RIVER'S BEND, P.C.

CLIENT FACE SHEET

RE-ADMISSION ☐ YES ☐ NO CASE # _____

CLIENT NAME _____ CITY _____ STATE _____ ZIP_____

ADDRESS _____

HOME PHONE _____WORK PHONE _____CELL PHONE _____

I AUTHORIZE THE OFFICE TO CONTACT ME AT: ☐ HOME ☐ WORK ☐ CELL

BIRTHDATE _____ AGE _____ SEX ☐ M ☐ F SS#_____

EMPLOYER _____ REFERRED BY _____

PARENT/GUARDIAN _____

ADDRESS (IF DIFFERENT THAN CLIENT)

_____

INSURANCE INFORMATION

INSURANCE COMPANY _____ PHONE _____

NAME OF INSURED/POLICY HOLDER _____

POLICY NUMBER _____ INSURED'S SS# _____

DATE OF BIRTH OF POLICY HOLDER _____ GROUP # _____

INSURED'S EMPLOYER _____

EMERGENCY CONTACT

NAME OF PERSON TO CONTACT IN CASE OF EMERGENCY _____

RELATIONSHIP _____ CONTACT'S PHONE #(s) _____

CONTACT'S ADDRESS _____ CITY _____ STATE _____ ZIP _____

SIGNATURE BELOW AUTHORIZES THE CLINIC TO CONTACT THE ABOVE-NAMED PERSON IN CASE OF EMERGENCY

_____ _____

CLIENT SIGNATURE DATE SIGNATURE (PARENT/GUARDIAN) DATE

For office use only:

RIVER'S BEND, P.C.

CONSENT TO TREATMENT STATEMENT

CLIENT NAME _____ CASE # _____

I, _____ the undersigned hereby attest that I have voluntarily entered into treatment with the staff of River's Bend, P.C. Further, I consent to have treatment provided by a Psychiatrist, Psychologist, or Social Worker under the supervision of the Psychiatric Director. I understand that therapy may be discontinued at any time by either party; however, we recommend that this decision be discussed with your psychotherapist and made as a joint decision whenever possible. This cooperation will facilitate better discharge planning and re-entry into the program should it be needed again at a later date.

CLINIC POLICY

Cancellation of appointment: You may cancel your appointment by calling our regular number (24 hours a day). BUT YOU MUST CANCEL AT LEAST 24 HOURS IN ADVANCE! If you do not cancel or keep your appointment, YOU, NOT YOUR INSURANCE COMPANY, WILL BE CHARGED FOR THE SESSION. All psychiatric appointment s require at least 72 hours for cancellation. Payment for services is expected at the time services are rendered, unless other arrangements have been made with the treating professional. I, the undersigned, agree and acknowledge that responsibility for full payment for services rendered, including any deductibles and/or co-payments is mine. If payment is delinquent and no responses or arrangement is made, your account may be handled by our Collections Department or Agency.

RECIPIENT'S RIGHTS

I certify that I have received the "Know Your Rights" pamphlet available at River's Bend and certify that I have read and understand its content. I understand that as a recipient of services, I may get more information about my rights from my Program Rights Advisor, Kristi Hopkins.

NON-VOLUNTARY DISCHARGE FROM TREATMENT

A client may be terminated from the program non-voluntarily by the therapist: (A) If the client exhibits physical violence, verbal abuse, carries weapons, or engages in illegal activity at the clinic. (B) If the client refuses to comply with stipulated program and case protocol or refuses to comply with treatment recommendations. The client will be notified of a non-voluntary discharge by client's therapist but this is seen as a last resort when other less drastic measures have proven ineffective. The client may appeal this decision with the program director, or request to re-apply for services at a later date.

CLIENT NOTICE OF CONFIDENTIALITY

The confidentiality of patient records maintained by the program is protected by federal law and regulations. Generally, the program may not say to a person outside the program that a patient attends the program, or disclose any information identifying a patient as an alcohol or drug abuser unless: (1) The patient consents in writing; (2) The disclosure is allowed by a court order, or; (3) The disclosure is made to medical personnel in a medical emergency or to qualified personnel for research, audit, or program evaluation.

Violation of the Federal law and regulations by a program is a crime. Suspected violations may be reported to appropriate authorities in accordance with Federal regulations.

Federal law and regulations do not protect any information about a crime committed by a patient either at the program or against any person who works for the program or about any threat to commit such a crime.

Federal law and regulations do not protect any information about suspected child abuse, neglect, or adult abuse from being reported under State law to appropriate State or local authorities.

My signature below indicates that I have been given a copy of my rights regarding confidentiality.

PAYMENTS

I hereby authorize billings to my primary insurance company for services rendered to me by RIVER'S BEND, P.C. I authorize payments by my insurance company to be made directly to RIVER'S BEND, P.C. and understand that I am liable for payments of all fees. Further, I understand that should the insurance information provided not cover these services, I am responsible for all costs incurred. All checks shall be made payable to: RIVER'S BEND, P.C. I authorize release of pertinent information to my insurance company for purposes of billing and payment.

_____ _____

SIGNATURE OF CLIENT/LEGAL GUARDIAN* DATE

_____ _____

WITNESS DATE

*In case a client is under 18 years of age, a legally responsible person acting on his/her behalf.

RIVER'S BEND, P.C.

Acknowledgement of Reviewing the Psychotherapist-Patient Services Agreement

HIPAA

CLIENT NAME _____ CASE # _____

River's Bend, P.C. has provided the Psychotherapist-Patient Services agreement and I acknowledge understanding of same.

Client Name (printed)_____

Client and/or Guardian Signature_____

Client Date of Birth_____

If guardian, please complete your relation to client_____

Guardian Date of Birth_____ Case #_____

PLEASE NOTE: If you desire an explanation of the HIPAA guidelines or a copy of the notice, please ask your clinician for a copy.

RIVER'S BEND, P.C.

MEDICATION FORMULARY

Client Name:_____ Case #_____ Date:_____

Person Completing Form:_____

Medication at Intake (please include vitamins and herbal supplements)	Date	Dosage/Frequency	Provide prescribing physician or if medication is over the counter and reason for medication.

Please list any known allergies:

_____

_____

Review questions or concern by medical staff:

_____

_____

_____

_____

Reviewed by:_____ Date:_____

(Medical Director / Consulting Psychiatrist)

RIVER'S BEND, P.C.

AUTHORIZATION FOR PROVIDER/PRIMARY CARE PHYSICIAN COMMUNICATION

CLIENT NAME _____ CASE # _____

CLIENT'S DATE OF BIRTH:_____

To Be Completed by Client: **Insurance Company**_____

I, _____ authorize/do not authorize _____
(please print) **(Provider's Name)**

my behavioral health provider and _____
(PCP Name) **(PCP address and phone number)**

to exchange information regarding my mental health/chemical dependency treatment and medical healthcare for coordination of care purposes as may be necessary for the administration and provision of my healthcare coverage. The information exchanged may include information on mental health or chemical dependency care and/or treatment such as diagnosis and treatment plan. I understand this authorization shall remain in effect for one year from the date of my signature below or for the course of this treatment, whichever is longer. I understand that I may revoke this authorization at any time by written notice to the above behavioral healthcare provider if I choose to change my Primary Care Physician.

PLEASE CHOOSE THE FOLLOWING:

X _____ _____
I Authorize Communication with my PCP Date
(Client or Guardian Signature)

X _____ _____
I Do Not Authorize Communication with my PCP Date
(Client or Guardian Signature)

X _____ _____
Witness Date

To Be Completed by Provider:

_____ **River's Bend, P.C. 800 Stephenson Suite 250 Troy, MI 48083 (248) 585-3239**
Provider's Name Facility Name Address City/State Phone

DSM IV Diagnostic Code & Name_____

Treatment Plan: Type:_____ Frequency:_____ Est. length of Tx:_____

Medication Prescribed:_____

Comment:_____

_____

☐ Conclusion of mental health/chemical dependency treatment
☐ Date of last session_____ Treatment completed? ☐ Yes ☐ No
☐ Notification of prescription or change in medications (see comments)
☐ Other_____

_____
Print Provider Name Signature/Credentials Phone number

A COPY OF THIS FORM MUST BE SENT TO THE PCP, RETAINING THE ORIGINAL IN THE CLIENT'S CHART.

_____ _____ ☐ Mail ☐ Fax
Date Sent Sent by (initials)

RIVER'S BEND, P.C.

REQUEST FOR TREATMENT

CLIENT NAME _____ CASE # _____

I acknowledge that I am voluntarily authorizing treatment for myself, or for my dependent, _____ at River's Bend, P.C. I have been informed of the purposes of treatment, the services which may be provided, and any attendant benefits, risks, and/or consequences.

I accept this as full notification that if I fail to schedule my/dependent's medication review appointment in a timely manner and/or cancel the appointment, there will be a $25.00 office charge if a medication refill is required.

_____
Initial

I agree that the fee per appointment will be $_____

The fees will be paid (check appropriate statement):

_____ By direct billing to _____ insurance company, plus a co-payment of $_____ or _____ % paid by me.

_____ By me in full

_____ By another arrangement (please state)_____

I understand that it is the policy of River's Bend P.C. that payment is due at the time of my appointment.

I understand that I am responsible for all charges not paid by my insurance company. I also understand that I will be charged the regular clinic fee for appointment not cancelled at least 24 hours in advance. All psychiatric appointments must be canceled at least 72 hours in advance. Accounts which are not direct insurance payments to the clinic and which are delinquent over thirty (30) days may be subject to collection.

I also understand that although the staff at River's Bend, P.C. will attempt to determine the status of my insurance benefits, I am ultimately responsible for knowing what they are, knowing when my benefits are exhausted, and for making the staff aware of any changes in my benefits.

I further state that I have informed River's Bend, P.C. of every medical insurance I have and accept full responsibility for any charges that may arise from my non-disclosure.

I authorize River's Bend, P.C. to release any information necessary to process claims to my insurance company.

I authorize payment of medical benefits to River's Bend, P.C.

I authorize River's Bend, P.C. to acknowledge the party that referred me here (_____ Authorization denied)

I have read this information, understand, and agree to the conditions specified above.

_____

Client's Signature (or Parent/Legal Guardian) Date

_____

Witness Signature Date

RIVER'S BEND, P.C.

CHILD AND ADOLESCENT QUESTIONAIRE

Child's name _____ Case # _____

Birth date _____ Person completing form _____

Why are you seeking counseling today? (Please describe the problems as best you can)

_____

_____

How long have these problems/symptoms been present?

_____

_____

What things have you tried to do in response to your child's problems?

_____

_____

Are there any situations at home or school that you think may be affecting your child?

_____

_____

How does your child feel about treatment?

_____

_____

SCHOOL ADJUSTMENT

What grade is your child in?_____
Has he/she ever repeated a grade and if so, what grade? ☐ No ☐ Yes _____
What sort of grades is your child receiving?_____
Has your child been psychologically tested? ☐ Yes ☐ No
If so, when? _____ And where? _____
Has your child ever had special education services? ☐ Yes ☐ No
Please explain_____
How does your child relate to peers?_____

PERSONAL ADJUSTMENT

☐ Angry, defiant	☐ Enthusiastic	☐ Often ill	☐ Shy
☐ Avoids adults	☐ Expects failure	☐ Overactive	☐ Sleepwalking
☐ Bedwetting	☐ Frequent daydreams	☐ Overall depression	☐ Sloppy hygiene
☐ Bizarre behavior	☐ Frequent headaches	☐ Overweight	☐ Slow moving
☐ Blinking, jerking	☐ Frequent injuries	☐ Police problems	☐ Soiling
☐ Bullies	☐ Friendly	☐ Poor appetite	☐ Speech problems
☐ Careless, reckless	☐ Generous	☐ Psychiatric problems	☐ Steals
☐ Clumsy	☐ Impulsive	☐ Pull out own hair	☐ Stomach aches
☐ Confident	☐ Irritable	☐ Quarrels	☐ Suicide attempt
☐ Cooperative	☐ Learning problems	☐ Sad, cries	☐ Suicide gesture
☐ Destructive	☐ Lies frequently	☐ Selfish	☐ Tics or twitch
☐ Difficult sleep	☐ Loner	☐ Sets fires	☐ Unusual thinking
☐ Drug/alcohol use	☐ Messy	☐ Sexual act out	☐ Weight loss
☐ Easy going	☐ Moody	☐ Short attention span	☐ Worries

Client's name _____ Case # _____

CHILD'S FAMILY

Relationship	Name	Age	Sex	Education	Employed	Marital
Father						
Mother						
Siblings						
Others in home						

Who is the legal guardian?_____
What is the marital status of his or her parents? ☐ Married ☐ Divorcing ☐ Separated ☐ Never married

RELIGION
Does the family have a religion? ☐ Yes ☐ No If yes, what?_____
Does the child practice? ☐ Yes ☐ No If yes, what?_____
Was the family or child ever a member of a formal religion? ☐ Yes ☐ No_____

CULTURAL/ETHNIC INFORMATION
What cultural or ethnic group do you come from? Do you closely identify with this group and if so, do you see this as a strength?_____
Do you have any concerns how your culture or ethnicity may affect therapy? ☐ Yes ☐ No

INCOME DATA
Family's annual income _____ Any financial problems? ☐ Yes ☐ No
Do both parents work? ☐ Yes ☐ No

LEGAL
Has the child ever been involved with the police or juvenile court system? ☐ Yes ☐ No
If yes, please explain_____
Are the parents involved in a divorce or custody issue currently? ☐ Yes ☐ No
If yes, please explain_____

HAS THE CHILD EXPERIENCED ANY OF THE FOLLOWING?

Current	Past	No		Current	Past	No	
☐	☐	☐	Death in the family	☐	☐	☐	Problems in school
☐	☐	☐	Emotional abuse	☐	☐	☐	Severe childhood illnesses
☐	☐	☐	Emotional difficulty due to divorce	☐	☐	☐	Severe injury
☐	☐	☐	Parenting problems	☐	☐	☐	Sexual abuse
☐	☐	☐	Physical abuse	☐	☐	☐	Sibling conflicts
☐	☐	☐	Physical/domestic violence	☐	☐	☐	Trauma from crime

Client's name _____ Case # _____

DESCRIBE HOW THE CHILD RELATES TO OTHER PEOPLE (e.g. easily, shy, leader, follower, outgoing, etc.)_____
Does the child isolate from others? ☐ Yes ☐ No
If yes, please explain_____
Do the child's social activities include the use of drugs or alcohol? ☐ Yes ☐ No
If yes, please explain_____

EMPLOYMENT/VOCATIONAL
Is your child currently employed? ☐ Yes ☐ No
If yes, please begin with the most recent job, give employment history. If no, continue to next section.

Employer	Dates	Job Description	Salary/hourly wage

LEISURE/RECREATIONAL
Describe special interests, hobbies, play patterns:
☐ Art ☐ Church ☐ Dance ☐ Music ☐ Sports
☐ Books ☐ Crafts ☐ Health ☐ Outdoors ☐ Other_____
Play patterns_____
Has your child's play pattern or activity level changed recently? ☐ Yes ☐ No

PLEASE LIST ALL PREVIOUS TREATMENT EXPERIENCES

Type of Treatment	Yes	No	Date(s)	# of times	Where	Outcomes
Counseling/Psychiatric Treatment						
Alcohol/Drug Treatment						
Hospitalizations						
Self-help groups: AA, Al-Anon, ACOA, Overeaters, Other(s) _____						

Have you ever experienced any suicidal thoughts? ☐ Yes ☐ No ☐ Current ☐ Past
If yes, please describe; and if they are current, please provide some details:

_____

Have you ever attempted suicide? ☐ Yes ☐ No
If yes, list how many times, the most recent date, and the method(s) used:

_____

Have you experienced any homicidal thoughts? ☐ Yes ☐ No ☐ Current ☐ Past
If yes, please describe; and if they are current, please provide some details:

_____

Have you ever acted on these thoughts? ☐ Yes ☐ No
If yes, list how many times, the most recent date, and the method(s) used:

_____

Have you ever assaulted anyone? ☐ Yes ☐ No
If yes, list how many times, and include the dates and how the assault(s) happened:

_____

Client's name _____ Case # _____

SUBSTANCE ABUSE HISTORY

Does the child have a problem with alcohol or drugs? ☐ Yes ☐ No

If yes, please explain _____

Has the child ever received substance abuse treatment? ☐ Yes ☐ No

If yes, please explain _____

Is there a family history of substance abuse? ☐ Yes ☐ No

If yes, please explain _____

ADDICTIVE OR CHEMICAL USE HISTORY

Substance	Method	Frequency	Age of first use	Age of last use	Used in 48 hours	Used in 30 days
Alcohol						
Barbiturates						
Valium/Librium						
Cocaine/Crack						
Heroin/Opiates						
Marijuana						
PCP/LSD/Mesc.						
Inhalants						
Caffeine						
Nicotine						
Over the counter						
Prescription drugs						
Other drugs						
Addictive gambling						

SUBSTANCE OF PREFERENCE:

1._____ 2._____

3._____ 4._____

Client's name _____ Case # _____

DEVELOPMENTAL HISTORY (check all that apply)

During pregnancy: Any bleeding? ☐ High blood pressure? ☐ Pounds gained? ☐ _____

Check any that were used during pregnancy: ☐ Tobacco ☐ Alcohol ☐ Drugs

Explain _____

Sickness of mother? _____

Other difficulties? _____

How old was the mother when the child was born? _____

Birth: ☐ Full term ☐ Premature Weight _____ Length of labor _____

Type of delivery (e.g. breech, Cesarean, normal) _____

Condition of the child at birth? _____

Did the child have oxygen at birth? _____

What age did your child:

Walk alone _____ Use single word _____ Sentences _____

Toilet train _____ Tie shoes _____ Write letters _____

Has your child ever had

An eye exam? ☐ Yes ☐ No Results _____

A hearing exam? ☐ Yes ☐ No Results _____

Has your child ever had seizures? ☐ Yes ☐ No

Has your child experienced injuries, hospitalizations? ☐ Yes ☐ No

If yes, please explain _____

Was your child adopted? ☐ Yes ☐ No If yes, at what age? _____

Does your child know? ☐ Yes ☐ No

Has either parent ever been separated from the child? ☐ Yes ☐ No

If yes, please explain _____

FAMILY AND CHILD HEALTH HISTORY

Have any of the following diseases occurred with the child or among the child's blood relatives? (child, parents, siblings, aunts, uncles, cousins, or grandparents). Please specify who.

☐ Allergies _____
☐ Anemia _____
☐ Asthma _____
☐ Bleeding _____
☐ Blindness _____
☐ Cancer _____
☐ Cerebral Palsy _____
☐ Cleft lips _____
☐ Cleft palate _____
☐ Deafness _____
☐ Diabetes _____
☐ Glandular _____
☐ Heart disease _____
☐ High blood pressure _____
☐ Kidney disease _____
☐ Mental illness _____
☐ Migraines _____
☐ Multiple Sclerosis _____
☐ Muscular Dystrophy _____
☐ Nervousness _____
☐ Perceptual Motor Disorder _____
☐ Retardation _____
☐ Seizures _____
☐ Spina Bifida _____
☐ Suicide/Homicide _____
☐ Other _____

Please identify any surgeries or other physical problems that your child may have, that is not covered above: _____

Client's name _____ Case # _____

SEXUAL HISTORY

Is your child sexually active? ☐ Yes ☐ No If yes, at what age did they become active? _____

For girls only: Menstrual period: Age at onset _____ Problems _____

Pregnancies ☐ Yes ☐ No

Client's name _____ Case # _____

ALLERGIES/DRUG SENSITIVITIES

☐ None
☐ Food (specify) _____
☐ Medicine (specify) _____
☐ Other (specify) _____

IMMUNIZATIONS

☐ Not applicable
Is your child's immunization current? ☐ Yes ☐ No
Has your child had or been immunized for the following diseases? Please check:
☐ Chicken Pox ☐ Diphtheria ☐ German Measles ☐ Hepatitis B ☐ Measles
☐ Mumps ☐ Polio ☐ Small Pox ☐ Tetanus ☐ Other_____

Tuberculin test:
☐ Not applicable
☐ Yes If yes, Year and Results:_____

CHILD'S PHYSICIAN

Name: _____
Address: _____
_____
Phone _____
Date of child's last physical examination_____
Results_____

Please list any past or present illnesses or medical conditions (type of illness or condition)	Are you currently being treated?	
	YES	NO
	☐	☐
	☐	☐
	☐	☐
	☐	☐

Please list your current medications on the Medication Formulary included in your intake paperwork

NUTRITIONAL ASSESSMENT

Please describe your eating pattern (please check those that apply):
☐ Two or three well-balanced meals/day ☐ One or two meals/day plus snacking
☐ Several small meals during the day ☐ Poor eating habits (lots of snacks, little nutrition)
☐ Makes self throw up to lose weight ☐ Other:_____
Recent weight gain or loss? ☐ gain ☐ loss Amount gained or lost _____
During what time period was the weight gain or loss_____
If weight lost, was this a result of purposeful dieting? ☐ Yes ☐ No

Client's name _____ Case # _____

PAIN ASSESSMENT

Is your child experiencing any physical pain? ☐ Yes ☐ No

If yes, describe location and type of pain (e.g. sharp, dull, throbbing) _____

If not experiencing physical pain, stop here.

Does the pain interfere with activities of daily living and/ or social activities? ☐ Yes ☐ No

If yes, how: _____

Is your child taking any prescribed, non-prescribed or over the counter medication for pain relief?

☐ Yes ☐ No

If yes, please list the medications: _____

Other pain relief measures your child is using: _____

What would you like to have happen while your child is in treatment here?

_____

_____

_____ _____

Parent/Guardian signature **Date**

THERAPIST SECTION:

NUTRITIONAL SCREENING FOLLOW UP (A gain or loss of greater than 10 lbs in 2 weeks if not a result of dieting should be referred for follow-up)

Client appears to have a nutritional pattern that requires further evaluation	☐ Yes	☐ No
Client currently being seen for eating disorder or nutritional problems	☐ Yes	☐ No
Client/Legal Guardian referred to PCP for follow-up	☐ Yes	☐ No

PAIN SCREENING FOLLOW-UP:

☐ Client currently receiving care for pain management

☐ Referred to PCP

☐ Other _____

THERAPIST QUESTIONS OR COMMENTS

_____

_____ _____

Therapist signature, credentials **Date**

Physician's recommendations:

A physical exam ☐ IS ☐ IS NOT necessary for treatment ☐ Is recommended

Other comments:

_____

_____ _____

Physician signature, credentials **Date**

(certifies review of above and recommendations)