FAMILY CARE CLINIC

"Treating Everyone Like Family"

Client Face Sheet

In case of emergency who should be notified?______________ Relationship:_______________ Phone: ( ) __________

PATIENT INFORMATION

Name:____ Home Phone ( ) ____________
Last Name First Name Middle Initial

Parent, Guardian, or personal Representative of Patient (if a minor)______________________ Relationship__________

Address:____ Cell Phone: ( ) ____________

City:________________________________ State:____________ Zip:____________

Email: ________________________________

Sex ☐M ☐F Age:__________ Birth date:______________ Patient Social Security #______________

Employment: ______________________________ Marital Status: ______________________

PRIMARY INSURANCE

Insurance Company:______________________________________ **Subscriber #**______________

Person responsible for account:____
Last Name First Name Middle Initial

Relation to Patient:______________________ Birth date__________ Soc. Sec. #______________

Address (if different from patient):______________________________ Phone: ( ) ____________

City:________________________________ State:____________ Zip:____________

If Tricare, what is the Sponsor's Name:______________________________ Sponsor SSN:______________

ADDITIONAL INSURANCE Is Patient covered by additional Insurance: ☐Y ☐N

Insurance Company:______________________________________ **Subscriber #**______________

Person responsible for account:____
Last Name First Name Middle Initial

ASSIGNMENT AND RELEASE

I certify that I and/or my dependents have insurance coverage with the above mentioned insurance and assign All Seasons Mental Health all insurance benefits, if any, otherwise payable to me for services rendered. I understand that I am financially responsible for all charges whether or not paid by insurance.
I authorize the use of my signature on all insurance submission. The above named agency may use my heath care information and may disclose such information to the above named Insurance Company(s) and their agents for the purpose of obtaining payment for services and determining insurance benefits or the benefits payable for related services.

HIPAA, Individual Rights, Our Legal Duty, and Consent for Purposes of Treatment, Payment and Healthcare Operations Agreement:
I acknowledge that I have read the HIPAA, Individual Rights, Our Legal Duty, and Consent for Purposes of Treatment, Payment and Healthcare Operations Agreement.
A copy is available upon request. **Please initial**______________

____ ______________________
Signature of Patient, Parent, Guardian or Personal Representative Date

*6933 W Emerald * Boise, ID 83704 Ph (208) 321-1028 * Fax (208) 489-5201*

FAMILY CARE CLINIC

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Are you currently receiving or have you received in the last 12 months any of the following services?

Case Management	☐ Yes	☐ No	Name of Agency:________________
PSR	☐ Yes	☐ No	Name of Agency:________________
Day Treatment	☐ Yes	☐ No	Name of Agency:________________
Developmental	☐ Yes	☐ No	Name of Agency:________________
Counseling	☐ Yes	☐ No	Name of Agency:________________
Med. Management	☐ Yes	☐ No	Name of Agency:________________
Children's Service Coordination	☐ Yes	☐ No	Name of Agency:________________
IEP	☐ Yes	☐ No	Name of Agency:________________

Has the client seen any specialists (cardiology, endocrinology, orthopedic, etc.) within the past year?

☐ Yes ☐ No If so, what specialist and why:________________________________

____

____

Has the client been hospitalized in the last 2 years for mental health reasons?

☐ Yes ☐ No If so, when and where: ________________________________

____

____

FAMILY CARE CLINIC

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Consent to Treatment

I do hereby consent to such clinic care encompassing medical treatment, diagnostic procedures, x-rays, laboratory, and other clinic services (including photographs as may be useful in treating or diagnosing my condition) by the physician or other health care provider or designee as necessary in the providers judgment and is normally provided in the clinic. *I understand that the practice of medicine and surgery is not an exact science and I acknowledge that no guarantees have been made to me regarding the treatment or examinations in the clinic.*

I understand that as part of treatment, I am subject to random drug testing.

I understand that in having any laboratory procedures done (blood draw, urine analysis, pathology and/or drug screening) that Family Care Clinic charges a collection and handling fee. The actual billing for the test(s) performed is done by a third party. This may result in me receiving a bill from the third part vendor. I understand that this bill is my responsibility.

I am aware of my rights to accept or refuse medical treatment.

I am aware that I may stop my treatment with this provider at any time. The only thing I will still be responsible for is paying for the services I have already received. I understand that I may lose other services or may have to deal with other problems if I stop treatment. I understand that if I stop treatment, I will be given only a one month supply of non-controlled medications. I understand that the provider may stop treatment if I am non-compliant for any reason.

I understand I am responsible for payment of all clinic charges regardless of insurance coverage. Family Care Clinic will submit claims to my insurance on my behalf for services rendered in relation to my care. I understand that my portion of payment for services rendered is due at the time of service including but not limited to deductibles, co-pays, and non-covered services. I understand that I will be billed for any services not covered by my insurance and will remit payment upon receipt of said billing. I also understand that if I do not have insurance, payment in full is required at the time of service.

______________________________ ______________

Signature of client (or person acting for the client) Date

______________________________ ______________

Printed Name Relationship to client (if necessary)

I have discussed the issues above with the client (and his/her parent/guardian or other representative. My observation of this person's behavior and response give me reason to believe that this person is fully competent to give informed and willing consent.

______________________________ ______________

Signature of Provider Date

All Seasons

Transform Your Care

6933 W Emerald • Boise, ID 83704
Ph (208) 321-0634 *• Fax (208) 321-1082*
1007 W. Orchard • Nampa, ID 83651
Ph (208) 461-2838 *• Fax (208) 461-5099*
1135 Airbase Road • Mountain Home, ID 83647
Ph (208) 587-2226 *• Fax (208) 587-4195*

All Seasons Mental Health / Family Care Clinic
Cancel/No Show and Treatment Policies

All Seasons Mental Health & Family Care Clinic (ASMH/FCC) are committed and excited to be a part of your treatment needs and want to assure you we will do our very best to help you meet your treatment goals. It is important for you to understand that there are certain policies that everyone must abide by in order for us to provide the best possible service to all.

ASMH/FCC appreciates prompt arrival for appointments. If you are late, your appointment may have to be cancelled and rescheduled. Please notify use at 208-321-0634 if you will be late. ASMH/FCC will attempt to contact you one business day before your scheduled appointment to remind you of your visits. If we are unable to verify your appointment with you (via text / automated call / email /or personal call), please contact our office in advance of your appointment if you need to cancel or reschedule. Otherwise the appointment will be considered late / cancelled or no showed.

ASMH/FCC requires 24 hours' notice to cancel scheduled appointments. Late cancelling or no showing appointments have a significant negative impact on our practice and the care we provide to our patients / clients. When a patient / client cancels or no shows it:

- Potentially jeopardizes the health of the patient / client who no shows
- Is unfair (and frustrating) to other patients / clients that would have taken the appointment slot.
- Disrespects not only the clinicians time, but also the time of the entire clinic.

If a patient / client continues to cancel or no-show appointments ASMH/FCC will remove that individual from the "preferred patient / preferred client" list and you will not receive medication refills / blood draws or other medical / mental health services until you reestablish care on a consistent basis.

- ❖ Refill on Medications (if applicable)

Refills will be processed within 72 hours of the time requests are received. It is your responsibility to monitor medication supplies within your control. Early notifications can prevent emergency situations or gaps in medication regimes. Please have your pharmacy fax all refill requests to Family Care Clinic at (208) 489-5201.

- ❖ Face to Face Requirement (if applicable)

Per our office policy, any individual taking controlled substances must be seen at least every 90 days for a face to face appointment. Controlled substances are monitored by the Idaho State Board of Pharmacy and require documentation through face to face appointment in order to continue prescribing. This is for your protection and the protection of the provider's license. The face to face appointment is a short appointment with your provider to review and refill all needed medications and to justify the need of such medication(s). All patients on controlled substances are subjected to random urine drug screens.

By following the above procedures, we can continue to offer the best possible care to all of our patients.

Patient Name: ______________________________ **Date:** ______________

Patient/Guardian Signature: ______________________________

FAMILY CARE CLINIC

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To Our Patients:

Due to HIPAA regulations, in order for us to discuss any medical or billing information with anyone other than you, the patient, we need your written permission.

I,____give Family Care Clinic medical staff and provider's permission to discuss information regarding my appointments, any test results, my medical history or condition, medications, or billing issues.

The following people shall be granted access to my medical information:

_____Spouse Name: ______________________________

_____Parent Name: ______________________________

_____Child Name: ______________________________

_____CBRS/CM Name: ______________________________

_____Therapist Name: ______________________________

_____Other Name: ______________________________

_____Other Name: ______________________________

_____(Please Initial) I agree to receive text message reminders regarding upcoming appointments.

This authorization shall be in effect until you, the patient revokes this. If there are any changes it is the patient's responsibility to advise the office and update this form.

______________________________ ______________________

Patient Signature Date

6933 W Emerald * Boise, ID 83704
1007 W. Orchard * Nampa, ID 83651

Ph (208) 321-1028 * Fax (208) 489-5201
Ph (208) 461-2838 * Fax (208) 489-5201

FAMILY CARE CLINIC

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Patient Health History

Primary Care Provider:____ Last Wellness Exam:________

Chief Complaint: *(what is the reason for your visit today? Please describe problem in detail including history of present illness :)*

____

____

____

Childhood Illness: ☐ Measles ☐Mumps ☐Rubella ☐Chickenpox ☐Rheumatic Fever ☐Polio

Immunizations: ☐Tetanus______ ☐Pneumonia ☐Influenza ☐Hepatitis ☐H1N1 ☐HPV

Screening Tests: ☐Cholesterol ☐Tuberculin Skin Test ☐Sigmoid/Colonoscopy ☐Mammogram ☐Prostate Blood Test ☐Pap smear

Past Medical History: Please check all that apply to you:

☐Arthritis ☐Epilepsy/seizures ☐Psychiatric Disease ☐Cancer
☐Heart Problems ☐Stroke ☐Depression ☐Heart Surgery
☐Thyroid ☐Diabetes ☐High Blood Pressure ☐Asthma/lung problems
☐Hearing Loss ☐Other:____________________ ☐None

List any current medical problems you have been diagnosed with:__________________________________

____

____

Previous surgeries: (*Please list past surgeries with approximate date :)*________________________________

____

____

Serious Injury: (*Please describe any serious injuries you have had :)*__________________________________

____

____

Hospitalizations: *(medical and mental health related)*____

____

____

List your prescribed drugs and over the counter medications:		
Medication	Strength	Frequency

FAMILY CARE CLINIC

"Treating Everyone Like Family"

Continued medication list:		
Medication	Strength	Frequency

Allergies: (*please list any allergies to medications and the reaction that you have*)______________________________
____
____

Health Habits:		
# of meals a day:___________	# cigarettes a day: _______________	# caffeinated drinks a day: ______
# hours of sleep a day: ______	# alcoholic drinks a week: _________	Days a week of exercise: _______
Have you ever used illegal drugs? Y/N If yes, which ones?	Are you currently using any illegal drugs? Y/N If yes, which ones?	Do you live alone? ☐Yes ☐No Do you have any children? ☐Yes ☐No Do you have frequent falls? ☐Yes ☐No

Family History*: Do you know of any blood relatives who have or had:*

- ☐Alcohol/Drug Abuse
- ☐Allergies / Sinus Problems
- ☐Anemia
- ☐Aneurysm
- ☐Arthritis
- ☐Asthma / Hay Fever
- ☐Birth Defects
- ☐Brain Tumor
- ☐Cancer, Type_______________
- ☐Colon / Bowel Problems
- ☐Colon / Rectal Cancer
- ☐Congenital Heart Defects
- ☐Depression / Emotional Problems
- ☐Diabetes
- ☐Epilepsy / Seizures
- ☐Headaches
- ☐Heart Problems
- ☐High Cholesterol
- ☐Kidney Disease
- ☐Leukemia
- ☐Liver Disease
- ☐Lung Disease / Emphysema
- ☐Multiple Sclerosis
- ☐Other:_____________________
- ☐Nervous Breakdown
- ☐Obesity
- ☐Psychiatric Disease
- ☐Rheumatic Fever
- ☐Sickle Cell Anemia
- ☐Sleep Apnea
- ☐Stomach Problems
- ☐Stroke
- ☐Thyroid
- ☐Migraines
- ☐None

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As you review the following list, please check any problems or conditions that you are experiencing or have experienced. If you do not have any of the problems listed in the section please check none.

General Health
- ❑Good general health
- ❑Recent weight change
- ❑Loss of appetite
- ❑Fatigue
- ❑Fever/chills

Allergies
- ❑Drug allergies
- ❑Food allergies
- ❑Hay fever
- ❑Other:_______________
- ❑None

Ears, Nose, Mouth, Throat
- ❑Difficulty swallowing
- ❑Earaches
- ❑Loss of hearing/deafness
- ❑Loss of smell
- ❑Loss of taste
- ❑Painful chewing
- ❑Ringing in ears
- ❑Sinus Infection
- ❑Sores in mouth
- ❑Other_______________
- ❑None

Eyes
- ❑Blind spots
- ❑Blurred vision
- ❑Double vision
- ❑Loss of vision
- ❑Glaucoma
- ❑Injury
- ❑Pain
- ❑Other_______________
- ❑None

Gastrointestinal
- ❑Blood in stools
- ❑Increasing constipation
- ❑Nausea
- ❑Painful bowel movements
- ❑Persistent diarrhea
- ❑Stomach or abdominal pain
- ❑Ulcer
- ❑Vomiting
- ❑Other______________________
- ❑None

Genitourinary
- ❑Blood in urine
- ❑Female: Irregular periods
- ❑Female: #pregnancies _________
- ❑# Miscarriages______________
- ❑Female: Vaginal discharge
- ❑Male: Prostrate disease
- ❑Male: Testicle pain
- ❑Kidney stones
- ❑Painful urination
- ❑Sexual difficulties
- ❑Sexually transmitted disease
- ❑Urgency with urination
- ❑Urine retention/incontinence
- ❑Other______________________
- ❑None

Heart and Lungs
- ❑Pain in chest
- ❑High blood pressure
- ❑High cholesterol
- ❑Irregular heart beat
- ❑Other______________________
- ❑None

Muscles/Joints/Bones
- ❑Back pain
- ❑Difficulty walking
- ❑Joint pain
- ❑Joint stiffness or swelling
- ❑Muscle pain or tenderness
- ❑Neck Pain
- ❑Other______________________
- ❑None

Neurological
- ❑Balance trouble
- ❑Blackouts/loss of consciousness
- ❑Difficulty speaking
- ❑Difficulty walking
- ❑Facial drooping
- ❑Headaches
- ❑Injury to the brain or spine
- ❑Light-headed or dizziness
- ❑Memory loss
- ❑Mental confusion
- ❑Migraines
- ❑Mini stroke
- ❑Neuropathy
- ❑Numbness or tingling
- ❑Paralysis
- ❑Stroke
- ❑Tremors
- ❑Weakness
- ❑Other:______________________
- ❑None

Are you:
- ❑Left handed
- ❑Right handed
- ❑Both

Psychiatric
- ❑Depression
- ❑Anxiety
- ❑Eating disorder
- ❑Other______________________
- ❑None

Pulmonary
- ❑Asthma
- ❑Blood in cough
- ❑Cancer
- ❑Chronic or frequent cough
- ❑Emphysema
- ❑Pneumonia
- ❑Shortness of breath
- ❑Other______________________

Skin
- ❑Rash or itching
- ❑Sun sensitivity
- ❑Hair loss
- ❑Color changes
- ❑Other______________________
- ❑None

Sleep
- ❑Snoring
- ❑Sleepwalking
- ❑Nightmares

Do you sleep well? ❑Yes ❑No

Do you feel rested when you wake ❑Yes ❑No

Do you fall asleep during the day? ❑Yes ❑No

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Release of Information

Name of Client:______________________________
Address:______________________________
Date of Birth:____________________ Social Security Number:____________________

To/From: (person or agency):______________________________
Address:______________________________

To/From: (person or agency): ______________________________
Address:______________________________

Type of information to be disclosed:___Primary Care notes____Drug/Alcohol___Psychiatric notes___HIV/AIDS

Date(s) of service: From:____________________To:____________________
Information (verbal/written) to be disclosed: (Patient **must initial** each item to be disclosed)

_______Allergy Records _______Medication List _______DX List
_______PCP Notes _______Immunization Records _______Lab/Imaging Results
_______Verbal/Written Consent _______H&P _______Other _______

PURPOSE FOR DISCLOSURE: **Continuity of Care**
EXPIRATION DATE: This authorization is good until _______unless revoked by me in writing or as required by law.
Right with respect to this authorization

I understand that I am under no obligaton to sign this form and the person(s) and/or listed above who I am authorizing to use and/or disclose my information may not condition treatment, payment, or enrollment in a health plan or eligibility for health care benefits on my decision to sign this authorization.

I understand that if the person(s) and/or organization(s) listed above are not health care providers, health plans or health care clearinghouse, who must follow the federal privacy standards. The health authorization disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information could be re disclosed without my authorization.

I understand I have a right to inspect or copy the health information I have authorized to be used or disclosed by this authorization. I understand that I have a right to receive a copy of this authorization.
Copy requested and received: __No ____Yes INITIAL: ____________

I release the person/agency, disclosing this information from any liability arising from the release of information to the person/agency designation above.

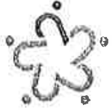
NOTICE RELEASE OF ALCOHOL&DRUG ABUSE RECORDS. The federal rule prohibit further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or otherwise permitted by 42 CFR part 2.

Signature of Client:______________________________Date:____________

Signature of Guardian:______________________________Date:____________

Signature of Witness:______________________________Date:____________

*****MAIL OR FAX ALL ROI'S TO ADDRESS BELOW*****



Family Care Clinic BHC Adult Screening (Meds/PHQ-9 / GAD-7 / SBIRT / Soc.Det)

PATIENT NAME:______________________ DOB:__________ DATE:__________

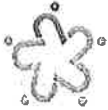
Adherence Estimator Survey						
Are you taking medications? (Circle One)	Yes (If yes, complete questions below)			No (Go to PHQ9)		
Question 1	0	0	7	7	20	20
I am convinced of the importance of my prescription medicine. (Circle Answer)	Agree Completely	Agree Mostly	Agree Somewhat	Disagree Somewhat	Disagree Mostly	Disagree Completely
Question 2	14	14	4	4	0	0
I worry that my prescription medicine will do me more harm than good. (Circle Answer)	Agree Completely	Agree Mostly	Agree Somewhat	Disagree Somewhat	Disagree Mostly	Disagree Completely
Question 3	2	2	0	0	0	0
I feel financially burdened by my out-of-pocket expenses for my prescription medicine. (Circle Answer)	Agree Completely	Agree Mostly	Agree Somewhat	Disagree Somewhat	Disagree Mostly	Disagree Completely
TOTAL SCORE						

Educational Resource: Adherence Estimator® is a registered trademark of Merck Sharp & Dohme Corp., a subsidiary of Merck & Co., Inc.

PHQ-9				
Choose the <u>one</u> description for each item that best describes <u>how many days</u> you have been bothered by each of the following over the past <u>2 weeks</u>:	None (0)	Several (1)	More than half (2)	Nearly Every Day (3)
1. Little interest or pleasure in doing things				
2. Feeling down, depressed, or hopeless				
3. Trouble falling/staying asleep, sleeping too much				
4. Feeling tired or having little energy				
5. Poor appetite or overeating				
6. Feeling bad about yourself – or that you are a failure or have let yourself or your family down.				
7. Trouble concentrating on things, such as reading the newspaper or watching television				
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.				
9. Thoughts that you would be better off dead or of hurting yourself in some way. *if 1-3 follow up required				
			TOTAL SCORE	

10. 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*

Continue with questions on back



All Seasons **Family Care Clinic BHC Adult Screening (Meds/PHQ-9 / GAD-7 / SBIRT / Soc.Det)**

GAD-7 Over the past 2 weeks, how often have you been bothered by any of the following problems?	None (0)	Several (1)	7 or More (2)	Nearly Every Day (3)
1. Feeling nervous, anxious, or on edge				
2. Unable to stop worrying				
3. Worrying too much about different things				
4. Problems relaxing				
5. Feeling restless or unable to sit still				
6. Feeling irritable or easily annoyed				
7. Being afraid that something awful might happen				
		TOTAL SCORE		

8. *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*

SBIRT		
Do you use alcohol or recreational drugs? (Circle one - If yes please complete questions 2-5)	Yes	No
	None	**1 or more**
1. **MEN:** How many times in the past year have had 5 or more drinks in a day?		
2. **WOMEN:** How many times in the past year have you had 4 or more drinks in a day?		
3. **DRUGS:** *Recreational drugs include methamphetamines (speed, crystal) cannabis (marijuana, pot), inhalants (paint thinner, aerosol, glue), tranquilizers (Valium), barbiturates, cocaine, ecstasy, hallucinogens (LSD, mushrooms), or narcotics (heroin).* How many times in the past year have you used a recreational drug or used a prescription medication for nonmedical reasons?		
4. **Do you use tobacco products and are you interested in quitting or reducing use? (Circle yes or No)**	Yes	No

Social Determinants	YES	NO
1. Are you having difficulty obtaining reliable transportation?		
2. Are you having difficulty providing food for yourself or your family?		
3. Do you have financial/insurance issues that significantly impact or limit patient access to healthcare?		
4. Do you feel safe in your home, work, or social setting?		
5. Do you feel social or emotional factors negatively affect your health?		

MA/PCP Complete Below

Name of PCP:____________________ **Patient MRN Number:**____________________

BHC referral or warm handoff is recommended:

PCP made a warm handoff to BHC: yes or no

1st BHC Screening: Yes / No / Unknown

PCP recommends BHC services: yes or no