## *Client Demographics*

| Client: | | SSN: | Date: |
|---|---|---|---|
| DOB: | Gender: | Phone: | Email: |

| Type of Residence: Family Certified Home Res. Hab. Independent Living Foster Care Other: |
|---|

| Physical Address: | City: | State: | Zip: |
|---|---|---|---|
| Mailing Address: Same | City: | State: | Zip: |

| Parent/Guardian: | Phone: | Email: |
|---|---|---|
| Parent/Guardian: | Phone: | Email: |
| Foster Parent: | Phone: | Email: |

If you <u>do not</u> want to receive text message or email reminders, please check here ☐ (Cell Number: _________________)

| Emergency Contact: | Relationship: | Phone: |
|---|---|---|
| Emergency Contact: | Relationship: | Phone: |
| Person(s) authorized to pick up client other than those listed above: | | |

## *Responsible Party*

| Name: | Birth Date: |
|---|---|
| SSN: | Address: |

## *Current Medications*

| Medication | Dosage | Date Prescribed | Doctor |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| Primary Care Doctor | | | |
| Any known Drug or Food Allergies | | | |
| Any special dietary needs | | | |

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Would you like to have someone to help you with any of the following:

Medical: Help with your healthcare/medication needs? □ YES □ NO
Counseling: Help with your mental health concerns? □ YES □ NO
Skills Building/CBRS: Help with learning skills at home or in the community? □ YES □ NO
Peer Support: Support and encouragement at home or in the community? □ YES □ NO
Family Support: Support and encouragement with your family? □ YES □ NO
Case Management: Help with connecting to needed services? □ YES □ NO

Developmental services (recommended services based on cognitive functioning)

Developmental Therapy: help with developing life and social skills? □ YES □ NO
Habilitative Interventions: help with changing behavior for children and adolescents? □ YES □ NO
Residential Habilitation: help with daily living skills? □ YES □ NO
Habilitative Supports: help with children to develop social skills with peers? □ YES □ NO

Please list any services you are receiving from another provider, including any of those listed above.

_______________________________________________________________________________

_______________________________________________________________________________

Please list preferred provider, if any.
Counselor ________________________ CBRS ______________________ Doctor ______________________

## FOR OFFICE USE ONLY

***Medicaid Information***

| Medicaid Number: | Medicaid Card Copied: Y/N | Basic / Enhanced |
|---|---|---|
| Healthy Connections Provider: | | |

***Private Pay Insurance Information***

| Name of Insurance: | |
|---|---|
| Insurance ID# | Group #: |
| Insured Name: | Relationship: |
| Date of birth: | Place of employment: |
| Address: | |

| EAP Program: | # Sessions: | Authorization # |
|---|---|---|

| Self Pay? Please Circle Yes : No | |
|---|---|

***Informed Consent for Outpatient Treatment***

By initialing & signing this document, you acknowledge that you understand and agree with the following:

______I acknowledge that I have been given a list of local providers and choose to receive services from *Positive Connections Plus, LLC.*

______While I expect benefits from this treatment, I understand and accept that the practice of Psychotherapy, Community Based Rehabilitation Services (CBRS, formerly PSR), other clinical services and/or Developmental Services is not an exact science and that because of factors beyond their control, the service providers at this office make no guarantees as to the outcome of my treatment.

______I understand the importance of regular attendance and review of treatment goals and agree to play an active role in the treatment process. I also understand that I may choose to seek the services of another provider or terminate treatment at any time.

______I understand that Positive Connections Plus is not providing emergency services and I have been informed of whom and/or where to call in an emergency during the evening, weekend, or after regular business hours.

______I acknowledge that if I become a threat to myself or others, or if a child, adult, or elderly person in treatment discloses being neglected or abused; *Positive Connections Plus* staff will take the necessary interventions to protect me, my child and/or others.

______I acknowledge that I have received a copy of the brochure "*Notice of Privacy Practices*" and "*Your Rights as a Client*" which includes "*Right to Voice Grievances*". I have read them and understand them completely. I also acknowledge that I have read and signed the Positive Connections Plus *"Financial Policy,"* and all other forms presented to me.

______I acknowledge that I give permission for treatment for myself or child. I allow permission to receive services on-site, in the community, and/or in home. I also allow for transportation in the community for activities as deemed necessary.

______I acknowledge that I give permission to *Positive Connection Plus* to contact the proper medical authorities for the client's emergency medical needs. *Positive Connections Plus* is not and shall not be responsible for any medical expenses acquired due to the emergency.

______I acknowledge that I hereby waive any and all claims which may arise against *Positive Connections Plus*, its employees, volunteer and assignees. As a result of services provided in this authorization with the exclusion of any willful or intentional acts which *Positive Connections Plus*, its employees, volunteers and assignees may commit and which may result in harm or injury to person(s) including transportation services provided by the agency.

______***By signing this form, I confirm that I: (a)***have had full opportunity to read and/or have been read to and consider the contents of this consent form and the Notice of Privacy Practices, and I have received and read the Consumer Rights Form and understand its contents. It has also been explained to me the procedures for handling questions and complaints; ***(b)***I am giving permission for treatment in the office, home, community, and school and that I authorize Positive Connections Plus staff to transport to activities in the community.

- As licensed psychotherapists, counselors are required to participate in ongoing continuing education and/or supervision to maintain their clinical licenses as therapists and enhance their therapeutic skills.

- I also give my consent for my counselor or student intern counselor to seek consultation and supervision as needed on my behalf. Including supervision provided by the physician that provides the medical oversight of this clinical office.

- I have been given sufficient information to understand the nature of treatment, the *Positive Connections Plus* health care operations, billing and payment policies, confidentiality including legal and ethical limits, possible risks and benefits of treatment, and alternative treatments available.

- ***Right to Revoke:*** I will have the right to revoke this consent at any time by giving Positive Connections Plus a written notice of my revocation. I understand that revocation of this consent will not affect any action Positive Connections Plus took in reliance on this consent before they received my revocation, and that Positive Connections Plus may decline to treat me or to continue treating me if I revoke this consent.

In addition, I understand that, by signing this consent form, **I am giving my consent to your use and disclosure of my protected health information to carry out treatment, payment activities and health care operations**

*By signing this agreement, I acknowledge that I have had the opportunity to fully discuss all aspects of treatment, have my questions answered, and understand the outpatient treatment process. Therefore, I agree to comply with treatment and authorize my designated provider to administer treatment to me and/or my child.*

______________________________
Name of Client

______________________________ ______________________
Signature of Client, Parent or Guardian Date

______________________________________________________
Signature of Positive Connections Plus Staff Date

**ONLY SIGN BELOW IF YOU ARE REVOKING YOUR CONSENT**

I ***revoke*** my consent for Positive Connections Plus to use and disclose my protected health information for treatment, payment activities and health care operations. I understand that revocation of my consent will *not* affect any action in reliance on my consent before Positive Connections Plus received this written notice of revocation. I also understand that Positive Connections Plus may decline to treat or continue to treat me after I have revoked my consent.

______________________________________________________
Signature of Client/Parent/Guardian Date

## *Financial Policy • Payment Contract for Services*

The staff at Positive Connections Plus, LLC is committed to providing caring and professional clinical and medical health care to our clients. As part of the delivery of healthcare services we have established the following financial policy, which provides payment policies and options to all consumers. Adjusted scale is available upon request.

Please read and initial the following:

______ Insurance information is due at initial appt. If not provided client will pay for the appointment and all charges at time of service or will not be seen until the insurance information is provided.

_______I am responsible for all charges at the time of service. Positive Connections may submit insurance information to my insurance company for processing but does so only as a courtesy for me. I am responsible to pay all charges before my insurance company pays or determines the amount I owe after insurance regardless of any billing mistakes or disputes.

______ My insurance policy, if any, is a contract between me and the insurance company. Positive Connections is not part of the contract with me and my insurance company. As a service to me, Positive Connections' billing staff will submit claims to insurance companies and other third-party payers but cannot guarantee benefits or the amounts covered. Positive Connections is not responsible for the collection of such payments and I will be responsible for payment.

______ The Person(s) Responsible for Payment will make payments for services, co-payments, and deductibles not paid by insurance. Your insurance company may not pay for services that they consider to be non-helpful, not medically or therapeutically necessary, or ineligible (not covered by policy, expired policy, policy not in effect). Clients are responsible for payments regardless of any insurance company's arbitrary determination of usual and customary rates. The Person(s) Responsible for Payment of Account is responsible for paying funds not paid by insurance companies or third-party payers within 60 days. Payments not received after 120 days are subject to collection action and will be charged interest.

______ **For those clients who qualify for Medicaid payment for services and are notified that their personal or family benefits will be discontinued, the client, parent or guardian is responsible to inform Positive Connections Plus. Clients are also responsible for informing Positive Connections Plus if their Healthy Connections Provider has changed. Clients, who fail to inform Positive Connections Plus and continue to receive services, are liable for payment for all services rendered after the discontinuation of Medicaid payments. According to Medicaid rules, you are legally responsible for any services not covered by Medicaid including charges for missed/late/cancelled appointments.**

The following fees are POSITIVE CONNECTIONS PLUS LLC's normal and customary charges for services. If you receive any other services during your appointment you will be charged accordingly.

______ ALL CO-PAYS AND PAYMENTS ARE DUE AT TIME OF SERVICE, PRIOR TO BEING SEEN UNLESS PRIOR ARRANGEMENTS HAVE BEEN ESTABLISHED.

______ THERE WILL BE A $25 FEE FOR ANY ELECTRONIC OR PAPER CHECKS RETURNED FOR ANY REASON.

**<u>Clinical</u>**

______ $200 per each Mental Health and/or Anger Assessment. The fee for intake and testing includes scoring and report writing time.
______ $120 for individual counseling. $150 for family and relationship counseling. A clinical hour is 45-50 minutes.
($90 to $200 depending on length and type of session)
______ $50 per group session.

**Neuropsychological Evaluation**

______ $200 initial appointment

______ $150 per hour of testing

______ $120 for feedback session

**Medical**

______ $300.00 for Initial Visit and Medical Examination

______ $125.00 for follow up appointments. $80.00 if cash payment paid date of service. Other charges may be assessed for additional procedures or testing.

**Substance Abuse**

______$294 Gain Assessment

______$30 Substance Testing

**Patient Authorization for Third Party Reimbursement of Provider**

I request that payment of Medicare, Medicaid, and/or Private Insurance benefits on my behalf for Positive Connections Plus for services. I authorize any holder of medical information about me to be released to the centers for Medical Services, and/or any third party payer (s) and their agents. This can be any information needed to determine the benefits payable for related services. ***I hereby authorize the payment of medical benefits to be paid to POSITIVE CONNECTIONS PLUS for services rendered to the insured parties by POSITIVE CONNECTIONS PLUS.***

I (we) have read, understand, and agree with the provisions of this Financial Policy/Payment Contract for Services.

______________________________ ______________

Signature of Person Responsible for Account Date

**ONLY COMPLETE THE FOLLOWING IF YOU HAVE MEDICAID and/or MEDICARE COVERAGE**

## Advanced Beneficiary Notice of Non-Coverage

Patient Name: ______________________ Medicare/Medicaid Number ______________________

**NOTE:** If Medicare/Medicaid does not pay for rendered services, you will have to pay yourself.

Medicare/Medicaid does not cover everything, even some care that you or your health care provider have good reason to think you need.

What you need to know:

- Read this notice so you can make an informed decision about your care.
- Ask us any questions you may have after you finish reading.
- Choose one option below about whether to receive the services offered.

**NOTE:** If you Choose option 1 or 2 we may help you to use any other insurance that you might have but Medicare/Medicaid can't request us to do this. Check only one box. We cannot choose a box for you.

## Options:

- ☐ **Option 1:** I want services. I want Medicare/Medicaid billed for an official decision on payment. I understand that if Medicare/Medicaid does not pay that I am responsible for payment. I will have the option to appeal the Medicare/Medicaid decision. If Medicare/Medicaid does pay, I will be given a refund of payment I made to Positive Connections Plus less co-pay and/or deductions.

- ☐ **Option 2:** I want services and I do not want Positive Connections Plus to bill Medicare/Medicaid. I will be responsible for payment and I cannot appeal if Medicare/Medicaid is not billed.

- ☐ **Option 3:** I do not want services. I understand with this choice that I am not responsible for payment and I cannot appeal to see if Medicare would pay.

______________________________________ ______________________

**Signature of Responsible Party** **Date**

# Notice of Privacy Practices

**Please review carefully**

**Summary of Notice of Privacy Practices (provided at initial session)**

By law we are required to provide you with our Notice of Privacy Practices. This notice describes how your medical information may be used and disclosed by Positive Connections Plus. It also tells you how you can obtain access to this information.

As a patient you have the following rights:

- The right to copy and inspect your information.
- The right to request corrections to your information.
- The right to request your information be restricted.
- The right to request confidential communications.
- The right to a paper copy of this notice.

We want to ensure that your health information is secure with us. This notice contains information about how we will insure that your information remains private.

If you have any questions about this, please contact us at our office during regular business hours.

I herby acknowledge that I have received a copy of this practice's Notice of Privacy Practices. I understand that if I have questions or concerns regarding my privacy rights that I may contact Positive Connections Plus. I further understand that the practice will offer me updates to this Notice of Privacy Practices should it be amended, modified, or changed in anyway.

| | |
|---|---|
| ______________________ | ______________________ |
| Patient or Representative Name (Print) | Patient or Representative Signature |
| ______________________ | ______________________ |
| Date | Patient refused/unable to sign (explain below) |

Positive Connections Plus LLC

Date: ____________________________ Client: ___________________________ Clinician: _________________________

## Current Problems and Medical History

Why are you here today?

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

What do you want to accomplish through treatment?

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

EMOTIONAL SYMPTOM CHECKLIST (Rate intensity of symptoms currently present)

**None** = this symptom not present at this time • **Mild** = Impacts quality of life, but no significant impairment of day-to-day functioning

**Moderate** = Significant impact on quality of life and/or day-to-day functioning • **Severe** = Profound impact on quality of life and/or day-to-day functioning

| | None | Mild | Moderate | Severe | | None | Mild | Moderate | Severe | | None | Mild | Moderate | Severe |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Depressed Mood | [ ] | [ ] | [ ] | [ ] | Phobias | [ ] | [ ] | [ ] | [ ] | Elevated Moods | [ ] | [ ] | [ ] | [ ] |
| Change in Appetite | [ ] | [ ] | [ ] | [ ] | Obsessions/compulsions | [ ] | [ ] | [ ] | [ ] | Hyperactivity | [ ] | [ ] | [ ] | [ ] |
| Sleep Disturbance | [ ] | [ ] | [ ] | [ ] | Eating Disorder | [ ] | [ ] | [ ] | [ ] | Self Mutilation | [ ] | [ ] | [ ] | [ ] |
| Problems with bladder | [ ] | [ ] | [ ] | [ ] | Weight Change | [ ] | [ ] | [ ] | [ ] | Emotional Trauma | [ ] | [ ] | [ ] | [ ] |
| Problems with Bowels | [ ] | [ ] | [ ] | [ ] | Feeling Hopeless | [ ] | [ ] | [ ] | [ ] | Physical Trauma | [ ] | [ ] | [ ] | [ ] |
| Fatigue/Low Energy | [ ] | [ ] | [ ] | [ ] | Feeling Worthless | [ ] | [ ] | [ ] | [ ] | Sexual Trauma | [ ] | [ ] | [ ] | [ ] |
| Racing Thoughts | [ ] | [ ] | [ ] | [ ] | Feeling Paranoid | [ ] | [ ] | [ ] | [ ] | Internet Addiction | [ ] | [ ] | [ ] | [ ] |
| Poor Concentration | [ ] | [ ] | [ ] | [ ] | Social Isolation | [ ] | [ ] | [ ] | [ ] | Pornography Addiction | [ ] | [ ] | [ ] | [ ] |
| Poor Grooming | [ ] | [ ] | [ ] | [ ] | Delusions | [ ] | [ ] | [ ] | [ ] | Substance Abuse | [ ] | [ ] | [ ] | [ ] |
| Mood Swings | [ ] | [ ] | [ ] | [ ] | Hallucinations | [ ] | [ ] | [ ] | [ ] | Addiction specify: | | | | |
| Physical Agitation | [ ] | [ ] | [ ] | [ ] | Aggressive Behaviors | [ ] | [ ] | [ ] | [ ] | __________ | [ ] | [ ] | [ ] | [ ] |
| Extreme Emotions | [ ] | [ ] | [ ] | [ ] | Trouble with the law | [ ] | [ ] | [ ] | [ ] | Other specify: | | | | |
| Irritability | [ ] | [ ] | [ ] | [ ] | Oppositional/Defiance | [ ] | [ ] | [ ] | [ ] | _____________ | [ ] | [ ] | [ ] | [ ] |
| Anxiety | [ ] | [ ] | [ ] | [ ] | Grief/Loss Issues | [ ] | [ ] | [ ] | [ ] | Other: specify: | | | | |
| Panic attacks | [ ] | [ ] | [ ] | [ ] | Feelings of Guilt | [ ] | [ ] | [ ] | [ ] | _____________ | [ ] | [ ] | [ ] | [ ] |

**COMMENTS** (Please explain any checked answers):

_______________________________________________

_______________________________________________

_______________________________________________

_______________________________________________

DEVELOPMENTAL HISTORY (check all that apply for client)

**Chldhood Emotional / Behavior Problems** (check all that apply):

[ ] drug use
[ ] stealing
[ ] assaults others
[ ] often sad
[ ] self-injury acts
[ ] easily distract
[ ] hyperactive
[ ] other __________

[ ] alcohol abuse
[ ] distrustful
[ ] animal cruelty
[ ] frequently tearful
[ ] indecisive
[ ] fire-setting
[ ] poor concentration

[ ] not trustworthy
[ ] violent temper
[ ] disobedient
[ ] extreme worrier
[ ] impulsive
[ ] bizarre behavior
[ ] lack of attachment

[ ] chronic lying
[ ] breaks things
[ ] repeats others
[ ] self-injury threats
[ ] immature
[ ] hostile/angry mood
[ ] frequent daydreams

**Developmental Problems:**

***[ ] autism**
***[ ] Epilepsy (age___)**
***[ ] *Cerebral palsy* (*age:* ____)**
***[ ] Mental Retardation Intellectual disability (age: ___)**
***[ ] Other Developmental diagnosis: (age: ____)**
*DT Qualifiers

**Comments:**

_______________________________________________

_______________________________________________

_______________________________________________

Date: ______________________ Client: ______________________ Clinician: ______________________

MEDICAL HISTORY (check all that apply for patient)

**Childhood health:**

[ ] chickenpox (age ___)
[ ] lead poising (age ___)
[ ] German measles (age ___)
[ ] mumps (age ___)
[ ] red measles (age ___)
[ ] diphtheria (age ___)
[ ] rheumatic fever (age ___)

[ ] poliomyelitis (age ___)
[ ] whooping cough (age ___)
[ ] pneumonia (age ___)
[ ] scarlet fever (age ___)
[ ] tuberculosis (age __)
[ ] bleeding
[ ] asthma

[ ] allergies to ______________________________ __
[ ] significant injuries ______________________________
[ ] chronic, serious health problems ______________________

**Past Medical History (medical problems that have required you to see a Dr, take medication or be hospitalized)**

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________
7. ______________________________
8. ______________________________

**Past Surgical History (procedure and date of surgery)**

1. ______________________________ Date: ______________________________
2. ______________________________ Date: ______________________________
3. ______________________________ Date: ______________________________

**Use of Tobacco** ( ) Never ( ) Chew Current pack/day ____________ Quit ____________
**Caffeine** ( ) Never ( ) Rarely ( ) Daily Type ______________________________

**Vaccinations**

☐ Flu Date: ______________________
☐ Tetanus Date: ______________________
☐ Pneumovax Date: ______________________

**Family Medical History (Have any of the following been diagnosed in your family?)**

| | | | | | |
|---|---|---|---|---|---|
| Diabetes | Y/N | AIDS | Y/N | Asthma or Lung Condition | Y/N |
| Heart | Y/N | Stroke | Y/N | High Blood Pressure | Y/N |

**COMPLETE NEXT SECTION FOR MEDICAL APPOINTMENTS**

---

**Review of System**

| **General** | | **Ear/Nose/Mouth/Throat** | | **Eyes** | | **Psychiatric** | |
|---|---|---|---|---|---|---|---|
| Fatigue | Y/N | Decreased Hearing | Y/N | Eye Pain | Y/N | Anxiety | Y/N |
| Fevers | Y/N | Earache | Y/N | Vision Loss | Y/N | Depression | Y/N |
| Weight Loss | Y/N | Hoarseness | Y/N | Dbl Vision | Y/N | Mental Illness | Y/N |
| Sleep Problem | Y/N | Nose Bleeds | Y/N | | | | |

| **Cardiovascular** | | **Respiratory** | | **Neurological** | | **Skin** | |
|---|---|---|---|---|---|---|---|
| Chest Pain | Y/N | Cough | Y/N | Headache | Y/N | Bruising | Y/N |
| Palpitations | Y/N | Coughing Blood | Y/N | Fainting Spell | Y/N | Rash | Y/N |
| Leg Swelling | Y/N | Shortness of Breath | Y/N | Dizziness | Y/N | Lesions | Y/N |

Date: ______________________________ Client: _____________________________ Clinician: __________________________

| **Gastrointestinal** | | **Musculoskeletal** | | **Allergic/Immunologic** | |
|---|---|---|---|---|---|
| Abdom. Pain | Y/N | Back Pain | Y/N | Hay Fever | Y/N |
| Constipation | Y/N | Neck Pain | Y/N | Persistent Infection | Y/N |
| Diarrhea | Y/N | Joint Pain/Swelling | Y/N | Hives | Y/N |
| **Hematologic/Lymphatic** | | **Endocrine** | | **Male Only** | |
| Bleeding Problems | Y/N | Cold/Heat Intolerance | Y/N | Difficult w/erection | Y/N |
| Varicose Veins | Y/N | Excessive Urination | Y/N | Increased Urination | Y/N |
| History of Cancer | Y/N | Unusual Thirst | Y/N | | |

| **Females Only** | | **Breasts** | |
|---|---|---|---|
| Vaginal Bleeding | Y/N | Masses | Y/N |
| Pelvic Pain | Y/N | Nipple Discharge | Y/N |
| Vaginal Discharge | Y/N | Pain | Y/N |

**COMMENTS** (medical in detail):

_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________
_____________________________________________________________________________________

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