discussed the issues above with the client. My observations of the person's behavior and responses give me no reason to believe that this person is not fully competent to give informed and willing consent.

_____________________________________________ __________________
Signature of therapist Date

___Copy accepted by client ___Copy kept by therapist

## Behavioral Healthcare Incorporated

## HIPAA 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.**

We are required by law to maintain the privacy and security of your protected health information ("PHI") and to provide you with this Notice of Privacy Practices ("Notice"). We must abide by the terms of this Notice, and must notify you if a breach of your unsecured PHI occurs. We can change the terms of this Notice, and such changes will apply to all information we have about you. The new Notice will be available upon request, in our office, and on our website.

Except for the specific purposes set forth below, we will use and disclose your PHI only with your written authorization ("Authorization"). It is your right to revoke such Authorization at any time by giving written notice of your revocation.

**Uses (Inside Practice) and Disclosures (Outside Practice) Relating to Treatment, Payment, or Health Care Operations Do Not Require Your Written Consent**. We can use and disclose your PHI without your Authorization for the following reasons:

1. **For your treatment**. We can use and disclose your PHI to treat you, which may include disclosing your PHI to another health care professional. For example, if you are being treated by a physician or a psychiatrist, we can disclose your PHI to him or her to help coordinate your care, although our preference is for you to give sign an authorization to do so.
2. **To obtain payment for your treatment**. We can use and disclose your PHI to bill and collect payment for the treatment and services provided by our clinic to you. For example, we might send your PHI to your insurance company to get paid for the health care services that we have provided to you, although our preference is for you to give us an authorization to do so.
3. **For health care operations**. We can use and disclose your PHI for purposes of conducting health care operations pertaining to our practice, including contacting you when necessary. For example, I may need to disclose your PHI to our attorney to obtain advice about complying with applicable laws.

**Certain Uses and Disclosures Require Your Authorization**.

1. **Records:** We keep a record of your treatment and you may request a copy of such record at any time, or you may request that your provider prepare a summary of your treatment. There may be reasonable, cost-based fees involved with copying the record or preparing the summary. In regards to psychotherapy/counseling notes, these requests are provider reviewed for provider discretion and if may be denied, if denied, reason will provided as to why.
2. **Marketing Purposes**. Our clinic does not use or disclose your PHI for marketing purposes.
3. **Sale of PHI**. We will not sell your PHI in the regular course of our business.

**Certain Uses and Disclosures Do Not Require Your Authorization**. Subject to certain limitations mandated by law, we can use and disclose your PHI without your Authorization for the following reasons:

1. When disclosure is required by state or federal law, and the use or disclosure complies with and is limited to the relevant requirements of such law.
2. For public health activities, including reporting suspected child, elder, or dependent adult abuse, or preventing or reducing a serious threat to anyone's health or safety.
3. For health oversight activities, including audits and investigations.
4. For judicial and administrative proceedings, including responding to a court or administrative order, although my preference is to obtain an Authorization from you before doing so.
5. For law enforcement purposes, including reporting crimes occurring on my premises.
6. To coroners or medical examiners, when such individuals are performing duties authorized by law.
7. For research purposes, including studying and comparing the mental health of patients who received one form of therapy versus those who received another form of therapy for the same condition.
8. Specialized government functions, including, ensuring the proper execution of military missions; protecting the President of the United States; conducting intelligence or counter-intelligence operations; or, helping to ensure the safety of those working within or housed in correctional institutions.
9. For workers' compensation purposes. Although my preference is to obtain an Authorization from you, we may provide your PHI in order to comply with workers' compensation laws.
10. Appointment reminders and health related benefits or services. We may use and disclose your PHI to contact you to remind you that you have an appointment with me. We may also use and disclose your PHI to tell you about treatment alternatives, or other health care services or benefits that we offer.

**Certain Uses and Disclosures Require You to Have the Opportunity to Object.**

1. **Disclosures to family, friends, or others**. We may provide your PHI to a family member, friend, or other person that you indicate is involved in your care or the payment for your health care, unless you object in whole or in part. The opportunity to consent may be obtained retroactively in emergency situations.

## YOUR RIGHTS YOUR REGARDING YOUR PHI

You have the following rights with respect to your PHI:

1. **The Right to Request Limits on Uses and Disclosures of Your PHI**. You have the right to ask us not to use or disclose certain PHI for treatment, payment, or health care operations purposes. We are not required to agree to your request, and we may say "no" if I believe it would affect your health care.
2. **The Right to Request Restrictions for Out-of-Pocket Expenses Paid for In Full.** You have the right to request restrictions on disclosures of your PHI to health plans for payment or health care operations purposes if the PHI pertains solely to a health care item or a health care service that you have paid for out-of-pocket in full.
3. **The Right to Choose How We Send PHI to You**. You have the right to ask us to contact you in a specific way (for example, home or office phone) or to send mail to a different address, and we will agree to all reasonable requests.
4. **The Right to See and Get Copies of Your PHI**. Other than "psychotherapy notes," you have the right to get an electronic or paper copy of your medical record and other information that I have about you. We will provide you with a copy of your record, or a summary of it, if you agree to receive a summary, within 30 days of receiving your written request, and we may charge a reasonable, cost-based fee for doing so.
5. **The Right to Get a List of the Disclosures I Have Made**. You have the right to request a list of instances in which we have disclosed your PHI for purposes other than treatment, payment, or health care operations, or for which you provided me with an Authorization. We will respond to your request for an accounting of disclosures within 60 days of receiving your request. The list we will give you will include disclosures made in the last six years unless you request a shorter time. we will provide the list to you at no charge, but if you make more than one request in the same year, I will charge you a reasonable cost-based fee for each additional request.
6. **The Right to Correct or Update Your PHI**. If you believe that there is a mistake in your PHI, or that a piece of important information is missing from your PHI, you have the right to request that we correct the existing information or add the missing information. We may say "no" to your request, but we will tell you why in writing within 60 days of receiving your request.
7. **The Right to Get a Paper or Electronic Copy of this Notice**. You have the right get a paper copy of this Notice, and you have the right to get a copy of this notice by e-mail. And, even if you have agreed to receive this Notice via e-mail, you also have the right to request a paper copy of it.

## HOW TO COMPLAIN ABOUT MY PRIVACY PRACTICES

If you think we may have violated your privacy rights, you may file a complaint with our office manager.

You can also file a complaint with the U.S. Department of Health and Human Services Office for Civil Rights by:

1. Sending a letter to 200 Independence Avenue, S.W., Washington, D.C. 20201;
2. Calling 1-877-696-6775; or,
3. Visiting www.hhs.gov/ocr/privacy/hipaa/complaints.

I will not retaliate against you if you file a complaint about my privacy practices.

---

**I acknowledge receipt of: HIPAA Notice of Privacy Practices**

***Patient Name:*** ____________________________________***Date:*** _____/_____/______

***Signature:*** **X**______________________________________________________

□ Client Accepted copy of **HIPAA NOTICE OF PRIVACY PRACTICES**
□ Client Denied copy of **HIPAA NOTICE OF PRIVACY PRACTICES**