RURAL
BEHAVIORAL HEALTH SERVICES

59448 Highway 10 West Bogalusa, LA 70427 985-732-0253

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

PLEASE PRINT **Date:** _____

Patient Name _____

Social Security# _____ Date of Birth _____

Address_____

Rural Behavioral Health Services (RBHS)/JMJ Psychological Services is hereby authorized to **disclose/request (circle one**) the following protected health information from the medical records of the patient listed above to/from:

Name of Entity _____

Mailing Address _____ Fax# _____
Medical Records Departments

City/State/Zip

_____

Disclose the following protected health information (Please check all that apply)
___ All records from _____ to _____ _____X-Ray Reports/MRI Reports

___ I understand that the information disclosed may contain information relating to Alcohol or Substance Abuse, Mental Health, AIDS, or HIV
The above protected health information is disclosed/requested for the following purposes (check all that apply)
___Medicare Care ____Medicaid _____Insurance ____Litigation ___Other

The Authorization shall expire upon this date or event_____
If I fail to specify an expiration date or event, this authorization will expire in one year from the date signed. I understand that I may revoke this authorization at any time in writing by contacting the office listed above. I understand that this revocation does not apply to information that has already been released in response to this authorization. I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by the federal privacy regulations, the information obtained may be re-disclosed and no longer protected by these regulations. A copy of this will have the same effect as the original. Failure to sign the authorization will have no adverse impact on delivery of care. I have read the above and authorize the use of disclosure of the protected health information as stated.

_____ _____
Signature of Patient or Legal Representative Date of Signature

If signed by legal representative, relationship to patient _____

_____ _____
Signature of Witness Date of Signature

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Client HIPAA Acknowledgment and Consent Form
Consent to Email or Text Usage for Appointment Reminders and Other Healthcare Communications

RBHS' clients may be contacted via email and/or text messaging to remind you of an appointment and/or to provide general health reminders/information.

If at any time I provide an email-or text address at which I may be contacted, I consent to receiving appointment reminders and other healthcare communications/information at that email or text address from the Practice.

_____ (Client Initials) I consent to receive text messages from the practice at my cell phone and any number forwarded or transferred to that number or emails to receive communication as stated above. I understand that this request to receive emails and text messages will apply to all future appointment reminders/feedback/health information unless I request a change in writing (see revocation section below).

The cell phone number that I authorize to receive text message for appointment reminders, feedback and general health information is (include area code)

_____

The email that I authorize to receive email messages for appointment reminders and general health reminders/feedback/information is

_____

RBHS does not charge for this service, but standard text messaging rates may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Patient Name (Print Clearly) _____

Patient Signature _____ Date_____

Revocation: I hereby revoke my request for future communications via email/or text.

____ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via text messages

____ I hereby revoke my request to receive any future appointment reminders, feedback, and general health via email.

NOTE: This revocation only applies to communication from this Practice.

Patient Name: _____

Patient/Patient Representative Signature _____

Date _____ Time_____

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CONSENT TO THERAPY

I acknowledge that I have received, have read (or have had read to me), and understand the "Information for Clients" brochure and/or other information about the therapy I am considering. I have had all my questions answered fully.

_____ I do hereby seek and consent to take part in the treatment by the therapist named below. I understand that developing a treatment plan with the therapist and regular reviewing our work toward meeting treatment goals are in my best interest. I agree to play an active role in this process.

_____ I understand that no promises have been made to me as to the results of treatment or of any procedures provided by this therapist.

_____ I am aware that I may stop my treatment with this therapist at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. (For example, if my treatment has been court-ordered, I will have to answer to the court.

_____ I know that I must call to cancel an appointment at least 24 hours before the time of the appointment. If I do not cancel or do not show up, I will be charged for that appointment.

_____ I am aware that an agent of my insurance company or other third-party may be given information about the type(s), cost(s), date, and providers of any service or treatment I receive. I understand that if payment for the services I receive here is not made, the therapist may stop my treatment.

My signature below shows that I understand and agree with all these statement

_____ _____

Signature of client (or person acting for client) Date

_____ I, the therapist, have discussed the issues above with the client(and/or his or her parent, guardian, or other representative) My observation of this 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

NAME:_____ 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**
☐	☐	☐	☐

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

Date: _____ Name: _____ DOB: _____

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all	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 _____

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

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Patient Agreement – Drug Screen

_____ I agree to take part in all aspects of the treatment plan that my doctor recommends for me.

_____ I agree to maintain an open and honest relationship with my doctor. I further agree to advise my doctor regarding any problem, potential problem, concern I may be experiencing from my prescription medication.

_____ I accept the responsibility of taking my medication/administering medication to my children as prescribed.

_____ I understand that if the analysis of my UDS (Urine Drug Screen) indicates that I have taken more of my prescription medication, or that directed, or there is no indication that I have been taking my medication, or there is a presence of an unauthorized prescription medication or illegal drug(s), I may be discharged from the program.

_____ I understand that my medication may be changed or adjusted to best benefit my treatment.

_____ I accept the responsibility of taking my prescription medication and I agree to take my prescription medication as directed.

_____ I understand that I may discontinue using my medication at any time and I agree to notify Rural Behavioral Health Services, LLC immediately upon discontinuing the use of my medication. I will not hold the agency or its doctor responsible for any issues, circumstances or situations that may occur as a result of me discontinuing my medications.

My signature indicates that I understand and agree to abide by each issue displayed on this page and I understand that if I fail to abide to any issue displayed on this page, I may be discharged from this practice.

_____ _____

Patient's Name (Printed) Patient's Name (signature) Signature/Date

I attest that I have explained each issue displayed on this page to said patient and said patient indicated their understanding of each issue by affixing their initials next to each issue and signing the bottom of each page.

_____

Staff's Signature/Date

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Client's Name _____ Date_____

NOTICE TO INDIVIDUAL: PLEASE READ THIS CAREFULLY AND ASK QUESTIONS IF YOU DO NOT UNDERSTAND ANY PART OF IT

I have been told about and have been given written information about the following recommended medicine(s):

RECOMMEDED MEDICINIE(S) AND DOSAGE

I understand that the dosage of the medicine(s) may change based on my condition. The physician has talked with me about the following:

- What medicine(s) I will be taking.
- What the medicine(s) are intended to do for me.
- Whether the medicine(s) chosen for me requires periodic blood testing.
- The possible side effects, risks, and benefits of the medicine(s)
- Any food-drug interaction which may occur with the medicine(s)

I understand that I have a right to refuse to take medicine(s) and what can happen if I refuse.

CONSENT

☐ I agree to take the medicine(s) listed above.
☐ I do not agree to take the medicine(s) above

_____
Psychologist Signature

_____
Client Signature

_____
Guardian Signature

_____
Guardian Printed Name

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CLIENT INFORMATION

Client Name: _____
Parent Name/Legal Guardian *(if client is a minor):* _____
Client's Date of Birth: _____ Age: _____
Male_____ Female_____
Client's Address: _____
City, State, Zip: _____
Adult Client's Occupation: _____ Employer: _____
Minor/Client's School: _____
Phone (h):_____ Messages okay at home? Yes_____ No _____
Phone (cell): _____Voice Messages okay on cell? Yes_____ No _____
Text Messages okay? Yes _____ No _____
Phone (w): _____ Messages okay at work? Yes_____ No _____
Email: _____E-mail Messages okay? Yes _____No _____
How did you find out about Rural Behavioral Health Services? _____
Emergency Contact: _____Phone: _____ Relationship: _____

INSURANCE INFORMATION

PRIMARY INSURANCE

Type of Insurance: (check one) ___Medicaid ___Medicare ____Tri-Care ___Private Insurance ___Self-Pay
Name of Insurance Co: _____
ID Number: _____ Group Number: _____
Insurance Customer Service Telephone Number: _____
Name of Subscriber *(person who carries insurance):* _____
Date of Birth of Subscriber? _____Subscriber's phone number: _____
Subscriber's Place of Employment: _____
Client Relationship to Subscriber: _____self, _____ spouse, _____child, _____ other
*SECONDARY INSURANCE *(please fill out if there is a second insurance)*
Name of Insurance Co: _____
ID Number: _____ Group Number: _____
Insurance Customer Service Telephone Number: _____
Name of Subscriber *(person who carries insurance):* _____
Date of Birth of Subscriber? _____Subscriber's phone number: _____
Subscriber's Place of Employment: _____
Client Relationship to Subscriber: _____self, _____ spouse, _____child, _____ other

Patient Name: Date:

Are you allergic to any medications? NO YES Please list:

Past Medical History: Circle item listed below

Current Medications

Diabetes	Osteoporosis	Blood Clots
Chest pain/Angina	Asthma/COPD	Peripheral Vascular Disease
High Blood Pressure	Stroke/CVA/TIA	Tuberculosis
Heat Disease	Seizures	Depression
Heart Attack	HIV/AIDS	Congestive Heart Failure
High Cholesterol	Hepatitis	Thyroid Disease
Pacemaker	Stomach Ulcer	**Other Please List Below**
Headaches	Liver Disease	
Kidney Stones	Heart Palpitations	
Kidney Disease	Arthritis	
Cancer	Heart Surgery	

ROS		**Please circle all CURRENT positive findings**
Constitutional		Weight loss Fevers Chills Poor appetite Fatigue Weight gain Insomnia Night sweats
Eyes		Blurry vision Eye-pain Eye discharge Eye redness Decrease in vision Dry eyes Double vision
ENT		Sore throat Hoarseness Ear pain Hearing loss Ear discharge Nosebleeds Tinnitus Sinus problems
Cardiovascular		Chest pain Palpitations Rapid heart rate Heart murmur Poor circulation Swelling the legs or foot
Respiratory		Shortness of breath Chronic cough Coughing up blood History of Tuberculosis Excess sputum production
Gastrointestinal		Nausea Vomiting Diarrhea Constipation Blood in the stool Frequent heartburn Trouble swallowing
Genitourinary		increased urinary frequency Blood in the urine Incontinence Painful urination Urinary retention Frequent UTIs
Skin		Rash Hives Hair loss Skin sores or ulcers Itching Skin thickening Nail changes Mole changes
Musculoskeletal		Joint pain Muscle aches Frequent leg cramps Muscle weakness Bone pain Joint swelling Back pain
Psychiatric		Anxiety Depression Alcohol or drug dependence Suicidal thoughts Panic attacks Use of anti-depressants
Endocrine		Goiter Heat intolerance Cold intolerance Increased thirst Change in skin pigment Excess sweating
Neurological		Seizures O Tremors Migraines Numbness Dizziness/Vertigo Loss of balance Slurred speech Stroke
Hem/Lymphatic		Low blood count Easy bruising Swollen lymph nodes Transfusions Prolonged bleeding Blood clots
Allergic/Immun		Allergic reactions Hay fever Frequent infections Hepatitis HIV positive Positive tuberculin skin test (PPD)

Social History: Marital Status _____ Occupation (or most recent job held)_____

___Non-Smoker (never smoked) ____Ex-Smoker ____Current Smoker How many packs per day?_____

Alcohol consumption: _____Never _____Occasional _____Frequent

Family History: (Please list any known medical problems)

Father: _____ Mother: _____

Siblings:_____

Your Children:

_____

_____

Additional Information: Use this space to provide any additional information which may be important to your health care.

_____ _____

Signature of Reviewing Physician Date Signature of Patient Date