Global Health Behavioral and Wellness LLC

CLIENT INFORMATION

Please complete all (12 pages) of the following new client paperwork prior to your first appointment. Once you have completed all the forms, please upload them through the office provided or fax them to our office.

If you have had any lab-work in the past year, please obtain a copy and bring it to your first appointment, or you can have it faxed to our office.

GENERAL INFORMATION

CLIENT INFORMATION

First Name:_____ Last Name:_____ MI:_____ DOB:_____

Gender (Sex at birth): M F I Gender Identity: Male Female Trans Non-binary

Marital status: Single Partnered Married Separated Divorced Widowed

Address:_____ City: _____ State: _____ Zip: _____

Cell Phone:_____ Work Phone:_____ Email:_____

Employer Name:_____ Employer Phone Number:_____

Emergency Contact Name:_____ Relationship: _____ Phone:_____

INSURANCE INFORMATION

Insurance:_____ **ID#:**_____ **Group #:**_____

Policyholder Name (if not client):_____ **Relationship:**_____ **Phone:**_____

Secondary Insurance:_____ **ID#:** _____ **Group #:**_____

Policyholder Name (if not client):_____ **Relationship:**_____ **Phone:**_____

CLIENT REPORT OF PROBLEM

Briefly describe your reason(s) for seeking help:_____

_____

How long have you had the issue?_____

What other ways have you tried to deal with this problem?_____

_____

Is there anything else you'd like me to know prior to our first appointment:_____

_____

_____

MENTAL HEALTH MEDICAL HISTORY

PRIOR OUTPATIENT COUNSELING/PSYCHIATRY

Therapist Name:_____ Dates Seen: _____ Helpful Unhelpful
Therapist Name:_____ Dates Seen: _____ Helpful Unhelpful
Therapist Name:_____ Dates Seen: _____ Helpful Unhelpful

Psychiatrist/Psychiatric Nurse NP:_____ Dates Seen: _____ Helpful Unhelpful
Psychiatrist/Psychiatric Nurse NP:_____ Dates Seen:_____ Helpful Unhelpful
Psychiatrist/Psychiatric Nurse NP:_____ Dates Seen:_____ Helpful Unhelpful

PRIOR INPATIENT TREATMENT

Facility Name:_____ Dates Seen_____ Helpful Unhelpful
Facility Name:_____ Dates Seer_____ Helpful Unhelpful
Facility Name:_____ Dates Seer_____ Helpful Unhelpful

FAMILY MENTAL HEALTH HISTORY

Relationship:_____Mental/Emotional Problem(s): _____
Relationship:_____Mental/Emotional Problem(s): _____
Relationship:_____Mental/Emotional Problem(s): _____

PRIOR PSYCHIATRIC MEDICATION USE

Medication Name:_____ Was it helpful? Yes No Not Sure Year(s) taken: _____
Diagnosis:_____ If you had a negative reaction, please explain:
_____
_____

Medication Name:_____ Was it helpful? Yes No Not Sure Year(s) taken:_____
Diagnosis:_____ If you had a negative reaction, please explain:
_____
_____

Medication Name:_____ Was it helpful? Yes □ No Not Sure Year(s) taken:_____
Diagnosis:_____ If you had a negative reaction, please explain:
_____
_____

CURRENT MEDICATION AND SUBSTANCE USE

CURRENT MARIJUANA/ALCOHOL USE

Are you currently using any form of marijuana? (any product containing THC, ie: lotion): Yes No
In what way are you ingesting? Smoking (including vape) Oils Edibles Pills or Liquid Other
Frequency of use: Daily Weekly Monthly c] Occasionally
Reason you started using: Physical Pain Anxiety/Depression Recreational Other
How long have you used marijuana: _____

Are you currently drinking alcohol? Yes No
I Have you ever abused alcohol? Yes No Unsure
Frequency of use: 1-2 Drinks Daily 1-2 Drinks Weekly A few drinks a Month on Occasion
Is there a specific reason you drink Pain/Numbing Anxiety/Depression Socially Other
Are you aware of any alcohol dependency in your family? Yes No Maybe/Unsure

CURRENT MEDICATION USE

Medication Name: _____ Dosage: _____
Medication Name: _____ Dosage: _____
Medication Name: _____ Dosage: _____
Medication Name: _____ Dosage: _____
Medication Name: _____ Dosage: _____
Medication Name: _____ Dosage: _____
Medication Name: _____ Dosage: _____

ALLERGIES TO MEDICATIONS

Medication Name: _____ Reaction: _____
Medication Name: _____ Reaction: _____
Medication Name: _____ Reaction: _____

OTHER MEDICAL CONDITIONS

Diagnosis: _____ Year: _____
Diagnosis: _____ Year: _____
Diagnosis: _____ Year: _____

Welcome to **Global health Behavioral and Wellness LLC**. Please read this document which contains vital information about my professional services and business policies. A Notice of Privacy Practices for use and disclosure of Protected Health Information (PHI), is also posted in the reception area.

The law requires that I obtain your signature acknowledging that I have provided you with this information and that you have agreed to its terms. When you sign this document, it will represent a contract between us. You may revoke this contract in writing at any time. That revocation will be binding on me unless I have already acted in reliance on it; if there are obligations imposed on me by your health insurer to process or substantiate claims made under your policy; or monies owed in connection with treatment.

PAYMENT OF SERVICE

Payment is required at the time of each visit and accepted payment options include cash, credit, debit, FSA and HSA cards as forms of payment. You will be responsible for the fees that are charged in connection with your treatment. My fee is $220.00 for the initial visit and $100.00 for any visit following. I will submit claims directly to insurance companies for which I am a contracted provider.

I cannot guarantee payment by your insurance company. If your claim is not paid, it will be your responsibility. If your account has not been paid for more than 60 days (about 2 months) and arrangements for payment have not been agreed upon in advance, I have the option of using legal means to secure the payment. This may involve employing the services of a lawyer or agency for collection purposes. In most collection situations, the only information I release regarding a patient's treatment is his/her name, the nature of the services and the amount due or other PHI allowed by HIPAA (Health Insurance Portability and Accountability Act).

I AGREE TO THE FOLLOWING BILLING PROCEDURES

_____ (initial) My copay will be billed the day before or day of my appointment, if my payment does not clear, I will be contacted for another form of payment. If I have not met my deductible, I understand the entire visit fee will be charged instead. This fee is based on individual contracted rates with your individual insurance. Should we cancel your appointment for any unforeseen reason, your payment on file will be reimbursed.

_____ **(initial)** If I would like to change the card on file, this must be done 24 hours prior to my upcoming appointment, or the card on file will be charged.

_____ **(initial)** I understand that payment arrangements cannot be made after the transaction has been processed. Reimbursements will not be made unless due to a clerical error.

_____ **(initial)** I understand that remaining balances cannot be carried over from appointments. My appointment must be paid for in full prior to my next appointment.

_____ **(initial)** Failure to cancel an appointment 24 business hours Monday through Friday prior to the scheduled time will result in a $75 fee. You may notify us by calling on the main practice phone line at 636 675 9979.

_____ **(initial)** Every effort is made to communicate in a timely fashion; however, I understand provider contact is not available outside of the clinic hours. Normal business hours are Monday through Friday 8 am to 5 pm. Most non-urgent questions should be reserved for the following scheduled appointment. In the event of an emergency, I understand I should call 911 or go to the nearest Emergency Room for assistance.

I AGREE TO THE FOLLOWING PRACTICE POLICIES

_____ (initial) The first appointment will be in person at my office unless there are extenuating circumstances approved by office.

_____ **(initial)** In the event I miss my appointment, I will be unable to receive a refill on my prescription until seen by my provider.

_____ **(initial)** Before contacting the office for a refill, I will double check with my pharmacy to see if there is already one on file.

_____ **(initial)** In the event I need an unforeseen refill prior to my next appointment, I understand I must call the office 24-48 hours (about 2 days) before the refill is needed. Under no circumstance can refills be fulfilled the day of.

_____ **(initial)** I understand that under the discretion of my provider at Global Health Behavioral and Wellness LLC, care may be terminated at any time by issuance of a 30-day notice. This is rare but will happen in the event treatment plans are not consistently followed or due to the dissolution of the therapeutic relationship.

FEES FOR ADDITIONAL SERVICES:

Your insurance company does not typically reimburse for activities that are not a part of direct patient care. The following is a list of some activities where an additional fee is required to be paid in advance.

1. Copying your clinical record (rate based on prevailing community standard)
2. Any forms to be filled in by the provider including but not limited to FMLA, work accommodations, emotional support letter, or other paperwork must be completed by appointment. We are unable to accommodate last-minute appointments to fulfill these requests, please call or email to schedule your appointment.
3. Time spent away from the office to testify in court ($175 an hour).
4. Consultation with other entities including but not limited to attorney, school, disability insurers, workers' compensation **($175 an hour).**

_____ **(initial)** I understand the above costs required for any additional services by Global Health Behavioral and Wellness LLC.

CONFIDENTIALITY

The law protects the privacy of all communications between the patient and the provider, social worker, or other medical provider. In most situations, I can only release information about your treatment to others if you sign a written authorization form that meets certain legal requirements by HIPAA. Your signature on this agreement provides consent for release of information consistent with HIPAA and state law.

A summary of the circumstances in which I may disclose private health information (PHI) without your consent is as follows:

1. If there is a situation that is potentially life threatening.
2. When child abuse is known or suspected. (Reporting required by state law)
3. When the abuse of an elderly or dependent person is known or suspected. (Reporting required by state law)
4. If you commit a crime against a staff member or another person on the premises
5. If you bring charges against, or sue, your provider.
6. When ordered by the court.
7. In some cases, details of your treatment may be discussed with another clinician for the purpose of consultation. When this is done, no identifying information will be included (ie, the patient is anonymous).
8. In some cases, records may be audited by the quality improvement activity of your insurance company.
9. If it becomes necessary to refer your account to a collection service. Only information to pursue collection will be released.

_____(initial) I understand the above circumstances in which **Global Health Behavioral Health and Wellness LLC** does not need my permission to disclose private health information.

TELEHEALTH AGREEMENT

Under certain circumstances and at the discretion of the provider, Telehealth may be used for an appointment via the HIPAA protected App. Please review the following statements and initial:

1. _____I hereby authorize Global Health Behavioral and Wellness LLC to use telepsychiatry when needed in the course of my diagnosis and treatment.
2. _____I decline to receive telepsychiatry visits and request to be seen only for a face-to-face visit with Global Health Behavioral and Wellness LLC
3. I accept that my provider can contact interactive sessions via video call; however, I am informed that the sessions can be conducted via regular voice communication (phone call) if the technical requirements such as internet speed are unable to be met.
4. I understand that my current insurance may not cover the additional fees of the telehealth practices, in this circumstance I may be responsible for any fee that my insurance company does not cover.
5. I agree that my medical records on telehealth can be kept for further evaluation, analysis and documentation, and in any of these, my information will follow the office confidentiality policies as stated in this form.

_____**(initial)** I agree to the above terms and conditions that require my compliance to be serviced via Telehealth.

PARENTS OF MINORS ONLY

Patients under 18 years of age who are not emancipated, and their parents, should be aware that the law may allow parents to examine their child's treatment records. Parents will need to sign a permission to treat form for services provided to a minor. In divorced families, patients under 18 need the consent of the custodial parent(s). A copy of the divorce decree may be requested prior to initiating evaluation and treatment.

I verify that I do have legal custody of this child_____ **(initial).**

APPROVAL FOR DISCLOSURE

Patient Consent to Exchange Information with My Primary Care Physician, Therapist, or other Specialist.

HIPAA policy allows collaboration between healthcare providers regarding your care. By my initials below, I authorize exchange of information with my/my child's Primary Care Physician, Therapist, or other healthcare provider. I place no limits on dates, history of illness, diagnostic and therapeutic information, including treatment for alcohol and/or drug abuse.

Please list providers/individuals that you would like permission to collaborate or release information regarding your care:

Physician/Therapist name:_____

Phone:_____ Fax:_____

Physician/Therapist name:_____

Phone:_____ Fax: _____ Physician/Therapist name:_____

Phone:_____ Fax:_____

_____ **(initial)** I hereby authorize the offices of Global Health Behavioral and Wellness LLC to disclose my medical records, genetic results, and labs to the above parties. In the event I want to change the name of a physician or family member that has permissible disclosure, it is my responsibility to contact the office of **Global Health Behavioral and Wellness LLC,** and or submit a new form. I have completed in full the information above to the best of my knowledge and ability.

CLARIFICATION

If any of these policies or procedures cause problems or seem confusing, please speak with me, so that I may clarify them for you. I make every effort to release only the minimum information about you that is necessary for the purpose requested. This information will become part of the insurance company files. I have no control over what they do with the information. In some cases, they may share the information with a national medical database. By signing this Agreement, you agree that

I can provide the necessary information to your insurance carrier or other designated third-party payers such as Medicare to process claims and for quality assurance activities.

Each party agrees that this agreement and any other documents to be delivered in connection herewith may be electronically signed, and that any electronic signatures (whether typed or electronically signed) appearing on this agreement or such other documents are the same as handwritten signatures for the purposes of validity, enforceability, and admissibility.

By signing the agreement below I am acknowledging that I have reviewed the entirety of this Patient Treatment Agreement and Consent to Treat document. I have read these policy statements and having been informed to my satisfaction, I give consent to treatment and/or evaluation by **Global Health Behavioral and Wellness LLC.**

I understand that by signing this agreement I am acknowledging that I understand the content on this form and agree to comply with all aspects of it.

_____

Patient Signature Date

_____

If Patient is a Minor (Guardian Signature) Date

CONTROLLED SUBSTANCE AGREEMENT

The following agreement is required for all clients who will be prescribed controlled substances by **Global Health Behavioral and Wellness LLC**. Since it has yet to be determined whether controlled substances will be a part of your care, please still fill out this form so that our office can have it on file for future use.

I,_____ understand that if my healthcare provider, **Global Health Behavioral and Wellness LLC,** has prescribed me controlled substances for the treatment of my medical condition, this treatment may carry risks and benefits, and that the effectiveness of the treatment may depend on how strictly I adhere to the prescribed regimen.

As a part of my treatment plan, I understand and agree to the following guidelines:

_____ **(initial)** I will only use the prescribed medication as directed by Global Health Behavioral and Wellness LLC. I will not alter the dose, frequency or route of administration without first consulting my healthcare provider.

_____ **(initial)** I will not request or accept controlled substance medications from any physician or individual while I am receiving such medication from NP/Dr_____. Besides being inappropriate to do so, it may endanger my health. The only exception is if it is prescribed while I am admitted in a hospital.

_____ **(initial)** I will report any side effects or adverse reactions to my healthcare provider immediately.

_____ **(initial)** I understand that long-term use of controlled substances can lead to physical and psychological dependence, and I will notify the office of Global health Behavioral and Wellness LLC if I feel like I am becoming dependent on the medication.

_____ **(initial)** I agree to submit to random drug screening as required by my provider and understand that refusal to submit to a drug screen may result in discontinuation of my medication.

_____ **(initial)** I understand that my healthcare provider may need to consult with other healthcare providers and utilize prescription drug monitoring programs to ensure safe and responsible prescribing.

_____ **(initial)** I will keep my medication in a secure location and out of reach of children or pets.

_____ **(initial)** I agree that I am responsible for my medicine. I will not share, sell, or trade my prescription and I will not take anyone else's prescriptions. I understand doing so is a felony.

_____ **(initial)** I understand that if my medicine is lost, stolen or used sooner than prescribed, it will not be replaced.

_____**(initial)** I agree to keep all appointments set up by the office of Global Health Behavioral and Wellness LLC. With my provider's additional treatment recommendations, including but not counseling and smoking cessation, may result in the discontinuation of the prescribed medications.

_____ (**initial**) I understand that medications are only part of my comprehensive treatment plan. I understand that failure to comply if I need to stop this medicine, I must do so slowly, or I may become very sick. If you become pregnant, please contact the office immediately.

_____ **(initial)** I understand that I may be asked to comply with additional guidelines as deemed necessary by Global Health Behavioral and Wellness LLC, given my specific treatment plan.

TERMINATION OF CONTROLLED SUBSTANCE AGREEMENT

If I break any of the rules, or if my provider, Global Health Behavioral and Wellness LLC, decides that this medicine is hurting me more than helping me, this medicine may be stopped by him in a safe way.

PROVIDER RESPONSIBILITIES

As your provider, Global Health Behavioral and Wellness LLC, I agree to perform regular checks to see how well the medicine is working.

I agree to provide psychiatric care for you even if you are no longer getting controlled substances from me except in the event, I am required to terminate care.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient First Name: _____ Last Name: _____ DOB: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: _____ Email: _____

Parent/Guardian Name (if patient is a minor): _____

Relationship: _____ Phone: _____

I hereby authorize the following health care professional, family member, employer, medical facility, mental health facility, or laboratory to release all health information about me including my entire medical record, treatment record, diagnostic record, record of labs, genetic testing results, and record of drug and/or alcohol consumption.

Person/Organization Name to Release Information: _____

Address: _____ City: _____ State: _____ Zip: _____

Phone Number: _____ Fax Number: _____

Relationship: _____ Phone: _____

The following person/organization is hereby authorized to receive my entire medical record, treatment record, diagnostic record, release of labs, genetic testing results, and drug and/or alcohol consumption record to the following person or organization:

Person/Organization Name to Release Information: _____

Address: _____ **City:** _____ **State:** _____ **Zip:** _____

Phone Number: _____ **Fax Number:** _____

Relationship: _____ **Phone:** _____

Please sign below to acknowledge that you understand fully the release of medical records and have completed the contents of the form to the best of your knowledge and ability. Additionally, by typing my name on this document I acknowledge that I am the patient and/or the patient's legal guardian.

_____

Patient Signature Date

_____

If Patient is a Minor (Guardian Signature) Date

CREDIT CARD AUTHORIZATION FORM

Please complete all fields. You may cancel this authorization at any time by contacting us. This authorization will remain in effect until it is cancelled. Your card will be charged the day of your visit. If you would like to organize a payment plan you must do so prior to your appointment. Charges cannot be refunded after they have been processed, unless due to clerical error.

Primary Card Information
Card Type: MasterCard VISA Discover AMEX Other:_____
Cardholder Name (as shown on card):
Card Number:
Expiration Date (MM/YY):
Security Code (3-digit):
Cardholder ZIP Code (from credit card billing address):

I _____, authorize **Global Health Behavioral and Wellness LLC** to charge my credit card above for agreed upon purchases. I understand that my information will be saved to file for future transactions on my account. For further questions regarding billing refer to

Patient Health Questionnaire and General Anxiety Disorder (PHQ-9 and GAD-7)

Date_____ Patient Name:_____ Date of Birth: _____

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

PHQ-9	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
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? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

Over the last 2 weeks, how often have you been bothered by any of the following problems?
Please circle your answers.

GAD-7	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? (Circle one)

Not difficult at all **Somewhat difficult** **Very Difficult** **Extremely Difficult**

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THE MOOD DISORDER QUESTIONNAIRE

Instructions: Please answer each question to the best of your ability.

	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 much 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 into 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?	○	○
3. How much of a problem did any of these cause you – like being unable to work; having family, money or legal troubles; getting into arguments or fights? *Please circle one response only.* No Problem Minor Problem Moderate Problem Serious Problem		
4. Have any of your blood relatives (i.e. 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?	○	○