SIOUXLAND MENTAL HEALTH CENTER

To better help us serve you or your child today, please answer the following questions:

Name: _____Birthdate: _____

1. Are you or your child currently being treated for a psychiatric diagnosis? YES NO
2. Do you or your child currently take psychiatric medication? YES NO
3. Are you or your child currently experiencing suicidal or homicidal thoughts? YES NO
4. Do you want to see someone about medication today? YES NO
5. Do you want to see someone today? YES NO

If yes: Therapy ☐ Psychiatry ☐ Substance Assessment ☐ OWI Assessment ☐

What is the reason to be seen today? _____
_____
_____
_____

***To see someone today it can take anywhere from 45-90 minutes

****ALL FORMS NEED TO BE SIGNED BY LEGAL GUARDIAN**

SIOUXLAND MENTAL HEALTH CENTER NEW CLIENT INFORMATION

Adult / Child

Date: _____ Account # _____

Patient's Information:

Name: _____

Gender: M F Date of Birth: _____ SSN: _____

Race:_____ Preferred language: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Primary Phone #: _____ Home ____ Cell_____ Work _____

Is it okay to leave a voice mail message? Yes No

Secondary Phone #: _____ Home ____ Cell _____Work _____

Is it okay to leave a voice mail message? Yes No

Email Address: _____

Type of Insurance: Primary: _____Secondary:_____

Military Status: Active Member ____Veteran ____NA____

Branch(es): Army ____Navy ____Air Force____ Coast Guard ____Marine Corps____

Referred by: _____

Do you have any family members seeing somebody here? Yes No

If yes, whom are they seeing? Doctor? _____Therapist? _____

Emergency contact: _____ Phone #: _____

Patient's relationship to emergency contact: _____

If under 18 or has a legal guardian (NEED PROOF), fill out guardian's information: ONLY LEGAL GUARDIAN CAN SIGN PAPERWORK: NO STEP-PARENTS, FAMILY MEMBERS, FOSTER PARENTS, STAFF MEMBERS, OR FACILITIES.

Guardian's name(s): _____

Guardian's DOB: _____ Guardian's SSN: _____

Guardian's Address if different than above: _____

Guardian's Primary Phone #: _____ Home ____ Cell ____ Work_____

Is it okay to leave a voice mail message? Yes No

Guardians Email Address: _____

Please list additional Parents/Guardians and the relationship to the child:

Name: _____ Relationship: _____ PH: _____

Employee initials: _____

Client Demographic Information

1. **What is your sex at birth?**

____Male ____Female

2. **Do you consider yourself to be (read choices):**

____Male ____Female ____Transgender (Male to Female) ____Transgender (Female to Male)
____Gender non-conforming ____Other ____Refuse

3. **Do you think of yourself as:**

____Straight or Heterosexual ____Homosexual (Gay or Lesbian) ____Bisexual ____Queer
____Pansexual ____Questioning ____Asexual ____Something Else ____Refused

4. **Are you (your child) Hispanic, Latino/a, or of Spanish origin?**

____Yes ____No ____Refused

If you answered NO to question 4, skip to question 6. If you answered YES to question 4, please answer question 5.

5. **What ethnic group do you (your child) consider yourself (themselves)? You may indicate more than one.**

____Central American ____Cuban ____Dominican ____Mexican ____Puerto Rican

____South American ____Other ____Refused

6. **What is you (your child's) race?**

____Black or African American ____White ____Native American ____Alaska Native ____South Asian
____Chinese ____Filipino ____Japanese ____Korean ____Vietnamese ____Other Asian
____Native Hawaiian ____Guamanian or Chamorro ____Samoan ____Other Pacific Islander ____Other
____Refuse

7. **Do you (your child) speak a language other than English at home?**

____Yes ____No ____Not Applicable (Under 5 years old)

If answer to question 7 is YES, please specify language: _____

Military Status:

____Active Duty ____Veteran ____Reserves ____National Guard ____NA

Military Branch(es) served:

____Army ____Navy ____Air Force ____Marine Corps ____US Coast Guard

SIOUXLAND MENTAL HEALTH CENTER

*Over the last **2 weeks**, how often have you or your child been bothered by any of the following problems?*

0= Not at all: 1= Several days; 2= More than half the days; 3= 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. Feeling nervous, anxious or on edge	☐ 0	☐ 1	☐ 2	☐ 3
4. Not being able to stop or control worrying	☐ 0	☐ 1	☐ 2	☐ 3

*Over the past **1 month**, have you or your child experienced the following?*

Have you wished you were dead or wished you could go to sleep and not wake up?
☐ Yes ☐ No

Have you had any thoughts of killing yourself?
☐ Yes ☐ No

Have you had any thoughts of wanting to harm others?
☐ Yes ☐ No

*Over the past **3 months** have you or your child experienced the following?*

Have you made a suicide attempt? Yes ☐ No ☐

Have you done anything to harm yourself? Yes ☐ No ☐

Do you feel you are able to keep yourself/your child safe after leaving here today?

☐ Yes ☐ No If No, please describe safety concerns: _____

Who referred you here today: ☐ Self ☐ Medical Staff ☐ Another Agency ☐ School Staff
☐ Other_____

What services do you need today: ☐ Crisis Intervention ☐ Intake for Services

☐ Other _____

Are you willing to participate in any of the following services?

☐ Therapy (Individual, Family, Group, Marital)
☐ Medication Management/Psychiatry
☐ Integrated Home Health
☐ Community Support

NAME_____DATE_____

Certified Community Behavioral Health Clinic

A Certified Community Behavioral Health Clinic (CCBHC) model is designed to ensure access to coordinated, comprehensive behavioral health care. CCBHCs are required to serve anyone who requests care for mental health or substance use, regardless of their ability to pay, place of residence, or age- including developmentally appropriate care for children and youth.

The purpose of CCBHC is to improve the quality of community behavioral health services through a comprehensive approach.

Informed Consent

I have voluntary chosen to receive treatment services with Siouxland Mental Health Center. I understand that I may terminate services at any time.

I understand that in the case of mental health treatment, no guarantee can be provided that concerns or issues for which I am seeking services will be resolved.

I understand that treatment for mental health is a cooperative effort between myself and my provider(s), and I will work with my provider(s) in a cooperative manner to resolve my difficulties.

I understand that during the course of my treatment material may be discussed with me that may be upsetting in nature and that this may be necessary to help me resolve my concerns.

I understand that records and information collected about me will be held or released in accordance with state and federal laws regarding confidentiality of such records and information, as outlined in the Notice of Privacy Practices provided to me.

I understand that if I chose to have another person with me during my appointments, they are privilege to the information that is disclosed during that appointment.

I understand that my provider(s) may disclose any and all records pertaining to my treatment if necessary for claims processing, care management, coordination of treatment, quality assurance or utilization of this facility and to the extent necessary to facilitate the provision of administrative and professional services.

I understand that state and local laws require that my provider(s) report all cases in which there exists a danger to self or others.

I understand there may be other circumstances in which the law requires my provider(s) to disclose confidential information and this is outlined in the Notice of Privacy Practices provided to me.

I understand that all the individuals participating in treatment are expected to conduct themselves in an appropriate and respectful manner.

I understand that any aggressive, violent, or threatening behavior or violation of confidentiality may be the basis for exclusion from some or all services at Siouxland Mental Health Center.

I understand that I may be contacted by Siouxland Mental Health during my treatment to ensure continuity and quality of my treatment and/or after the completion of treatment, to assess the outcome of treatment.

I understand that CCBHCs are required to collect and report data regarding client treatments and outcomes to Substance Abuse and Mental Health Services Administration (SAMHSA) and other governmental entities and I am agreeable to be part of this process.

I have read and understand the basic rights of individuals as seen at Siouxland Mental Health. These rights include:

1. The right to be informed of the various steps and activities involved in receiving services.
2. The right to confidentiality under federal and state laws relating to the receipt of services.

3. The right to humane care and protection from harm, abuse, or neglect.
4. The right to make an informed decision on whether to accept or refuse treatment.
5. The right to contact and consult with counsel at my expense.
6. The right to select practitioners of my choice at my expense.

I understand that I can revoke my consent at any time, except to the extent that treatment has already been rendered or that action has been taken in reliance on this consent, and that if I do not revoke this consent, it will expire automatically one year after discharge of treatment.

Client Acknowledgement and Consent to Privacy Notice

I have received an orientation to the Center, which has explained the policies and procedures, and I consent to Siouxland Mental Health Center privacy notice, a copy of which has also been made available to me. By signing below, I acknowledge I have read and understand the above information.

_____ _____

Signature of Client/Client Representative **Date**

_____

Relationship to client (if applicable)

Reviewed by: _____

Staff Signature

Primary Insurance:

Name of insurance company: _____

Cardholder's Name: _____ Patients relationship to cardholder: _____

Gender of the cardholder: _____ Cardholder's date of birth: _____

Certificate (ID) #: _____ Group #: _____

Cardholder's social security #_____Place of employment: _____

Secondary Insurance:

Name of insurance company: _____

Cardholder's Name: _____ Patients relationship to cardholder: _____

Gender of the cardholder: _____ Cardholder's date of birth: _____

Certificate (ID) #: _____ Group #: _____

Cardholder's social security #_____Place of employment: _____

You are required to provide Siouxland Mental Health Center with any changes to your insurance coverage as they occur. If this is not provided, you will be financially responsible for the services that were provided to you. In the event your insurance company pays you directly, you are responsible to reimburse Siouxland Mental Health Center for the amount that your insurance company pays you. All payments made to Siouxland Mental Health Center must be by cash, debit/credit card or check.

I understand that this will become a part of my service record; information accumulated in the record may be confidentially reviewed by the accrediting agency for Siouxland Mental Health Center. *I authorize Siouxland Mental Health Center to file an insurance claim and receive the payment for services rendered on my behalf.* Some insurance coverage requires copayment and/or a deductible portion, which is due at the time of service.

_____ _____

Print name of client **Signature of client/guardian**

Date: _____

SMHC Client Responsibilities when Scheduling Appointments

Name: _____ DOB: _____

I understand that as the client/client's guardian, it is my responsibility to keep track of all my upcoming appointments at SMHC.

I understand that if I cannot make the appointment, I am required to give at least 24-hour notice to cancel or reschedule the appointment.

I understand that if I do not give 24-hour notice, I run the risk of this being counted as a No Show Appointment.

I understand that if I do not show up to my scheduled appointment and do not cancel or reschedule, this WILL be counted as a No Show Appointment.

I understand that if I have too many No Show Appointments, I will lose my privilege to schedule appointments with my medication provider or therapist.

I understand that if I do lose my privileges to schedule appointments with my medication provider or therapist, I will need to attend Pathways Therapy Group to regain scheduling privileges.

I understand that if I No Call/No Show to my initial Psychiatric Evaluation appointment, I will lose my scheduling privileges and will need to attend Pathways group to reschedule this appointment.

I understand that if I No Call/No Show to any 2 appointments with my medication provider or therapist in the revolving year, I will lose my scheduling privileges and will need to attend Pathways group.

I understand that if I lose scheduling privileges, all future appointments will be cancelled.

I understand that if I lose my scheduling privileges, I will still be able to access crisis appointments, psychiatric urgent care, and the Crisis Center if I am in crisis.

I understand that if I do not wish to attend Pathways group and I would still like to see my provider, I can walk into the clinic and wait in the lobby until there may be an opening in my provider's schedule to be seen. I further understand that this is no guarantee that I will be seen by my provider or any other provider that day.

I understand that SMHC will send reminder phone calls, text messages, or emails (depending on my stated preference) for all appointments. I also understand that while SMHC makes every attempt to remind clients of their appointments, there may be some communication systems failures that may prevent me from getting my reminder notifications.

I understand that if I No Call/No Show to a scheduled therapy or medication appointment, I may be charged anywhere from $25-$50, depending on the appointment type.

By signing below, I acknowledge that I have been informed of my responsibilities when scheduling/keeping appointments and that I understand all information presented above.

_____ _____

Signature of client/representative **Date**

_____ **Staff Signature: _____**

Relationship to Client (if applicable)

CONSUMER RIGHTS AND RESPONSIBILITIES

Consumer Rights Policy. The policy of Siouxland Mental Health Center is that all consumers will receive treatment subject to the following protection:

1. Each consumer has the right to participate in the development of his/her treatment/service plan.
2. Services are made available to all Woodbury County residents on an equal basis.
3. Each consumer has the right to assume that all treatment information will be held in confidence and will not be released to anyone unless one of the following situations exists:
    a. Written request is made by a consumer to released portion of file information.
    b. That a court order requires submission of certain file materials.
    c. That, in the opinion of the professional staff members of center, a life-threatening situation exists.
4. Each consumer of the Center has the right to be fully informed about any risks that might be entailed in the treatment or as the result of research studies.
5. Each consumer of the Center has the right to expect treatment with dignity and respect and without unnecessary invasion of privacy.
6. Each consumer has the right to refuse treatment.
7. Each consumer has the right to treatment with as little delay as possible.
8. Only information that is needed to assist the center's professional staff and their treatment process will be obtained from a consumer/guardian.
9. Each consumer has the right to be treated in the least restrictive setting possible.
10. Each consumer has the right to express his/her opinion concerning the services delivered at the center.
11. Consumers of Siouxland Mental Health Center, and their guardians, have the right to appeal any policy, procedure, or action of Siouxland Mental Health Center in order to adequately protect the consumer's rights using the following procedure:
    a. Client's may file a grievance wither by calling SMHC or in writing.
    b. All grievances will be directed to the Patient Engagement Specialist at SMHC.
    c. The Patient Engagement Specialist will reach out to the client and attempt to resolve the issue with the client.
    d. If the issue cannot be resolved, the Patient Engagement Specialist will inform take the grievance to departmental supervisors, as appropriate in an attempt to resolve the grievance.
    e. Departmental supervisors and other staff members, as appropriate will follow up with the client and resolve the grievance. The client will then be notified of SMHC's decision.
    f. All grievances will be given due consideration without reprisal or discrimination.
12. I have voluntarily chosen to receive treatment services by Siouxland Mental Health Center. I understand that I may terminate services at any time.

Consumer Responsibilities: I understand that in addition to having the rights listed above, I also agree to abide by the following responsibilities. I understand that failure to do so can result in my discharge from services.

1. I will take my medication as prescribed by the doctor to be the best of my ability.
2. I will attend all scheduled appointments with my providers. If I cannot attend, I will call 24 hours in advance to cancel.
3. I will attempt to fulfill the goals I have set my service plan to the best of my ability or, notify my provider if I feel the goal is no longer appropriate.
4. I will treat my worker respectfully in the same manner that I would like to be treated.
5. I will refrain from abusing drugs and alcohol to the best of my ability.
6. I will contact my provider on a regular basis.
7. I understand that it will be necessary for me to sign documents in order to continue to receive services with Siouxland Mental Health Center.

_____ _____

Print name of client **Signature of client/guardian**

Date: _____

PSYCHIATRIC ADVANCE DIRECTIVE NOTIFICATION FORM & MEDICATIONS

Do you have a Psychiatric Advance Directive Form or a Durable Power of Attorney for Medical Care Form?

Yes No

If yes, do you wish to provide a copy to Siouxland Mental Health?

Yes No

Copy provided to intake person?

Yes No

PRIMARY CARE PHYSICIAN FORM

NAME OF PHYSICIAN: _____

_____I want you to contact my Primary Care Physician

_____I do not want my Primary Care Physician contacted

_____I do not have a Primary Care Physician

PLEASE LIST ALL CURRENT MEDICATIONS AND DOSE:

_____

_____

_____

_____

_____ _____

Print name of client **Signature of client/guardian**

Date: _____

Siouxland Mental Health Center
Informed Consent for Telehealth Services

Client Name: _____ **Date of Birth**: _____

Telehealth is the delivery of behavioral health services using interactive audio and visual electronic systems between a provider and a client that are not in the same physical location.

As with any medical or behavioral health treatment, there are certain potential benefits and risks to receiving telehealth services.

The potential benefits of receiving telehealth services are:

- Reduced wait time to receive behavioral healthcare
- Avoiding the need to travel to a psychiatrist or therapist office

The potential risks of receiving telehealth services are:

- Telehealth sessions will not be exactly the same and may not be as complete as a face-to-face service.
- There could be some technical problems (video quality, internet connection) that may affect the virtual care session and may affect the decision making capability of the provider.
- The provider may not be able to provide medical treatment using interactive electronic equipment nor provide for, or arrange for emergency care that you may require.
- A lack of access to all the information that might be available in a face-to-face visit, but not in a telehealth visit may result in errors in judgement.
- Delays in medical evaluation and treatment may occur due to deficiencies or failures of the equipment.
- SMHC utilized software that meets the recommended standards to protect the privacy and security of the telehealth session, however SMHC cannot guarantee total protection against hacking or tapping into the telehealth session by outsiders. The risk of this happening is small, but it does exist.

Alternatives to the use of telehealth services:

- Traditional face-to-face sessions

Client's Rights and responsibilities when receiving telehealth services:

1. I have the right to withhold or withdraw consent for telehealth services at any time, including during a telehealth session without affecting my right to future care or treatment or risking the loss or withdrawal of any program benefits to which I would otherwise be entitled.
2. The laws that protect the confidentiality of my medical information also apply to telehealth services.
3. The potential benefits and risks of receiving telehealth services have been explained to me and I understand the potential risks and benefits.
4. I have had the chance to ask any questions and have received clarification regarding telehealth services.
5. I understand that telehealth services may not be as complete as face-to-face services. I also understand that there are potential risks and benefits associated with any form of behavioral health services and that despite my efforts and the efforts of my provider, my condition may not improve and in some cases may get worse.
6. I understand that I may benefit from telehealth services, but that results cannot be guaranteed or assured.
7. I understand that my telehealth session will not be recorded by my provider.
8. I understand that it is the policy of SMHC that I am not able to record any sessions, whether they are face-to-face or telehealth.
9. I understand that if it is known that I am or have recorded a session, my appointment will be cancelled and my eligibility to receive telehealth services may be suspended, based on provider discretion.
10. I understand that I have a right to access my medical information and copies of medical records in accordance with the Health Insurance Portability and Accountability Act of 1996.

11. I understand that in order to maintain confidentiality I must ensure that I am in a private setting during my telehealth session. If I am unable to ensure that I am in a private setting, I understand that my telehealth session will be cancelled.
12. I understand that my provider will ensure that they are in a private setting when conducting my telehealth session.
13. I understand that to participate in my telehealth session, I cannot be actively driving.
14. I understand that I must physically be in the state of Iowa during my telehealth session.
15. I understand that I and my provider must have our cameras turned on during my telehealth session.
16. I understand that if my appointment cannot be conducted or completed, I run the risk of the appointment being counted as a no call/no show per provider discretion.
17. I understand that I, not my provider, am responsible for the configuration of any electronic equipment used for telehealth services on my electronic device.
18. I understand that it is my responsibility to ensure the proper functioning of all electronic equipment before my session begins.
19. I understand that my provider determines whether or not the condition being diagnosed and/or treated is appropriate for a telehealth encounter.

I hereby consent to engaging in telehealth services with Siouxland Mental Health Center as part of my behavioral healthcare. I understand that telehealth services includes the practice of healthcare delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio and video data communications. I have read and understand the information provided above regarding telehealth services.

_____ _____

Signature of Client/Client Representative **Date**

_____

Relationship to client (if applicable)

Reviewed by: _____

Staff Signature

Siouxland Mental Health Center
Email Authorization

Client Name: _____ DOB: _____

Siouxland Mental Health Center offers its clients the ability to communicate with certain members of their care team via email. Both the client and Siouxland Mental Health Center must enter into an agreement for this.

Privacy and Security of E-mail

Siouxland Mental Health Center cannot and does not guarantee the privacy or security of any messages being sent via email. There is the potential that these messages can be intercepted and read by others when sent through the internet. If this is of concern to you, you should not communicate with Siouxland Mental Health Center via email.

Additionally, you should be aware of and understand that if you use email provided by your employer, any message sent or received on your employer's system may be viewed by your employer.

This document along with Siouxland Mental Health Center's "Notice of Privacy Practices" constitutes a notice of privacy practices for email use.

Keeping Records of E-mail

E-mail communications will be documented in an electronic note maintained in your medical record chart.

Authorization to Use E-mail

I have been informed and understand the risks and procedures involved with using email. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of e-mail as one form of communication with Siouxland Mental Health Center.

A copy of this signed form to keep for your records is available upon request.

_____ _____

Signature of Client or Representative **Date**

_____

Relationship to Client (if applicable)

Reviewed by: _____

Staff Signature

Siouxland Mental Health Center
Text Messaging Authorization

Client Name: _____ DOB: _____

Siouxland Mental Health Center offers its clients the ability to communicate with certain members of their care team via text message. Both the client and Siouxland Mental Health Center must enter into an agreement for this.

Privacy and Security of text messaging

Siouxland Mental Health Center cannot and does not guarantee the privacy or security of any messages being sent via text message. There is the potential that these messages can be intercepted and read by others. If this is of concern to you, you should not communicate with Siouxland Mental Health Center via text messaging.

Additionally, you should be aware of and understand that if you use any phone provided by your employer, any text message sent or received on your employer's system may be viewed by your employer.

This document along with Siouxland Mental Health Center's "Notice of Privacy Practices" constitutes a notice of privacy practices for text messaging use.

Keeping Records of text messaging

Text message communications will be documented in an electronic note maintained in your medical record chart.

Authorization to Use Text Messaging

I have been informed and understand the risks and procedures involved with using text messaging. I agree to the terms listed on this form and hereby voluntarily request, consent to, and authorize the use of text messaging as one form of communication with Siouxland Mental Health Center.

A copy of this signed form to keep for your records is available upon request.

_____ _____

Signature of Client or Representative **Date**

_____

Relationship to Client (if applicable)

Reviewed by: _____

Staff Signature

Client Name: _____ Client DOB: _____

Consent to Share Information with Cync Health

Siouxland Mental Health Center is inviting you to join Cync Health in order to better coordinate care for you and your care team. Cync Health is a database that will notify members of your care team at Siouxland Mental Health Center when you have been in the emergency department or have been hospitalized, either for physical or mental health concerns.

Siouxland Mental Health Center will provide Cync Health with the following information:

Medical Record Number
First Name
Middle Name or initial
Last Name
Date of Birth
Social Security Number
Address
Phone Number

This information will be placed in their database so that when you are hospitalized or in the emergency department, Siouxland Mental Health Center will receive a notification. The information placed in the Cync Health portal by Siouxland Mental Health will not be shared with any other individual or agency outside of Cync Health or Siouxland Mental Health Center.

Consent for Cync Health

I understand the above information regarding Cync Health. I also understand that I do have the option to revoke this consent at any time.

☐I give consent to share the above information with Cync Health.

☐I **DO NOT** give consent to share the above information with Cync Health.

_____ _____

Signature of Client/Representative **Date**

_____

Relationship to Client (if applicable)

Reviewed by: _____

Staff Signature

SIOUXLAND MENTAL HEALTH CENTER

Patient Name: _____ DOB: _____

I have given Siouxland Mental Health Center permission to bill my insurance for services that are provided to me. I understand that if my insurance does not cover a provided service, I am responsible to pay the remaining bill to Siouxland Mental Health Center. The prices for services are listed below:

Service	**Price**
Therapy Intake New and Established Clients	$141-$287
Individual Therapy	$94-270 per session
Group Therapy	$67-$149 per session
Family Therapy	$125-$207 per session
Therapy Crisis Appointment	$94-$326
Substance Use Evaluation-Not for OWI	$165
OWI Substance Use Evaluation	$125
Individual Substance Use Session	$94-$270 per session
Extensive Outpatient Substance Use Group	$67 per session
Intensive Outpatient Substance Use Group	$155 per session
New Client Psychiatric Evaluation	$180-$650
Existing Client Psychiatric Evaluation	$289-$536
Medication Check	$80-$557
Nurse Visit	$35
Injection Administration	$31
Interpreting Services	$20
UA Dip	$15
No Call/No Show	$25-$50

By signing this form, I acknowledge that I have seen the price list for services offered that could be billed to my insurance.

_____ _____

Signature of Client/Client Representative **Date**

_____

Relationship to Client (if applicable)

Reviewed by: _____

Staff Signature