CENTER FOR
Behavioral Wellness

William Abrokwa, APRN | Jeannie Dilworth, APRN | Stacey Hansen, LMFT | Tracy Lewis, LCSW | Holly Monroe, LMFT

PATIENT REGISTRATION FORM

DATE:

PERSONAL INFORMATION:

Name: _____ Date of Birth: ____/____/____

Gender Identity: ☐ Identifies as male ☐ Identifies as Female ☐ Transgender Male/Female-to-Male (FTM)
☐ Transgender Female/Male-to-Female (MTF) ☐ Gender non-conforming (neither exclusively male nor female)
☐ Additional gender category/ other, please specify _____ ☐ Choose not to disclose

Address: _____ Town: _____ State: _____ Zip Code: _____
Preferred Number: (____) _____ Is it ok to leave a voicemail and/or text? ☐ Yes ☐ No
Other Number: (____) _____ Is it ok to leave a voicemail and/or text? ☐ Yes ☐ No
Email: _____ Can we communicate via email? ☐ Yes ☐ No

Social Security #: _____ Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed
Employment Status: ☐ Full-time ☐ Part-time ☐ Self-employed ☐ Unemployed ☐ Disabled ☐ Child ☐ Student
If Employed: Employers Name/Address: _____
If you are a student, are you attending: ☐ High School ☐ College ☐ Graduate School Highest grade completed: _____
Primary Language: ☐ English ☐ Spanish ☐ Other: _____

Race: ☐ American Indian/Alaska Native ☐ Asian ☐ Black/African American ☐ Native Hawaiian/Other Pacific Islander
☐ Multi-Racial ☐ White ☐ Declined to Specify ☐ Other: _____
Ethnicity: ☐ Hispanic or Latino ☐ Not Hispanic or Latino ☐ Declined to Specify

Preferred Pharmacy: _____ Phone Number: (____) _____
Primary Care Physician: _____ Phone Number: (____) _____
Emergency Contact: _____ Phone Number: (____) _____
In case of emergency, preferred hospital/ER: _____
Referred By: _____ Phone Number: (____) _____
Previous Psychiatric Services: _____

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INSURANCE INFORMATION:

Primary Medical Insurance: _____ Policy Number: _____

Secondary Medical Insurance: _____ Policy Number: _____

Insured Party: ☐ Self ☐ Spouse ☐ Parent

Party responsible for payment: ☐ Spouse ☐ Parent ☐ Other: _____

**Please complete this section ONLY if someone other than the client is responsible for payment:*

Name: _____ Date of Birth: ____/____/____

Address: _____ Town: _____ State: _____ Zip Code: _____

Preferred Number: (____) _____

BILLING CONSENT

I, _____, hereby give my consent for Center for Behavioral Wellness to bill my/my child's insurance carrier for the services rendered to me/ my child/family. In addition, I agree to pay Center for Behavioral Wellness any deductibles or uncovered charges in accordance with my health care plan.

_____

Signature of Client/Parent/Legal Representative Date Print Name

If not signed by the client indicate relationship of authorizing person to client:

☐ Parent or guardian of minor child
☐ Guardian or conservator of conserved client
☐ Beneficiary or personal Representative of a deceased individual

I,_____, hereby give my consent for electronic billing statements by providing my email on the patient registration form and signing below.

_____

Signature of Client/Parent/Legal Representative Date Print Name

*Please Note: If no email is provided, paper billing statements will be mailed to the address on file.

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POLICY STATEMENT

All clients or the client's legal guardian will have access to a copy of this written policy regarding the client's registration procedures, financial policies, and billing policies at the time of registration.

___ Appointments: All services are provided by appointment, in-person or telehealth. For in-person appointments, clients are required to check in with the front desk and make any payments due upon arrival for the appointment. For telehealth services it is the client's responsibility to maintain consistent payments for services rendered as notified by monthly billing statements. To make, change, or cancel an appointment, please call the office Monday-Friday 9:00 a.m.-5:00 p.m. If a receptionist is not available during hours of operation, you may leave a voicemail and your call will be returned as it is processed. Please note that voicemails can also be left outside of office hours as needed, and will also be responded to as they are processed during normal office hours.

___ Billing Policy: Your insurance policy is a contract between you and your insurance company; CBW is not a part of that contract. It is your responsibility to know and understand the provisions, limits, and requirements of your individual benefit plan(s). As a service to you, our office will file your insurance claim for you; however, we cannot guarantee benefits or payments. If your insurance carrier denies payment for services, you remain financially responsible for payment regardless of any insurance company determination, quote, or misquote, except where prohibited by law or prior contractual agreement. The responsible party agrees to provide all insurance information, at or prior to the first appointment. The responsible party also agrees to notify CBW of any changes in insurance coverage within 10 days.
**CBW is contracted with Lightning MD, an outside billing service company. Per HIPAA regulations, we have a formal business contract with Lightning MD company will adhere to all requirements of confidentiality as required by law.

___ Financial Policy: It is expected that fees for any professional services be paid when services are rendered. All co-payments and fees for services not covered by insurance are expected to be paid upon notification. CBW maintains the right to cancel and/or not schedule future appointments if balances are not paid consistently as agreed to in this policy statement. In-person clients are expected to make payments at the time of arrival for scheduled appointments. Telehealth clients are responsible for being aware of balances due and making payments by mail/phone before the time of scheduled appointments. All clients will receive monthly billing statements and can also inquire about balances during office hours.

We accept cash, personal checks, and all major credit cards. Clients will be responsible for covering any and all bank fees associated with returned checks. If a client fails to be responsible for the account, and it is necessary to refer a delinquent account into the hands of a collection agency/attorney, the client agrees to pay all costs affixed by the court, collection agency, or attorney. A collections warning letter will be sent to any client who has not made a payment in 3 billing cycles. Failure to respond to this letter will lead to accounts being submitted to collections. Any clients with delinquent accounts sent to collections will no longer be considered for treatment with any provider at CBW.

___ Cancellation/No Show fees: It is important that clients attend all scheduled appointments. A missed appointment fee of $100 (or a $50 fee for a missed group session) will be applied if a client fails to cancel an appointment within 24hours advanced notice or provide proper documentation of an emergency. The missed appointment fee is due before the next scheduled appointment. This policy is aimed at minimizing the waiting time and ensuring availability of prompt care. Appointment reminder calls/texts are made 48hours prior to scheduled appointments as a courtesy and are not guaranteed. Clients are responsible for maintaining scheduled appointment times even if a reminder call/text is not received.
**CBW reserves the right to discontinue treatment for missed appointments with less than 24 hours notice on two occasions, as well as habitually cancelling/rescheduling appointments.
*Please note that insurance carriers cannot be billed for these fees and it is entirely client responsibility to make these payments promptly.

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___ Medical Records: Medical records created by our office shall only be released pursuant to signed authorization in accordance with HIPAA or other controlling laws (or under other circumstances as required by law). In accordance with Connecticut law, we charge a photocopying fee of $.65 per page, and have up to 30 days to produce your records. If permitted under the law, we may charge higher fees to attorneys who request your records. Certain services (e.g., family conferences, completing forms, producing narrative reports, personal letters, etc.) may entail additional fees. CBW reserves the right to withhold records for clients who are actively engaged in treatment or that have been discharged from the practice.

___ Termination of Treatment: If a client is discharged from the practice, it means the client will no longer be able to schedule appointments, receive medication refills, or consider any provider at CBW an active treating practitioner. Treatment can be terminated if a client fails to keep scheduled appointments as per office policies, noncompliance or failure to follow the recommended treatment plan, abusive to staff, and failure to pay a balance. Treatment may also be terminated if an appointment has not been scheduled for a period of 90 days.
**If a client is discharged, a written notification letter will be sent to the address on file. Medical records may be sent to a new provider upon request following our record release protocol.

___ No Smoking Policy: CBW will not condone clients, staff, or providers smoking near and/or around the practice location. We care about your health, the health of others, and wish to promote healthy behaviors.

___ Professional Record Keeping: The laws and standards require that the psychological and behavioral healthcare providers maintain clinical records for all services provided. The following information may be included in a clinical record: reasons for seeking services; symptoms; diagnosis; treatment plan; session information and progress; medical, social, and family history; records from other providers; billing information; phone calls and other communications; information provided by other individuals; and other information related to the clinical services. Paper documents will be scanned into a digital format and saved within our electronical medical records system. All electronic medical records are maintained as a part of our EMR. The information is maintained as part of a HIPAA compliant on-line program.

___ Closings/Delays: In the event that our office needs to close during regular business hours, our practice will update our voicemail. In the event of inclement weather, we recommend calling the office prior to the scheduled appointment time to ensure knowledge of any changes. If appointments have been cancelled, the client is responsible for rescheduling.

CONSENT TO TREATMENT/ASSISNMENT OF BENEFITS: I hereby authorize Center for Behavioral Wellness and associated providers, through its appropriate personnel, to perform or have performed upon me, or the client, appropriate assessment and treatment procedures.

I consent to receive calls, text messages and/or emails from Center for Behavioral Wellness for my protected healthcare and other services at the phone number(s) provided on the Patient Registration Form. I understand that I may be charged for such calls and/or text messages by my wireless carrier and that such calls and/or text messages may be generated by an automated dialing system.

I hereby assume financial responsibility for and agree to make payment in full to Center for Behavioral Wellness and associated providers for any and all charges for services received by me and/or any dependents not otherwise authorized or paid by my insurance carrier. Co-payments and fees for services not covered by insurance are required at the time services are rendered. I understand and agree to inform Center for Behavioral Wellness of changes in my insurance within 10 days so that claims can be filed within the insurance carrier's deadline, and I will be responsible for the full fee for services rendered if not covered by my insurance carrier.

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I authorize Center for Behavioral Wellness and associated providers to release my information for all claims and payment purposes, as may be required by my insurance company or any third-party payer, and release Center for Behavioral Wellness and associated providers from any liability related to such release of information.

I authorize Center for Behavioral Wellness to disclose any information needed to confirm the validity of my prescription, as well as any information needed to the dispensing pharmacy to whom I present my prescription or to whom my prescription is called/sent/faxed, and to third party payors. *This information has been disclosed to you from records protected by Federal confidentiality rules (Title 42, Part 2, Code of Federal Regulations [42 C.F.R. Part 2]). The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the individual to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose.

I assign all benefits and rights to payment for services provided by Center for Behavioral Wellness and associated providers and authorize payment to be made directly to Center for Behavioral Wellness and associated providers by any third-party payer that provides benefits or payment for such services.

The HIPAA Privacy Rule requires that "covered entities" (e.g. hospitals and clinics) deliver a copy of their Notice of Privacy Practices to their clients at their first visit. It also requires that we seek a written acknowledgement from our clients that we did, in fact, deliver that notice. Accordingly, Center for Behavioral Wellness asks you to acknowledge that we delivered to you a copy of our "Notice of Privacy Practices" by signing this form.

ACKNOWLEDGEMENT OF POLICY STATEMENT

Signature of Client/Parent/Legal Representative Date Print Name

If not signed by the client indicate relationship of authorizing person to client:

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved client
- ☐ Beneficiary or personal Representative of a deceased individual

*PLEASE NOTE THAT YOU MAY REQUEST A COPY OF THIS SIGNED STATEMENT FROM OUR FRONT DESK STAFF

Center for Behavioral Wellness, LLC

CONSENT FOR TELEMENTAL HEALTH SERVICES

This form is to be used in conjunction with, but does not replace the signed Service Agreement and Consent for Treatment that that is required for all clients receiving services from Center for Behavioral Wellness, LLC.

WHAT IS TELEMENTAL HEALTHCARE?

Telemental health is a subset of telehealth services that uses online, interactive videoconference software to provide mental health services from a distance. The Center for Behavioral Health currently uses Doxy.me for telemental services. Clinicians who are not prescribing medications may use the telephone to provide services (telehealth). Private insurance companies and CT state specific plans are required by law to cover telemental health services. Telemental services are determined by insurance plans and must be verified by each client.

SOME POTENTIAL RISKS OF TELEMENTAL HEALTH

- Technological failures such as unclear video, loss of sound, poor internet connection, or loss of internet connection
- Nonverbal cues might be more difficult to observe and interpret during therapist and client interactions
- Must electronically share m practice and consent forms and accept risks that come with transmitting information and documents over the internet.

BENEFITS OF TELEMENTAL HEALTH

- Less limited by geographical location and transportation concerns
- Decrease in travel time and ability to meet virtually during inclement weather conditions
- Ability to participate in treatment from your own home or other environment where you feel safe, secure, and comfortable

ELIGIBILITY

Center for Behavioral Wellness LLC is only able to provide telemental health services to clients located in Connecticut where our clinicians hold valid CT State Licenses. New clients must present a valid ID during the initial consultation and need to have a valid photo ID on file in the Center for Behavioral Wellness medical record. Telemental health may not be the most effective form of treatment for certain individuals or presenting problems. If it is believed the client would benefit better from another form of service (e.g. face-to-face sessions) or another provider, an appropriate recommendation will be made. Again, telehealth benefits must be verified by the client prior to initiating treatment as telemental services are determined by insurance plans.

PRIVACY AND CONFIDENTIALITY

The current laws that protect privacy and confidentiality also apply to telemental health services. Exceptions to confidentiality are described in the Notice of Privacy Practices. All existing laws regarding client access to mental health information and copies of mental health records apply. Telemental health services are provided through the HIPAA compliant, secure software via Doxy.me. No permanent video or voice recordings are kept from telemental health sessions. Clients may not record or store video from sessions.

Center for Behavioral Wellness, LLC

CLIENT EXPECTATIONS DURING TELEMENTAL HEALTH SESSIONS

- Mac/PC/Chromebook, smart phone, or tablet with camera, microphone, and speakers
- Internet connection with at least 750kb/s download and upload speeds
- Access to Google Chrome or Mozilla Firefox (latest release versions) web browsers
- Proper lighting and seating to ensure a clear image of each party's face
- Dress and environment appropriate to an in-office visit
- Engage in sessions in a private location where you cannot be heard by others
- Only agreed upon participants will be present; the presence of individuals unapproved by both parties will be cause for termination of the session
- Client must disclose the physical address of their location at the start of the session; unknown locations will be cause for termination of the session
- Client shall provide a phone number where they can be reached in the event of service disruption
- Session will be terminated if client is driving

EMERGENCY PROTOCOL

In the case of a mental health emergency during a session where a client is at imminent risk of harming themselves or someone else, your clinician will contact the client's local emergency services. The contact information for the client's nearest emergency room will be on record. Release of Information forms will be completed for necessary entities unless confidentiality must be breached to protect the safety of the client or another identified individual.

PAYMENT PROCEDURES

Copays must be received for each session by calling the Center for Behavioral Wellness office at (860)432-7771 after each session. Telehealth appointments will be cancelled if client has an outstanding balance.

CONSENT FOR TELEMENTAL HEALTH TREATMENT

I hereby consent to engage in telemental health services with Center for Behavioral Wellness, LLC. I understand that telemental health includes mental health care delivery, diagnosis, consultation, treatment, transfer of medical data, and education using interactive audio, video, telephone and/or data communications. I understand that telemedicine also involves the communication of my medical and mental health information. I have the right to withhold or withdraw consent at any time without affecting my right to future care or treatment. I am responsible for notifying the Center for Behavioral Wellness of any change in demographics and/or insurance.

_____ _____

Client Signature Printed Name of Client

_____

Date

CENTER FOR
Behavioral Wellness

NAME: _____

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ADULT SELF-ASSESSMENT

Please list the reason for your visit today: _____

CURRENT MEDICATIONS:

Medication/Dose	Reason	Medication/Dose	Reason

Who is prescribing your medications?: _____

Previous Medications:

Medication/Dose	Reason	Medication/Dose	Reason

Have you received Mental Health services before?: _____

Past Surgeries: (type of surgery and approximate year) ☐ None

1. _____
2. _____
3. _____

Past Injuries: (type of injury and approximate date) ☐ None

1. _____
2. _____
3. _____

Have you had any frightening or traumatic experiences? If yes, please describe.

- Accident:
  ☐ No ☐ Yes: _____
- Medical Trauma:
  ☐ No ☐ Yes: _____
- Other:
  ☐ No ☐ Yes: _____

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Have you ever experienced sexual or physical abuse? If yes, please describe.

- Physical Abuse:
  ☐ No ☐ Yes: _____
- Sexual Abuse:
  ☐ No ☐ Yes: _____
- Sexual Assault:
  ☐ No ☐ Yes: _____
- Neglect by parent(s):
  ☐ No ☐ Yes: _____
- Neglect by relative(s):
  ☐ No ☐ Yes: _____

Have you ever been a witness to violence? If yes, please describe.

- Witness to domestic violence::
  ☐ No ☐ Yes: _____
- Witness to other violence:
  ☐ No ☐ Yes: _____

Have you ever used/abused any of the following?

Substance:	Date of last use:	Age of first use:	Method of use:	Amount/Frequency of use:	Type:
Alcohol					
Marijuana					
Tobacco					
Cocaine					
PCP					
Heroin					
Sedatives					
Amphetamines					
Prescription Drugs					
Internet					
Video Games					
Other					

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Have you ever felt the need to cut down on your drinking/substance abuse? ☐ Yes ☐ No

Have you ever felt annoyed by criticism of your drinking/substance abuse? ☐ Yes ☐ No

Have you ever felt guilty feelings about drinking/substance abuse? ☐ Yes ☐ No

Have you ever been to a detox program or drug rehab program? ☐ Yes ☐ No

If yes, when?: _____ Where?: _____

MEDICAL HISTORY:

Have you ever had any of the following health problems?	Yes	No	When
1. Loss of consciousness or head injury	☐	☐	
2. Seizures or convulsions	☐	☐	
3. Rashes or skin problems	☐	☐	
4. Meningitis	☐	☐	
5. Asthma	☐	☐	
6. Food allergies	☐	☐	
7. Drug or medication allergies	☐	☐	
8. Pneumonia	☐	☐	
9. Anemia or low blood count	☐	☐	
10. Heart Problems	☐	☐	
11. Kidney or urinary problems	☐	☐	
12. Bowel problems	☐	☐	
13. Trouble with vision	☐	☐	
14. Trouble with hearing	☐	☐	
15. Lack of weight gain	☐	☐	
16. Poisoning or medication overdose	☐	☐	
17. Serious injury	☐	☐	
18. Hospitalization	☐	☐	
19. Surgery	☐	☐	
20. Diabetes	☐	☐	
21. Sexually Active	☐	☐	
22. Last menstrual period	☐	☐	

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Are you aware of any difficulties/issues during:

☐ Birth: _____

☐ Early Childhood: _____

☐ Elementary school: _____

☐ Middle school: _____

☐ High school: _____

☐ College: _____

FAMILY ILLNESSES:

Illness	Biological Mother	Biological Mother's Family	Biological Father	Biological Father's Family	Siblings
Allergies					
Asthma or Emphysema					
Diabetes					
Heart Trouble					
Mental Retardation					
Seizure Disorder					
Depression					
Anxiety					
OCD					
Bipolar Disorder					
ADHD					
Schizophrenia					
Other Psychiatric Disorder					
Learning Difficulties					
Behavioral Problems					
Alcohol Dependency					
Drug Dependency					

LEGAL PROBLEMS:

☐ None ☐ Arrests ☐ CHINS ☐ Probation ☐ DYS ☐ Victim/ Witness ☐ Restraining Order

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REVIEW OF PHYSICAL SYSTEMS: (mark any of the following that frequently apply or are currently a concern to you)

HEAD:

- ☐ dizziness / vertigo
- ☐ blurred vision
- ☐ loss of vision
- ☐ loss of hearing
- ☐ loss of smell
- ☐ loss of taste
- ☐ eye pain
- ☐ ear pain
- ☐ ringing / buzzing
- ☐ sinus drainage

NEUROLOGIC:

- ☐ headache
- ☐ memory loss
- ☐ difficulty concentrating
- ☐ speech difficulty
- ☐ blackout / fainting
- ☐ seizures
- ☐ trouble walking
- ☐ falling
- ☐ clumsiness
- ☐ weakness
- ☐ numbness / tingling
- ☐ shaking / tremor
- ☐ cramping / twitching

MUSCULOSKELETAL:

- ☐ neck pain
- ☐ back pain
- ☐ joint pain

CARDIOVASULAR:

- ☐ chest pain
- ☐ palpitations
- ☐ irregular heart beat
- ☐ swelling of feet
- ☐ heart murmur

RESPIRATORY:

- ☐ shortness of breath
- ☐ wheezing
- ☐ coughing

GASTROINTESTINAL:

- ☐ nausea
- ☐ vomiting
- ☐ stomach pain/heartburn
- ☐ difficulty swallowing
- ☐ blood in stool
- ☐ constipation
- ☐ diarrhea
- ☐ loss of bowel control

GENITOURINARY:

- ☐ frequent urination
- ☐ painful urination
- ☐ loss of bladder control
- ☐ sexual problems
- ☐ irregular menstruation
- ☐ heavy menstruation
- ☐ excessive cramping

HEMATOLOGIC/LYMPHATIC:

- ☐ bleeding tendency
- ☐ blood clots
- ☐ easily bruises

ENDOCRINE:

- ☐ heat intolerance
- ☐ cold intolerance
- ☐ excessive thirst

SKIN:

- ☐ rash
- ☐ hair loss
- ☐ sores
- ☐ dryness/flaking

GENERAL:

- ☐ unexplained fevers
- ☐ weight loss
- ☐ weight gain
- ☐ severe fatigue
- ☐ difficulty with sleep

FOR STAFF USE:

_____

_____

_____

_____

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MEDICATION AGREEMENT & REFILL POLICY

Controlled Medications are governed by multiple Federal and State laws and monitored through multiple agencies. Monitoring agencies include the Drug Enforcement Agency (DEA), Connecticut Department of Public Health, Connecticut Board of Medicine, and the Connecticut Board of Pharmacy. Connecticut Board of Nursing Prescribers and pharmacists themselves can monitor any controlled prescription ever filled by a given client (irrespective pf payment type, including cash), by logging on to the Connecticut Prescription Monitoring Program System (aka CTPMP). If our staff has any questions regarding your healthcare, including medications, we reserve the right to contact your other treating physicians and pharmacies.

If you need a refill of your prescribed medications prior to your next scheduled appointment, notify your pharmacy to fax this office with your prescription information (Please do not call the office directly). Center for Behavioral Wellness personnel and/or your provider will be available to fill refills on weekdays during normal office hours only. Please notify your pharmacy at least 48 business hours before your medication runs out or we may not be able to respond to your request.

- Medications require prescriber monitoring. We will not refill prescriptions for clients who have not had adequate follow-up visits. The longest interval between visits while being prescribed a medication is three months and one month for a controlled medication.
- You are responsible for the any medications prescribed to you. If your prescription is lost, misplaced, stolen, or misused your medication, please understand it will not be replaced.
- We do not consider medication refills an "emergency." If you run out of medication over the weekend/holiday and forgot to request a refill, it will have to wait until normal business hours.

TERMS AND CONDITIONS: (Please read and the following important information and initial next to each item in the space provided.)

____ I agree to obtain all controlled medications from the same pharmacy. Should the need arise to change pharmacies, I will inform this providers office.

____ I agree to follow the dosing schedule prescribed to me by my prescriber.

____ I agree to never sell or exchange my medications with anyone for any reason. This is a felony and very dangerous.

____ I understand that medication refills for controlled medication require a scheduled appointment with my prescriber in the office. For this type of medication, refills cannot be called into a pharmacy and dosages will not be adjusted by phone.

____ I agree to keep all scheduled appointments. I understand that no medications will be given for canceled or no show appointments. I understand that if I am more than 15 minutes late to my scheduled appointment time, I will have to reschedule for another time.

____ I understand Center for Behavioral Wellness reserves the right to perform a drug screen, via saliva, urine or blood, as well as any random pill counts of medications prescribed by my provider, at any time while I am being treated with a controlled substance. I understand that I have 24 hours to comply with the requested drug screen. Failure to do so will result in immediate discharge from the practice.

____ I agree to conduct myself in a courteous manner in the office. I agree not to arrive at the office intoxicated or under the influence of drugs. I understand that any misconduct will lead to the termination of my treatment.

____ I understand that dealing with a forged, falsified, or altered prescription will result in a report to the police and termination from this practice.

____ I understand that failure to adhere to these policies and/or failure to comply with my providers' treatment plan may result in possible discharge from this practice. I understand that if I am discharged, it means I can no longer schedule appointments, or receive medication refills.

I, the undersigned client, attest that I have read, fully understand, and agree to all of the above requirements and instructions. I affirm that I have the full right and power to sign and be bound by this agreement.

Signature of Client/Parent/Legal Representative Date Print Name

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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**
⑤	⑤	⑤	⑤

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

Over the last 2 weeks, how often have you been bothered by the following problems?	Not at all sure	Several days	Over half the days	Nearly every day
1. Feeling nervous, anxious, or on edge	0	1	2	3
2. Not being able to stop or control worrying	0	1	2	3
3. Worrying too much about different things	0	1	2	3
4. Trouble relaxing	0	1	2	3
5. Being so restless that it's hard to sit still	0	1	2	3
6. Becoming easily annoyed or irritable	0	1	2	3
7. Feeling afraid as if something awful might happen	0	1	2	3
Add the score for each column	+	+	+	
Total Score *(add your column scores)* =				

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

Not difficult at all _____
Somewhat difficult _____
Very difficult _____
Extremely difficult _____

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

PCL-C

The next questions are about problems and complaints that people sometimes have in response to stressful life experiences. Please indicate how much you have been bothered by each problem in the past month. For these questions, the response options are: "not at all", "a little bit", "moderately", "quite a bit", or "extremely".

		Not at all	A little bit	Moderately	Quite A Bit	Extremely
PCL1	Repeated, disturbing memories, thoughts, or images of a stressful experience from the past?	1	2	3	4	5
PCL2	Repeated, disturbing dreams of a stressful experience from the past?	1	2	3	4	5
PCL3	Suddenly acting or feeling as if a stressful experience from the past were happening again (as if you were reliving it)?	1	2	3	4	5
PCL4	Feeling very upset when something reminded you of a stressful experience from the past?	1	2	3	4	5
PCL5	Having physical reactions (e.g., heart pounding, trouble breathing, sweating) when something reminded you of a stressful experience from the past?	1	2	3	4	5
PCL6	Avoiding thinking or talking about a stressful experience from the past or avoiding having feelings related to it?	1	2	3	4	5
PCL7	Avoided activities or situations because they reminded you of a stressful experience from the past?	1	2	3	4	5
PCL8	Having trouble remembering important parts of a stressful experience from the past?	1	2	3	4	5
PCL9	Loss of interest in activities that you used to enjoy?	1	2	3	4	5
PCL10	Feeling distant or cut off from other people?	1	2	3	4	5
PCL11	Feeling emotionally numb or being unable to have loving feelings for those close to you?	1	2	3	4	5
PCL12	Feeling as if your future somehow will be cut short?	1	2	3	4	5
PCL13	Having trouble falling or staying asleep?	1	2	3	4	5
PCL14	Feeling irritable or having angry outbursts?	1	2	3	4	5
PCL15	Difficulty concentrating?	1	2	3	4	5
PCL16	Being "superalert" or watchful or on guard?	1	2	3	4	5
PCL17	Feeling jumpy or easily startled?	1	2	3	4	5

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?	O	O
...you were so irritable that you shouted at people or started fights or arguments?	O	O
...you felt much more self-confident than usual?	O	O
...you got much less sleep than usual and found you didn't really miss it?	O	O
...you were much more talkative or spoke much faster than usual?	O	O
...thoughts raced through your head or you couldn't slow your mind down?	O	O
...you were so easily distracted by things around you that you had trouble concentrating or staying on track?	O	O
...you had much more energy than usual?	O	O
...you were much more active or did many more things than usual?	O	O
...you were much more social or outgoing than usual, for example, you telephoned friends in the middle of the night?	O	O
...you were much more interested in sex than usual?	O	O
...you did things that were unusual for you or that other people might have thought were excessive, foolish, or risky?	O	O
...spending money got you or your family into trouble?	O	O
2. If you checked YES to more than one of the above, have several of these ever happened during the same period of time?	O	O

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?	O	O
5. Has a health professional ever told you that you have manic-depressive illness or bipolar disorder?	O	O

PATIENT NAME _____ DATE _____

YALE-BROWN OBSESSIVE COMPULSIVE SCALE (Y-BOCS)*

Questions 1 to 5 are about your obsessive thoughts

Obsessions are unwanted ideas, images or impulses that intrude on thinking against your wishes and efforts to resist them. They usually involve themes of harm, risk and danger. Common obsessions are excessive fears of contamination; recurring doubts about danger, extreme concern with order, symmetry, or exactness; fear of losing important things.

Please answer each question by circling the appropriate number.

1. TIME OCCUPIED BY OBSESSIVE THOUGHTS SCORE _____

How much of your time is occupied by obsessive thoughts?

0	=	None
1	=	Less than 1 hr/day or occasional occurrence
2	=	1 to 3 hrs/day or frequent
3	=	Greater than 3 and up to 8 hrs/day or very frequent occurrence
4	=	Greater than 8 hrs/day or nearly constant occurrence

2. INTERFERENCE DUE TO OBSESSIVE THOUGHTS SCORE _____

How much do your obsessive thoughts interfere with your work, school, social, or other important role functioning? Is there anything that you don't do because of them?

0	=	None
1	=	Slight interference with social or other activities, but overall performance not impaired
2	=	Definite interference with social or occupational performance, but still manageable
3	=	Causes substantial impairment in social or occupational performance
4	=	Incapacitating

3. DISTRESS ASSOCIATED WITH OBSESSIVE THOUGHTS SCORE _____

How much distress do your obsessive thoughts cause you?

0	=	None
1	=	Not too disturbing
2	=	Disturbing, but still manageable
3	=	Very disturbing
4	=	Near constant and disabling distress

4. RESISTANCE AGAINST OBSESSIONS SCORE _____

How much of an effort do you make to resist the obsessive thoughts? How often do you try to disregard or turn your attention away from these thoughts as they enter your mind?

0	=	Try to resist all the time
1	=	Try to resist most of the time
2	=	Make some effort to resist
3	=	Yield to all obsessions without attempting to control them, but with some reluctance
4	=	Completely and willingly yield to all obsessions

5. DEGREE OF CONTROL OVER OBSESSIVE THOUGHTS SCORE _____

How much control do you have over your obsessive thoughts? How successful are you in stopping or diverting your obsessive thinking? Can you dismiss them?

0	=	Complete control
1	=	Usually able to stop or divert obsessions with some effort and concentration
2	=	Sometimes able to stop or divert obsessions
3	=	Rarely successful in stopping or dismissing obsessions, can only divert attention with difficulty
4	=	Obsessions are completely involuntary, rarely able to even momentarily alter obsessive thinking.

The next several questions are about your compulsive behaviors.
Compulsions are urges that people have to do something to lessen feelings of anxiety or other discomfort. Often they do repetitive, purposeful, intentional behaviors called rituals. The behavior itself may seem appropriate but it becomes a ritual when done to excess. Washing, checking, repeating, straightening, hoarding and many other behaviors can be rituals. Some rituals are mental. For example, thinking or saying things over and over under your breath.

6. TIME SPENT PERFORMING COMPULSIVE BEHAVIORS SCORE _____

How much time do you spend performing compulsive behaviors? How much longer than most people does it take to complete routine activities because of your rituals? How frequently do you do rituals?

0	=	None
1	=	Less than 1 hr/day or occasional performance of compulsive behaviors
2	=	From 1 to 3 hrs/day, or frequent performance of compulsive behaviors
3	=	More than 3 and up to 8 hrs/day, or very frequent performance of compulsive behaviors
4	=	More than 8 hrs/day, or near constant performance of compulsive behaviors (too numerous to count)

7. INTERFERENCE DUE TO COMPULSIVE BEHAVIORS SCORE _____

How much do your compulsive behaviors interfere with your work, school, social, or other important role functioning? Is there anything that you don't do because of the compulsions?

0	=	None
1	=	Slight interference with social or other activities, but overall performance not impaired
2	=	Definite interference with social or occupational performance, but still manageable
3	=	Causes substantial impairment in social or occupational performance
4	=	Incapacitating

8. DISTRESS ASSOCIATED WITH COMPULSIVE BEHAVIOR SCORE _____

How would you feel if prevented from performing your compulsion(s)? How anxious would you become?

0	=	None
1	=	Only slightly anxious if compulsions prevented
2	=	Anxiety would mount but remain manageable if compulsions prevented
3	=	Prominent and very disturbing increase in anxiety if compulsions interrupted
4	=	Incapacitating anxiety from any intervention aimed at modifying activity

9. RESISTANCE AGAINST COMPULSIONS SCORE _____

How much of an effort do you make to resist the compulsions?

0	=	Always try to resist
1	=	Try to resist most of the time
2	=	Make some effort to resist
3	=	Yield to almost all compulsions without attempting to control them, but with some reluctance
4	=	Completely and willingly yield to all compulsions

10. DEGREE OF CONTROL OVER COMPULSIVE BEHAVIOR SCORE _____

How strong is the drive to perform the compulsive behavior? How much control do you have over the compulsions?

0	=	Complete control
1	=	Pressure to perform the behavior but usually able to exercise voluntary control over it
2	=	Strong pressure to perform behavior, can control it only with difficulty
3	=	Very strong drive to perform behavior, must be carried to completion, can only delay with difficulty
4	=	Drive to perform behavior experienced as completely involuntary and over-powering, rarely able to even momentarily delay activity.

TOTAL SCORE _____

Y-BOCS Symptom Checklist

Instructions: Generate *a Target Symptoms List from* the attached Y-BOCS Symptom Checklist by asking the patient about specific obsessions and compulsions. Chock all that apply. Distinguish between current and past symptoms. Mark principal symptoms with a "p". These will form the basis of the Target Symptoms *List*. Items marked may "*" or may not be an OCD phenomena.

Current Past

AGGRESSIVE OBSESSIONS

___ ___ Fear might harm self
___ ___ Fear might harm others
___ ___ Violent or horrific images
___ ___ Fear of blurting out obscenities or insults
___ ___ Fear of doing something else embarrassing*
___ ___ Fear will act on unwanted impulses (e.g., to stab friend)
___ ___ Fear will steal things
___ ___ Fear will harm others because not careful enough (e.g. hit/run motor vehicle accident)
___ ___ Fear will be responsible for something else terrible happening (e.g., fire, burglary
Other:

CONTAMINATION OBSESSIONS

___ ___ Concerns or disgust w\ with bodily waste or secretions (e.g., urine, feces, saliva Concern with dirt or germs
___ ___ Excessive concern with environmental contaminants (e.g. asbestos, radiation toxic waste)
___ ___ Excessive concern with household items (e.g., cleansers solvents)
___ ___ Excessive concern with animals (e.g., insects)
___ ___ Bothered by sticky substances or residues
___ ___ Concerned will get ill because of contaminant
___ ___ Concerned will get others ill by spreading contaminant (Aggressive)
___ ___ No concern with consequences of contamination other than how it might feel

SEXUAL OBSESSIONS

___ ___ Forbidden or perverse sexual thoughts. images. or impulses
___ ___ Content involves children or incest
___ ___ Content involves homosexuality*
___ ___ Sexual behavior towards others (Aggressive)*
___ ___ Other:

HOARDING/SAVING OBSESSIONS

(distinguish from hobbies and concern with objects of monetary or sentimental value)

___ ___ _____

RELIGIOUS OBSESSIONS (Scrupulosity)

___ ___ Concerned with sacrilege and blasphemy
___ ___ Excess concern with right/wrong, morality
___ ___ Other:

OBSESSION WITH NEED FOR SYMMETRY OR EXACTNESS

___ ___ Accompanied by magical thinking (e.g., concerned that another will have accident dent unless less things are in the right place)
___ ___ Not accompanied by magical thinking

MISCELLANEOUS OBSESSIONS

___ ___ Need to know or remember
___ ___ Fear of saying certain things
___ ___ Fear of not saying just the right thing
___ ___ Fear of losing things
___ ___ Intrusive (nonviolent) images
___ ___ Intrusive nonsense sounds, words, or music
___ ___ Bothered by certain sounds/noises*
___ ___ Lucky/unlucky numbers
___ ___ Colors with special significance
___ ___ 3 superstitious fears
___ ___ Other:

Current Past

SOMATIC OBSESSIONS

___ ___ Concern with illness or disease*
___ ___ Excessive concern with body part or aspect of Appearance (eg., dysmorphophobia)*
___ ___ Other

CLEANING/WASHING COMPULSIONS

___ ___ Excessive or ritualized handwashing
___ ___ Excessive or ritualized showering, bathing, toothbrushing grooming, or toilet routine Involves cleaning of household items or other inanimate objects
___ ___ Other measures to prevent or remove contact with contaminants
Other

CHECKING COMPULSIONS

___ ___ Checking locks, stove, appliances etc.
___ ___ Checking that did rot/will not harm others
___ ___ Checking that did not/will not harm self
___ ___ Checking that nothing terrible did/will happen
___ ___ Checking that did not make mistake
___ ___ Checking tied to somatic obsessions
___ ___ Other:

REPEATING RITUALS

___ ___ Rereading or rewriting
___ ___ Need to repeat routine activities jog, in/out door, up/down from chair)
___ ___ Other _____

COUNTING COMPULSIONS

___ ___ _____

ORDERING/ARRANGING COMPULSIONS

___ ___ _____

HOARDING/COLLECTING COMPULSIONS

(distinguish from hobbies and concern with objects of monetary or sentimental value (e.g., carefully reads junk mail, piles up old newspapers, sorts through garbage, collects useless objects.)

___ _____

MISCELLANEOUS COMPULSIONS

___ ___ Mental rituals (other than checking/counting)
___ ___ Excessive listmaking
___ ___ Need to tell, ask, or confess
___ ___ Need to touch, tap, or rub*
___ ___ Rituals involving blinking or staring*
___ ___ Measures (not checking) to prevent: harm to self - harm to others terrible consequences
___ ___ Ritualized eating behaviors*
___ ___ Superstitious behaviors
___ ___ Trichotillomania *
___ ___ Other self-damaging or self-mutilating behaviors*
___ ___ Other

Adapted from Goodman, W.K., Price, L.H., Rasmussen, S.A. et al.:
"The Yale-Brown Obsessive Compulsive Scale."
Arch Gen Psychiatry 46:1006-1011,1989

Adult ADHD Self-Report Scale (ASRS-v1.1) Symptom Checklist

Patient Name		Today's Date	

Please answer the questions below, rating yourself on each of the criteria shown using the scale on the right side of the page. As you answer each question, place an X in the box that best describes how you have felt and conducted yourself over the past 6 months. Please give this completed checklist to your healthcare professional to discuss during today's appointment.

	Never	Rarely	Sometimes	Often	Very Often
1. How often do you have trouble wrapping up the final details of a project, once the challenging parts have been done?					
2. How often do you have difficulty getting things in order when you have to do a task that requires organization?					
3. How often do you have problems remembering appointments or obligations?					
4. When you have a task that requires a lot of thought, how often do you avoid or delay getting started?					
5. How often do you fidget or squirm with your hands or feet when you have to sit down for a long time?					
6. How often do you feel overly active and compelled to do things, like you were driven by a motor?					

Part A

7. How often do you make careless mistakes when you have to work on a boring or difficult project?					
8. How often do you have difficulty keeping your attention when you are doing boring or repetitive work?					
9. How often do you have difficulty concentrating on what people say to you, even when they are speaking to you directly?					
10. How often do you misplace or have difficulty finding things at home or at work?					
11. How often are you distracted by activity or noise around you?					
12. How often do you leave your seat in meetings or other situations in which you are expected to remain seated?					
13. How often do you feel restless or fidgety?					
14. How often do you have difficulty unwinding and relaxing when you have time to yourself?					
15. How often do you find yourself talking too much when you are in social situations?					
16. When you're in a conversation, how often do you find yourself finishing the sentences of the people you are talking to, before they can finish them themselves?					
17. How often do you have difficulty waiting your turn in situations when turn taking is required?					
18. How often do you interrupt others when they are busy?					

Part B

CENTER FOR
Behavioral Wellness

Jeannie Dilworth, APRN | Stacey Hansen, LMFT | Tracy Lewis, LCSW | Holly Monroe, LMFT | William Abrokwa, APRN

HIPAA AUTHORIZATION TO OBTAIN AND/OR RELEASE PROTECTED HEALTH INFORMATION

Name (First, MI, Last): _____ Date of Birth ____/____/____

Phone Number (_____) _____

I, or my authorized representative, authorize disclosure of my Protected Health Information as follows:

CENTER FOR BEHAVIORAL WELLNESS TO OBTAIN:	CENTER FOR BEHAVIORAL WELLNESS TO DISCLOSE:
I authorize: _____ To disclose health information to: Center for Behavioral Wellness 925 Sullivan Avenue, Unit 2 South Windsor, CT 06074 Phone: 860-432-7771 Fax: 860-432-7774	I authorize Center for Behavioral Wellness to disclose health information to: Name: _____ Address: _____ _____ Phone: _____ Fax: _____

Method of Release: ☐ Fax ☐ Verbal ☐ Mail ☐ For Review Only

Specific information to be released, requested, or discussed:

Date(s) of Treatment: _____

☐ Complete Medical Record (Includes Mental health, Alcohol/Drug/Substance, Genetic, HIV/AIDS, & Medication History)

☐ Contact/Discuss Treatment ☐ Notification of Treatment ☐ Progress Notes ☐ Lab/Test Results ☐ Genetic Testing ☐ Billing Reports

☐ Initial Psychiatric/Psychological History/Evaluation ☐ Medications/Pharmacy ☐ Other: _____

Initial _____ Date ___/___/___ Alcohol or Drug Use/Abuse Treatment Initial _____ Date ___/___/___ HIV Status or Treatment

This information is to be used for the following purpose(s):

☐ Continuing treatment, care and continuity of care ☐ Disability ☐ Transfer of care ☐ Care coordination or case management

☐ Billing, collection or payment of claims ☐ Patient Request ☐ Other: _____

This authorization is valid one year from the date this authorization is. This authorization may be revoked at any time through written request provided to this office by the client.

I have had an opportunity to review and understand the content of this authorization form. By signing this form, I am authorizing Center for Behavioral Wellness and associated providers to send and/or receive protected health information and that it accurately reflects my wishes. No third party medical information will be released by Center for Behavioral Wellness for any medical record request received.

_____

Signature of Client/Parent/Legal Representative Date Print Name

If not signed by the patient, indicate relationship of authorizing person to patient:

☐ Parent or guardian of minor child

☐ Guardian or conservator of conserved patient

_____

Witness Date Print Name