RESTORE COMPASSIONATE CARE BH
CLIENT DEMOGRAPHIC FORM

LAST NAME:	FIRST NAME:		M.I.:
D.O.B.:	GENDER: Male Female Transgender		MARITAL STATUS: Single Married Divorced Widowed
SOCIAL SECURITY NUMBER:			PREFERRED LANGUAGE: ENGLISH OTHER INDIAN SPANISH RUSSIAN
RACE: American Indian Alaska Native Asian Native Hawaiian/Other Pacific Black African American White Hispanic Other		Ethnicity: Hispanic Latin Not Hispanic or Latin Refuse to Report	
HOME ADDRESS:	CITY:	STATE:	ZIP CODE:
EMPLOYER:	WORK PHONE:	EMAIL:	
ALLERGIES (Medical Alert):			
Pharmacy:			
PRIMARY CARE PHYSICIAN:	PHONE:	REFERRING PHYSICIAN:	
What brings you do our office?			
What do you hope to achieve?			
IN CASE OF EMERGENCY CONTACT:			
FIRST NAME:	LAST NAME:	RELATION:	PHONE:
INSURANCE INFORMATION - PRIMARY:			
Insured Name:	Relationship to Patient:	D.O.B.:	
Insurance Company:			
Insurance Company Address:			
City:	State:	Zip Code:	Phone:
Policy No.:	Group No.:	Employer:	
INSURANCE INFORMATION - SECONDARY:			
Insured Name:	Relationship to Patient:	D.O.B.:	
Insurance Company:			
Insurance Company Address:			
City:	State:	Zip Code:	Phone:
Policy No.:	Group No.:	Employer:	

STATEMENT OF FINANCIAL RESPONSIBILITY/ASSIGNMENT OF BENEFIT: I acknowledge that I am legally responsible for all charges in connection with the medical care and treatment provided by representatives of the Restore Compassionate Care BH. I assign and authorize payments to Restore Compassionate Care BH. I understand that my insurance carrier may not approve or reimburse my medical services in full due to usual and customary rates, benefit exclusions, coverage limits, lack of authorization, or medical necessity. I understand that I am responsible for fees not paid in full, co-payments of _____, and policy deductibles and co-insurance except where my liability is limited by contract or state or federal law.

I give permission to leave a phone message YES / NO

_____

Patient and/or Guardian Signature Date

HEALTH QUESTIONNAIRE

PATIENT NAME:	DOB:	TODAY'S DATE:

MEDICATIONS: List all medications you are currently taking (including over the counter medications). If you need more space, use the back of this form.

ALLERGIES: List all allergies to medications. Write "NONE" if you have no known allergies.

MEDICAL HISTORY: Do you have or have had any of the following?

AIDS/HIV	COPD	Hepatitis	Multiple Sclerosis (MS)
Alcoholism	Diabetes	Herpes/Shingles	Myocardial Infarction
Anemia	Diverticulitis	High Blood Pressure	Osteoporosis
Asthma	Fibromyalgia	_Kidney disease _Kidney stones	Pneumonia/Pleurisy
_Arthritis _Rheumatoid	Gastric ulcers	Liver disease	Psoriasis
Bronchitis	Glaucoma	Lupus	Seizures
Cancer type: ______	Heart disease type: ______	Mental Illness: __Anxiety __Bipolar _Depression _PTSD _Schizophrenia	STD type: ______
Chronic pain	Heart murmur	Migraine	Stroke
Colitis	MRSA	Thyroid disease	Tuberculosis

SURGERIES/HOSPITALIZATIONS: List all and include date if known. Use the back of this form if more space is needed.

FAMILY HISTORY: Has any blood relative ever had any of the following? Match the NUMBER(S) of the medical condition with the corresponding relative.

	MEDICAL CONDITION #	Alive	Deceased (circle Alive or Deceased for each family member)			
Mother:		Alive	Deceased	1. Diabetes	6. Cancer	11. Asthma
Father:		Alive	Deceased	2. Hypertension	7. Unknown	12. Hepatitis
Sister/Brother:		Alive	Deceased	3. Heart Disease	8. Alcoholism	13. Osteoarthritis
Grandparents:		Alive	Deceased	4. Stroke	9. Thyroid	
Aunt/Uncles:		Alive	Deceased	5. Mental Illness	10. Arthritis	

SYMPTOMS: Please mark a "C" for a current problem or a "P" for a past problem. Leave unmarked if no problem(s).

EYE/EAR/NOSE/THROAT	SOCIAL HISTORY	GASTROINTESTINAL	CARDIOVASCULAR
Decreased hearing	Smoke: __YES __NO	Loss of appetite	Chest pain/Angina
Ringing in ears	Former smoker: __	Difficulty swallowing	Irregular pulse
Frequent ear infections	Quit date: U__	Heartburn	Palpitations
__ Dizzy spells __ Fainting	**STREET DRUG USE**	Persistent nausea	Swollen Ankles
Failing vision	__YES __NO	Abdominal pain	Calf pain
Nose bleeds (recurrent)	Type: __	Jaundice	Phlebitis
Sinus trouble	**ALCOHOL USE**	____ Diarrhea ____ Constipation	Varicose veins
Sore throats (frequent)	Daily: __YES __NO	Diverticulitis/Colitis	**DERMATOLOGY/ENDOCRINE**
Prolonged hoarseness	____ oz. per day	Bloody or Tarry stool	Eczema
RESPIRATORY	**COFFEE/CAFFEINE**	**NEUROLOGICAL**	Psoriasis
Allergies/hay fever	____ cups per day	Headaches (frequent)	____ Rashes ____ Hives
Shortness of breath	**SLEEPING AT NIGHT**	Numbness/tingling	Tattoos/Body piercing
Chronic cough	____ YES ____ NO	Tremors/hand shaking	**PSYCHOLOGICAL**
URINARY/GYNECOLOGICAL	**EXERCISE**	Weakness	Sleeping/concentration
Urinate more than 2x / night	____ x per week	Seizures/stroke	Nervousness/anxiety
Urgency/frequency	**FEMALES ONLY**	**MUSCULOSKELETAL**	Suicidal
Decreased stream	Date of last Menses:	Back pain (recurrent)	Memory loss
Frequent urinary infections	______	Bone fractures/joint injury	Feeling of worthlessness
Blood in urine	Current birth control	Joint pain	Phobia
Pain urinating	Type: ______	Leg pain when walking	

Informed Consent/Confidentiality

Restore Compassionate Care BH is a Mental Health and Addiction Treatment center dedicated to providing caring, innovative service to all our clients coupled with professional excellence. In order to protect your confidentiality, only your counselor, medical provider, the owner of Restore Compassionate Care BH, and the trained staff will have access to your health information in order to provide the highest quality of care to you. If using health insurance, the insurance company may request information of services in order to cover treatment. This will automatically be provided to them if you elect to use your health insurance. Counselors at Restore Compassionate Care BH may also share relevant clinical information with other counselors on staff in order to treat you in the most comprehensive manner.

We will always ensure you understand relevant medical information and the implications of treatment alternatives, so you are able to make an independent, voluntary decision. We will present the relevant information accurately and sensitively in keeping with your preferences for receiving medical information, including your diagnosis, the nature and purpose of recommended interventions, and the burdens, risks, and expected benefits of all options, including forgoing treatment.

If you believe your privacy rights have been violated, you have the right to contact the owner or send a complaint to the State of Ohio Mental Health and Addiction Services Board.

Risks and Benefits of treatment:

You have the right to know and understand the risks and benefits of treatment, as well as alternatives of treatment. You have the right to withdraw consent of medication treatment and/or therapy at any time.

At the beginning of your psychotherapy and counseling, it is possible that past negative emotions, traumatic experiences, relationship issues, and drug and alcohol use can come forward in ways that may make you feel worse in the short term, putting you at risk of losing friends and family. By continuing treatment, however, you will be able to resolve past conflicts and negative emotions, and achieve your personal goals.

There are also side-effects to medications. For example, anti-psychotics can cause weight gain, akathisia, and tardive dyskinesia. However, these medications can also help control psychotic symptoms, stabilize mood, and improve depression. Anti-depressants can cause weight gain and sexual side effects, and, in rare cases, suicidal thoughts. However, long-term treatment can improve your depression and help you become better able to succeed in your work and personal life. The risks and benefits of specific medications will be discussed will be discussed with you during your visits.

Confidentiality:

It is your responsibility to sign the necessary Authorization for Release of Protected Health Information form if you desire to share your information with another party, or have another party share your information with us. For example: Family member, friend, family physician, attorney, etc. It is also your responsibility to revoke this sign of release if you no longer want this information to be shared. The Authorization of Release of Protected Health Information form will be provided to you upon request.

There are multiple exceptions to your confidentiality. In a situation of potential harm to yourself and/or others, confidentiality may not be ensured. In cases of child abuse, neglect, or dependency, confidentiality may not be protected and may require mandated reporting to the appropriate authorities.

Regarding these exceptions to your confidentiality for substance abuse treatment, we will follow the rules and regulations outlined in 42 CFR Part 2:

In case of a medical emergency, your providers and clinician can communicate with emergency doctors and other providers to provide continuous and safe care.

Law enforcement agencies can be notified in an immediate threat to the health and safety of an individual exists due to a crime on program premises or against program personnel. We are permitted to report the crime or attempted crime to a law enforcement agency or to see kits assistance. We are able to disclose information regarding the circumstances of such an incident, including the suspect's name, address, last known whereabouts, and status as a patient in at this program.

A court order may authorize disclosure of confidential communications made by a patient to this program in the course of diagnosis, treatment, or referral for treatment, if, among other reasons, the disclosure is necessary to protect against an existing threat of life or serious bodily injury, including circumstances which constitute suspected child abuse and neglect. We may also be required to disclose your information with valid subpoena issued by a court.

We are permitted to disclosure your information to persons and organizations authorized to conduct audits and evaluations activities. However, any individual or organization conducting the audit or evaluations must agree in writing that it will only redisclose identifying information back to the program, or pursuant to a court order to investigate or prosecute the program (not a patient), or to a government agency that is overseeing a Medicare or Medicaid audit or evaluation.

Patient Signature: _____ Date: _____

Patient Printed Name: _____ Date: _____

WRITTEN SUMMARY OF FEDERAL REGULATIONS: CONFIDENTIALITY OF ALCOHOL & DRUG ABUSE CLIENT RECORDS

RCBH staff will not convey to a person outside the program that a client receives or disclose any information identifying a client as an alcohol or other drug servlces client consent in writing for the release of information, the disclosure is allowed by a court order, or the disclosure is made to qualified personnel for a medical emergency, research, audit, or program evaluation purposes.

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

Federal laws and regulations do not protect any information about suspected child abuse or neglect from being reported under State law to appropriate State or Local Authorities.

PATIENT RIGHTS AND GRIEVANCE PROCEDURE

All Restore Compassionate Care BH patients have the following rights:

(1) The right to be treated with consideration and respect for personal dignity, autonomy and privacy;

(2) The right to reasonable protection from physical, sexual or emotional abuse, neglect, and inhumane treatment;

(3) The right to receive services in the least restrictive, feasible environment;

(4) The right to participate in any appropriate and available service that is consistent with an individual service plan (ISP), regardless of the refusal of any other service, unless that service is a necessity for clear treatment reasons and requires the person's participation;

(5) The right to give informed consent to or to refuse any service, treatment or therapy, including medication absent an emergency;

(6) The right to participate in the development, review and revision of one's own individualized treatment plan and receive a copy of it;

(7) The right to freedom from unnecessary or excessive medication, and to be free from restraint or seclusion unless there is immediate risk of physical harm to self or others;

(8) The right to be informed and the right to refuse any unusual or hazardous treatment procedures;

(9) The right to be advised and the right to refuse observation by others and by techniques such as one-way vision mirrors, tape recorders, video recorders, television, movies, photographs or other audio and visual technology. This right does not prohibit an agency from using closed-circuit monitoring to observe seclusion rooms or common areas, which does not include bathrooms or sleeping areas;

(10) The right to confidentiality of communications and personal identifying information within the limitations and requirements for disclosure of client information under state and federal laws and regulations;

(11) The right to have access to one's own client record unless access to certain information is restricted for clear treatment reasons. If access is restricted, the treatment plan shall include the reason for the restriction, a goal to remove the restriction, and the treatment being offered to remove the restriction;

(12) The right to be informed a reasonable amount of time in advance of the reason for terminating participation in a service, and to be provided a referral, unless the service is unavailable or not necessary;

(13) The right to be informed of the reason for denial of a service;

(14) The right not to be discriminated against for receiving services on the basis of race, ethnicity, age, color, religion, gender, national origin, sexual orientation, physical or mental handicap, developmental disability, genetic information, human immunodeficiency virus status, or in any manner prohibited by local, state or federal laws;

(15) The right to know the cost of services;

(16) The right to be verbally informed of all client rights, and to receive a written copy upon request;

(17) The right to exercise one's own rights without reprisal, except that no right extends so far as to supersede health and safety considerations;

(18) The right to file a grievance;

(19) The right to have oral and written instructions concerning the procedure for filing a grievance, and to assistance in filing a grievance if requested;

(20) The right to be informed of one's own condition; and,

(21) The right to consult with an independent treatment specialist or legal counsel at one's own expense.

I have read or have had this form read to me, and I fully understand its contents.

Signature: _____ Date: _____

Witness: _____ Date: _____

RESTORE COMPASSIONATE BEHAVIORAL HEALTH
FEE SCHEDULE AND POLICIES

Code	Description	Pay
90791	PSYCH DIAGNOSIS INTERVIEW	200.00
90792	PSYCHIATRIC DIAGNOSIS INTERVIEW	250.00
90832	PSYCHOTHERAPY (30 minutes)	140.00
90834	PSYCHOTHERAPY (45 minutes)	150.00
90837	PSYCHOTHERAPY (60 minutes)	185.00
90847	FAM PSYTX W/ PATIENT	200.00
99201	NEW PT. OFFICE VISIT 10 MINUTES	150.00
99202	NEW PT. OFFICE VISIT 20 MINUTES	175.00
99203	NEW PT. OFFICE VISIT 30 MINUTES	200.00
99204	NEW PT. OFFICE VISIT 45 MINUTES	225.00
99205	NEW PT. OFFICE VISIT 60 MINUTES	250.00
99212	PT. OFFICE VISIT 10 MINUTES	150.00
99213	PT. OFFICE VISIT 15 MINUTES	185.00
99214	PT. OFFICE VISIT 25 MINUTES	200.00
99215	PT. OFFICE VISIT 40 MINUTES	250.00
	SELF-PAY PSYCH DIAGNOSIS INTERVIEW	150.00
	SELF-PAY PSYCHIATRIC DIAGNOSIS INTERVIEW	150.00
	SELF-PAY PSYCHIATRIC COUNSELING AND FOLLOW-UP	75.00

MISSED APPOINTMENTS OR LATE CANCELLATIONS:

There will be no charge for appointments cancelled at least 24 hours before the scheduled appointment time. However, due to the nature of psychological and psychiatric services, payment for the time reserved is necessary for late cancellations (less than 24 hours prior to the scheduled appointment) and missed appointments. Unlike many professional practices which allow "overbooking", brief visits, and crowded waiting rooms, your appointment means you have reserved a session of professional time. This is time that, for practical purposes, is lost and cannot be made up if the appointment is cancelled late. It also is time that may have been utilized for the benefit of another person with proper advanced cancellation. Therefore, there will be a charge of $50.00 for late cancellations. Missed appointments with no prior notification will be charged $50.00. these are charges not covered by health insurance.

PAYMENT:

Cash, Discover, American Express, Visa, and MasterCard is accepted. A fee will be charged for any check returned due to insufficient funds. Full payment is due following each session.

INSURANCE COVERAGE:

RCBH has agreed to contractual arrangements with many insurance or managed care companies, as well as Medicare and Medicaid. The terms of these contractual agreements, which typically include allowed charges, will supersede the above fee schedule. For individuals who have Medicaid, no additional out of pocket costs are required as Medicaid payments are accepted as full payment. RCBH will make reasonable efforts to determine your specific coverage and financial responsibilities in advance of treatment; though responsibility for the accuracy of coverage details remains yours. It is the clients responsibility to notify RCBH of changes in coverage; and failure to notify RCBH may result in charges to the patient due to insurance denial of payment. You will need to provide RCBH with the necessary information describing your coverage, as well as your signature for authorization for RCBH to provide information required by your insurance company. It is RCBH policy that co-payments are due at the time of service. Following the processing of the insurance claim, the insurance company typically provides an Explanation of Benefits (EBO), which identifies the patient balance due for the service, such as an amount applied to the deductible. This amount will then be due in full.

Signature: _____ Date: _____

PATIENT HEALTH QUESTIONNAIRE-9 (PHQ-9)

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

FOR OFFICE CODING 0 + _____ + _____ + _____

=Total Score: _____

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all	Somewhat difficult	Very difficult	Extremely difficult
☐	☐	☐	☐

Mood Disorder Questionnaire (MDQ)

Name: _____ Date: _____

Instructions: Check (Ø) the answer that best applies to you. Please answer each question as best you can.	Yes	No
1. Has there ever been a period of time when you were not your usual self and...		
...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 you didn't really miss it?	◯	◯
...you were much more talkative or spoke 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 much 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? *Please check 1 response only.*	◯	◯
3. How much of a problem did any of these cause you — like being able to work; having family, money, or legal troubles; getting into arguments or fights? *Please check 1 response only.* ◯ No problem ◯ Minor problem ◯ Moderate problem ◯ Serious problem		
4. Have any of your blood relatives (ie, children, siblings, parents, grandparents, aunts, uncles) had manic-depressive illness or bipolar disorder?	◯	◯
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	◯	◯

This questionnaire should be used as a starting point. It is not a substitute for a full medical evaluation. Bipolar disorder is a complex illness, and an accurate, thorough diagnosis can only be made through a personal evaluation by your doctor.

Adapted from Hirschfeld R, Williams J, Spitzer RL, et al. Development and validation of a screening instrument for bipolar spectrum disorder: the Mood Disorder Questionnaire. *Am J Psychiatry.* 2000;157:1873-1878.

Generalized Anxiety Disorder 7-item (GAD-7) scale

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	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's 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
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

If you checked off any problems, how difficult have these 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

Scores of 5, 10, and 15 are taken as the cut-off points for mild, moderate and severe anxiety, respectively. When used as a screening tool, further evaluation is recommended when the score is 10 or greater.

Using the threshold score of 10, the GAD-7 has a sensitivity of 89% and a specificity of 82% for GAD. It is moderately good at screening three other common anxiety disorders - panic disorder (sensitivity 74%, specificity 81%), social anxiety disorder (sensitivity 72%, specificity 80%) and post-traumatic stress disorder (sensitivity 66%, specificity 81%).

Source: Spitzer RL, Kroenke K, Williams JBW, Lowe B. A brief measure for assessing generalized anxiety disorder. *Arch Intern Med.* 2006;166:1092-1097.

Restore Compassionate Behavioral Health

725 Boardman Canfield Rd L1, L2, M

Youngstown, OH 44512

Patient Name:_____

Date of Birth:_____

Emergency Contact(s)

I would like the following person(s) to be contacted in case of Emergency:

Name of person:_____

Relationship to patient:_____

Phone # of contact:_____

Name of person:_____

Relationship to patient:_____

Phone # of contact:_____

Release of Medical Information Authorization

_____ I do not authorize release of my medical information to anyone but myself

_____ I authorize release of my medical information to the following:

Name:_____ Relationship:_____

Name:_____ Relationship:_____

Patient or Parent/Guardian Signature:_____ Date:_____

Restore Compassionate Behavioral Health

725 Boardman Canfield Rd L1

Boardman, OH 44512

Informed Consent Controlled Substance Agreement

Because of the recent increase in addiction and long terms risks of combination of Stimulants and Benzodiazepine, Ambien, Lunesta etc. like products, we will no longer be using those combinations for more than 60 days.

We will safely taper those medications and encourage you to work with your counselors to deal with coping mechanisms and skills.

Any patients prescribed a controlled substance is subject to a random Pillcount and random urine drug screen. You will have 48 hours to comply with the Pillcount and/or urine drug screen. It is the patient's responsibility to notify the front desk of any changes with your phone number or address.

We will be more than happy to transfer your records to other providers if you chose so.

Patient Name:_____

Patient Signature:_____

Date_____