Adult

Behavioral Medicine Patient Registration

Please fill out the following information completely

Patient Name_____ Date_____ Age_____

DOB:_____ Male_____ Female_____ Social Security #_____-_____-_____ (required)

Mailing Address_____ City_____Zip_____

Home Address_____(if different from mailing address) City_____ Zip_____

Home Phone_____Cell Phone_____

Marital Status_____ How Long?_____ Previous Marriage(s): Yes / No Give dates_____

Race:_____ Decline_____ Ethnicity: Hispanic_____ Non Hispanic_____ Decline_____

Primary Language Spoken:_____

Religious Preference (optional)_____ Military Service_____ Referred By_____

Employer_____ Occupation_____ Years Employed_____

Employer Address_____ Work Phone #_____

Spouse Employer_____ Work Phone #_____

Primary Physician_____ Phone #_____

Emergency Contact Person_____ Relation_____ Phone #_____

Email_____

INSURANCE INFORMATION

Primary Insurance Co._____ Insurance I.D.#_____

Name of Policy Holder/Sponsor_____ SS#_____-_____-_____ DOB_____

Employer_____ Group #_____

Secondary Insurance Co._____ Insurance I.D#_____

Name of Policy Holder/Sponsor_____ SS#_____-_____-_____ DOB_____

Employer_____ Group #_____

ADULT SYMPTOM RATING SCALE

Please rate the highest severity of each symptom listed below during the *past two months* by putting an X in the appropriate box to the right as follows:
0=None 1=Mild 2=Moderate 3=Severe 4=Profound

	Symptom Description	0	1	2	3	4
1.	DEPRESSED/SAD MOOD	☐	☐	☐	☐	☐
2.	LOSS OF INTEREST OR PLEASURE IN THE USUAL THINGS	☐	☐	☐	☐	☐
3.	APPETITE CHANGE - INCREASE OR DECREASE	☐	☐	☐	☐	☐
4.	WEIGHT GAIN OR LOSS	☐	☐	☐	☐	☐
5.	PROBLEMS FALLING OR STAYING ASLEEP	☐	☐	☐	☐	☐
6.	SLEEPING TOO MUCH	☐	☐	☐	☐	☐
7.	FATIGUE, NO ENERGY	☐	☐	☐	☐	☐
8.	FEELINGS OF GUILT OR WORTHLESSNESS	☐	☐	☐	☐	☐
9.	CONCENTRATION PROBLEMS	☐	☐	☐	☐	☐
10.	THOUGHTS OF DEATH WITHOUT INTENT TO SUICIDE	☐	☐	☐	☐	☐
11.	CRYING SPELLS	☐	☐	☐	☐	☐
12.	SEXUAL PROBLEMS	☐	☐	☐	☐	☐
13.	LACK OF FEELINGS	☐	☐	☐	☐	☐
14.	NIGHTMARES, FLASHBACKS, REPEATED THOUGHTS OF PAST UPSETTING TRAUMAS	☐	☐	☐	☐	☐
15.	INTENSE REACTION TO SOME REMINDERS OF PAST TRAUMA	☐	☐	☐	☐	☐
16.	TRYING TO AVOID THINKING OF PAST TRAUMA(S) OR OTHER REMINDERS OF THEM	☐	☐	☐	☐	☐
17.	NERVOUS, ON GUARD	☐	☐	☐	☐	☐
18.	ANXIETY, WORRY	☐	☐	☐	☐	☐
19.	IRRITABILITY, ANGER	☐	☐	☐	☐	☐
20.	EXCESS DIETING, VOMITING	☐	☐	☐	☐	☐
21.	OFTEN MISS WORK	☐	☐	☐	☐	☐
22.	DRINKING PROBLEM	☐	☐	☐	☐	☐
23.	DRUG USE PROBLEM	☐	☐	☐	☐	☐
24.	SUBSTANCE ABUSE	☐	☐	☐	☐	☐
25.	HOME LIFE PROBLEMS	☐	☐	☐	☐	☐
26.	SOCIAL LIFE PROBLEMS	☐	☐	☐	☐	☐
27.	PROBLEMS WITH CHILD	☐	☐	☐	☐	☐
28.	WORK PROBLEM	☐	☐	☐	☐	☐
29.	INTENSE DISCOMFORT OR FEARS PEAKING IN 10 MINUTES	☐	☐	☐	☐	☐
30.	UNEXPECTED SPELLS OR ATTACKS	☐	☐	☐	☐	☐
31.	FEAR OF LEAVING HOME, CROWDS, PLACES YOU CAN'T LEAVE	☐	☐	☐	☐	☐
32.	FEAR OF HUMILIATION CAUSES FEAR OF BEING WATCHED OR SEEN AND SOCIAL PROBLEMS	☐	☐	☐	☐	☐
33.	EXCESS WORRY ABOUT TWO OR MORE DIFFERENT ISSUES	☐	☐	☐	☐	☐
34.	EXCESS WORRY FOR 6 MONTHS	☐	☐	☐	☐	☐
35.	MUSCLE TENSION	☐	☐	☐	☐	☐
36.	REPETITIVE ACTS LIKE COUNTING, CHECKING, WASHING	☐	☐	☐	☐	☐
37.	DISTRESSING THOUGHTS YOU CAN'T GET RID OF	☐	☐	☐	☐	☐
38.	OTHER FEARS AND PHOBIAS	☐	☐	☐	☐	☐

ADULT SYMPTOM RATING SCALE

Please continue rating the severity of symptoms within the *past two months*:
0=None 1=Mild 2=Moderate 3=Severe 4=Profound

Symptom Description	0	1	2	3	4
39. TROUBLE FINISHING PROJECTS, ATTENTION DRIFTING	☐	☐	☐	☐	☐
40. PROBLEMS ORGANIZING TASKS	☐	☐	☐	☐	☐
41. FORGETTING APPOINTMENTS, ETC.	☐	☐	☐	☐	☐
42. FRUSTRATED CAREER GOALS	☐	☐	☐	☐	☐
43. OTHER MEMORY PROBLEMS	☐	☐	☐	☐	☐
44. CONFUSION	☐	☐	☐	☐	☐
45. BELIEFS THAT SEEM STRANGE TO MOST OTHERS	☐	☐	☐	☐	☐
46. CHRONIC PAIN	☐	☐	☐	☐	☐
47. HEADACHES	☐	☐	☐	☐	☐
48. STOMACH PROBLEMS	☐	☐	☐	☐	☐
49. HEART PALPITATIONS	☐	☐	☐	☐	☐
50. SHORTNESS OF BREATH	☐	☐	☐	☐	☐
51. NUMBNESS OR TINGLING	☐	☐	☐	☐	☐
52. DIZZINESS	☐	☐	☐	☐	☐
53. BODY WEAKNESS	☐	☐	☐	☐	☐
54. BLACKOUTS	☐	☐	☐	☐	☐

Please continue, but now rate the highest severity of the following symptoms that you have *ever* experienced in your lifetime, not just during the past two months, by using the same severity scale as before. Place an X in the appropriate column to the right.

0=None 1=Mild 2=Moderate 3=Severe 4=Profound

Symptom Description	0	1	2	3	4
55. WIDE DAILY MOOD SWINGS	☐	☐	☐	☐	☐
56. NEEDED LESS SLEEP, YET NOT TIRED FOR DAYS	☐	☐	☐	☐	☐
57. HIGH ENERGY FOR DAYS	☐	☐	☐	☐	☐
58. EXTRA TALKATIVE FOR DAYS	☐	☐	☐	☐	☐
59. RACING THOUGHTS FOR DAYS	☐	☐	☐	☐	☐
60. COMPULSIVE SPENDING	☐	☐	☐	☐	☐
61. HEARING VOICES WHEN NO ONE IS THERE	☐	☐	☐	☐	☐
62. SEEING THINGS THAT ARE NOT THERE	☐	☐	☐	☐	☐
63. THOUGHTS OF HOMICIDE	☐	☐	☐	☐	☐
64. THOUGHTS OF SUICIDE	☐	☐	☐	☐	☐
65. SUICIDAL ATTEMPT(S)	☐	☐	☐	☐	☐

Please describe the symptoms that most concern you in more detail here:

Patient Signature _____ Date _____

INITIAL ASSESSMENT QUESTIONNAIRE

Briefly describe why you are seeking treatment today. Please include the Psychological and Social factors and provide a brief history.

What single *specific event* made you seek consultation *today* as opposed to an earlier time?

How long has the chief complaint been present?

What are your medical concerns? Explain below or check None _____

Any Special Status Issues? Court Mandated ☐ Criminal Family Court ☐ Work Related ☐ Disability ☐ None ☐

What are the expectations for treatment outcome?

Household Members

Names	Age	Relationship
1.		
2.		
3.		

MEDICAL AND BEHAVIORAL HEALTH HISTORY

Behavioral Health History:

Has patient been in counseling before? Yes ☐ No ☐
When? Where? How Long? With Whom? Successful? Why Stopped?

For what was the patient being treated? Diagnosis?
Do you want the Therapist to get records? Yes ☐ No ☐

Has patient been hospitalized for a mental health illness? Yes ☐ No ☐
When? Where? How Long?

Is there a history of suicidal thoughts or attempts? Yes ☐ No ☐
Please Explain.

Any history of self-injury? Yes ☐ No ☐

Is there a family history of suicide or homicide? Yes ☐ No ☐

Have any close relatives used medication for mental health? Yes ☐ No ☐

Please mark below any family members who have suffered with mental illness or alcoholism.

Biological Father		Biological Mother	
Brothers		Sisters	
Paternal Grandparents		Maternal Grandparents	
Paternal Aunts & Uncles		Maternal Aunts & Uncles	
Paternal Cousins		Maternal Cousins	
		None	

Has patient been hospitalized for alcohol or drug abuse/dependency? Yes ☐ No ☐
If yes, please explain.

Does patient use alcohol? Yes☐No☐ How often? How long?

Does patient smoke? Yes☐No☐ How often? How long?

Does patient use caffeine? Yes☐No☐ How often? How long?

Has patient ever had medication prescribed for mental health reasons? Yes ☐ No ☐

Please describe any allergies or bad side effects from previously prescribed medications: or☐None

Does patient have allergies? Yes ☐ No ☐ Please describe below:

PLEASE LIST ALL CURRENT MEDICATIONS:

	Medications	Amount	How Often	Reason
1.				
2.				
3.				
4.				
5.				
6.				
7.				

Prescribing Physician's Name Address Phone #

Do you want to sign Release Of Information to the M.D.? Yes☐ No☐

Medical History:

Are there current medical problems? Yes☐ No☐
If yes, please explain. What effect does your medical condition have on your mental health?

Please check box if you have had or are experiencing any of the following conditions:

- ☐ Cardiovascular disease
- ☐ Heart disease
- ☐ Chest pain or angina
- ☐ Swelling of hands, feet or ankles
- ☐ Hypertension
- ☐ Stroke(s)
- ☐ Gastrointestinal disorder
- ☐ Frequent diarrhea
- ☐ Peptic ulcer
- ☐ Endocrine Disorder
- ☐ Hormonal change
- ☐ Hormone Replacement
- ☐ Diabetes
- ☐ Colder than before
- ☐ Frequent infections or boils
- ☐ Skin is becoming dryer
- ☐ Thyroid dysfunction
- ☐ Genitourinary problems
- ☐ Renal (kidney) disease
- ☐ Liver disease
- ☐ Hepatitis
- ☐ Jaundice
- ☐ Neurological disorder
- ☐ Seizures
- ☐ Rendered unconscious
- ☐ Concussion or head injury
- ☐ Blood disorders
- ☐ Malignancy
- ☐ Eye disorders
- ☐ Glaucoma
- ☐ Respiratory problems
- ☐ Asthma or wheezing
- ☐ None of the above

Please give details below to the above medical conditions to which you responded, "Yes".

Has there been a recent medical check up, or lab work done? Yes☐ No☐
If yes, When? _____

Do you want release of information signed for your medical history? Yes☐ No☐

Please mark an "X" in the appropriate box for anyone in the family history who have had any of the following, whether formally diagnosed or not:
Key: B=brother;S=sister;F-father;GM=grandmother;GF=grandfather;U=uncle; A=aunt; C=cousin.

Family Behavior History				Father's Side of Family						Mother's Side of Family					
Condition	Self	B	S	F	GM	GF	U	A	C	M	GM	GF	U	A	C
Attention Deficit or Inattention															
Hyperactivity															
Oppositional Defiance															
Bipolar															
Depression															
Anxiety															

Social History

Is patient married or in a current relationship? Yes ☐ No ☐
Is the relationship supportive or problematic? Please be specific:

Is patient experiencing any current problems with family members? Yes ☐ No ☐ Please Explain:

Patient's birth order among siblings _____

How was the patient raised?
Natural parents_____ Foster Parents_____ Adopted_____ Intact Family_____
Single Parent Home_____ Parents Separated _____ Divorced _____

Please describe the parental style of your parents. Include events which may be relevant.

Please circle the major stressors in your life from the following:

Health ◯ Finances ◯ Housing ◯ Relationships ◯ Work ◯ Culture ◯ Religion ◯ Ethnicity ◯
Education Age Related Concerns Other *(please explain below)*:

Notes:

AUTHORIZATION TO BILL INSURANCE

Patient Name: _____ DOB: ___/___/_____

I hereby authorize the release of information:

TO AND FROM

Yucca Family Medical Care, Inc.
57675 29 Palms Hwy, Suite 111 Yucca Valley, CA 92284
(760) 365-8500 *telephone* (760) 365-5014 *fax*

AND

Health Insurance Company: _____

Please read the following declaration then sign and date below where indicated.

I request that payment of authorized medical services furnished to me or my minor child be made by my insurance company, on mine or my minor child's behalf, to the provider of service indicated above. I authorize the medical provider listed above and his agents to release any information concerning my medical care to my insurance company and any of its agents for the sole purpose of determining benefits payable on my medical related charges.

I understand my signature on this form authorizes my insurance company to make payment directly to the provider referenced above and that I am authorizing my provider to release all medical information necessary to adjudicate my medical claims. The patient is responsible for deductibles, coinsurance, in any non-covered services. This policy applies to secondary and subsequent plans as well.

_____ _____

Signature of Patient (Parent/Guardian/Conservator)

Pain Health and Nutrition Screening

PAIN SCREENING Are you experiencing any ongoing physical pain?

Yes No

If NO - No Further questions are required - Go to the next section: Health Screening.

Location of Pain:

How would you rate the intensity of the pain on a scale from 1 to 10 with 10 being the worst pain you could imagine?

1 2 3 4 5 6 7 8 9 10

How long have you had this pain?

Are you currently being treated for this pain? Yes No

Is the treatment effective? (A pain rating of 4 or above indicates ineffective treatment)

Yes No

**If not being treated or treatment is not effective, a recommendation and/or a referral should be made for client to see a healthcare provider.*

HEALTH SCREENING

Date of last Health and Physical Exam:

Do you have any medical conditions not being treated? Yes No

Do you have any Medical Diagnosis not being treated? Yes No

If yes to any of the above questions, or the date of the last Health and Physical Exam exceeds 12 months, a recommendation should be made for client to see Primary Health Provider and document recommendation.

NUTRITION SCREENING

Does client have a severe food allergy? Yes No

Food Preferences / Dislikes: Yes No

Special Needs (Texture, Supplements, Cultural/Religious Factors, etc.): Yes No

Does client have a difficulty chewing or swallowing? Yes No

Has the client experienced a decrease in food intake and/or appetite? Yes No

Does the client have eating habits or behaviors that may be indicators of an eating disorder, such as bingeing or induding vomiting? Yes No

Has the client experienced an unintentional weight loss or gain within the last month (10#

Dentures: Yes No

Partial Dentures: Yes No

Full Dentures: Yes No

Is the Client currently experiencing Dental Problems? Yes No

If Yes, a referral to a Dentist should be provided.

Patient Name _____

Patient Signature _____ Date _____/_____/_____

Therapist Signature _____ Date _____/_____/_____

Name: _____ Date: _____

Life Events Checklist

(Adapted from the LEC-5)

Instructions: Listed below are a number of difficult or stressful things that sometimes happen to people. For each event check one or more of the boxes to the right to indicate that: (a) it happened to you personally; (b) you witnessed it happen to someone else; (c) you learned about it happening to a close family member or close friend; (d) you were exposed to it as part of your job (for example, paramedic, police, military, or other first responder); (e) you're not sure if it fits; or (f) it doesn't apply to you.

Be sure to consider your entire life (growing up as well as adulthood) as you go through the list of events.

Event	Happened to me	Witnessed it	Learned about it	Part of my job	Not sure	Doesn't apply
1. Natural disaster (for example, flood, hurricane, tornado, earthquake)						
2. Fire or explosion						
3. Transportation accident (for example, car accident, boat accident, train wreck, plane crash)						
4. Serious accident at work, home, or during recreational activity						
5. Exposure to toxic substance (for example, dangerous chemicals, radiation)						
6. Physical assault (for example, being attacked, hit, slapped, kicked, beaten up)						
7. Assault with a weapon (for example, being shot, stabbed, threatened with a knife, gun, bomb)						
8. Sexual assault (rape, attempted rape, made to perform any type of sexual act through force or threat of harm)						
9. Other unwanted or uncomfortable sexual experience						
10. Combat or exposure to a war-zone (in the military or as a civilian)						
11. Captivity (for example, being kidnapped, abducted, held hostage, prisoner of war)						
12. Life-threatening illness or injury						
13. Severe human suffering						
14. Sudden violent death (for example, homicide, suicide)						
15. Sudden accidental death						
16. Serious injury, harm, or death you caused to someone else						
17. Neglect (e.g., physical, medical, emotional)						
18. Exploitation (being taken advantage of for someone else's benefit – financially, sexually,						

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

THIS AUTHORIZATION TO RELEASE, REQUEST OR DISCLOSE INFORMATION IS TO COMPLY WITH THE TERMS OF THE CONFIDENTIALITY OF MEDICAL INFORMATION ACT 1981, SECTION 56 ET SEQ., OF THE CALIFORNIA CIVIL CODE.

Patient Name _____ Date of Birth ___/___/___

Address _____ City _____ State _____ Zip _____

For coordination of care, I hereby authorize the release of information:

☐ TO AND FROM ☐ TO ☐ FROM _____

Yucca Family Medical Care, Inc.
57675 29 Palms Hwy, Suite 111 Yucca Valley, CA 92284
(760) 365-8500 *telephone* (760) 365-5014 *fax*

And my (the patient's) physician: Doctor's Name: _____

Address: _____ Phone: _____

Limits on information disclosure: ☐ None ☐ Limit to _____

-OR-

☐ At this time I do NOT wish to have any information released to my physician.

I understand that I can receive a copy of this authorization upon my request. This authorization may be removed in writing at any time by the undersigned, and if not earlier revoked, shall terminate on:

_____
Date or terms

Office Policies and Financial Contract with Consent for Treatment

We want your psychological needs to get the best and most proficient attention possible. A sound relationship between patient and therapist is based on a mutual understanding of these general office policies and the fees and financial arrangements involved. Sessions are by appointment only. After office hours, please leave a voicemail to re-schedule or cancel an appointment.

Treatment Philosophy

Outpatient psychotherapy consists of face-to-face contacts between a mental health professional and patient, and may include individual, group, family, short or long term therapy, or crisis intervention. If your contract is with managed care, therapy will be brief and problem focused. You will be expected to participate in setting and achieving treatment goals. A Case Manager oversees your number of sessions and will request information about your therapy. You will be asked to sign a release of confidential information for that purpose.

Attendance and Cancellation Notice Regular attendance is necessary to receive the maximum benefit possible from treatment. Appointments are generally 45 minutes long and are reserved for you in our calendar. It is customary and reasonable to require that you give a 24-hour notice for a cancellation of a scheduled appointment. A pattern of failure to keep appointments or failure to give 24-hour notice to cancel may be terms for off-schedule and/ or discontinuation of treatment according to our policy. (Please initial_____).

Financial Contract, Deductibles, and Co-payments

You are responsible for obtaining prior authorization from your insurance or managed Care Company prior to treatment. If this office accepts your insurance or we are contracted with your care company, you are responsible for the co-payment amount and the deductible as set by your benefit plan. If for any reason your insurance company does not pay these contracted rates, you will be held accountable for paying your balance. (Please initial_____). Co-payment amounts are set by your benefit plan. These payments are due and payable at the beginning of each appointment. If you desire services not provided by your managed care company or benefits beyond your benefit contract, you will need to sign a separate written contract with this office. (Please initial_____).

Telephone Calls

If there should occur a time where essential concerns must be discussed on the telephone, the Provider charges at the same rate as in-person service, based on the amount of time spent on the telephone. These charges will be your personal expense if they cannot be billed to your insurance company. (Please initial_____).

Limits of Confidentiality

All information and records obtained during the course of treatment shall remain confidential and will not be released without a signed written consent. The legal exceptions to your confidentiality are as follows:

1. If a therapist believes that a patient intends to eminently commit serious bodily harm to another identifiable person or persons, it is the therapist's duty to warn the person or persons of intended harm as well as the authorities (Tarassoff v s. Regents of University of C al., 1976).
2. If a therapist believes that a patient intends to eminently commit serious bodily harm to them self, it is the therapist's duty to take necessary action to protect the individual, which may include notifying authorities (Johnson v. County of Los Angeles, 1983).
3. If a patient becomes involved in certain kinds of very important court cases, a judge may subpoena records and/or testimony. This is rare, but the therapist's ability to shield confidentiality in these cases may be compromised and varies from case-to-case.
4. If a therapist suspects that a child, elder, or dependent adult either i s currently being abused, or has been abused in the past (where t here is a risk of re-offense), and the authorities don't already know about it, it is the therapist's duty to inform the authorities (Welfare & Institution Codes, Penal Codes Section 11165, 11166 and others).

Releases of Information

Certain insurance companies (Medicare) and managed care companies ask us to get a release to the primary care physician to coordinate care. You may refuse this request or you can allow it. You will be asked if you wish to sign a release of confidentiality form. If you are electing to use your insurance or managed care benefits, you will be required to sign a release of confidential information to your benefit plan so as to process claims for certification, case management, quality assurance, benefit administration and other purposes such as utilization. If you do not want such information to be shared with your benefit plan, you may pay privately without using your insurance company.

Consent for Treatment

I authorize and consent to treatment, which may include various psychological assessment techniques, psychological exams and diagnostic procedures. I understand that while psychotherapy is intended to be helpful, no guarantees as to outcome can be made. The psychotherapeutic process can cause a person to experience unpleasant emotions, feelings and reactions such as anxiety, sadness, and anger. These responses are normal, if they should occur, and I agree to work through these responses with my therapist. I accept and consent to the office policies, financial arrangements, as well as the terms of each of the foregoing paragraphs of this contract.

Patient Name _____

Patient Signature _____ Date / /

EMERGENCY SERVICES GUIDE

Police/Fire/Ambulance: (24 hours daily) For Medical Emergencies or Hostile Situations: Call 911

San Bernardino County – Sheriff's Department – Morongo Basin Region (760) 366-3781
Morongo Basin Fire Dept. (760) 365-3335

Hospital

High Desert Medical Center
6601 White Feather Road, Joshua Tree, CA 92252
760-366-3711

Crisis Walk-In Center (24 Hour)

Valley Star Crisis Walk In Center
7293 Dumosa, Suite 2, Yucca Valley, 92284
760-365-2233

Hotlines

Suicide Prevention Hotline (24 hours daily):
(800) 273-8255

ACCESS Unit phone number 888-743-1478

Poison Control (24 hours daily):
(800) 876-4766

Child Protective Services (24 hours daily):
(909) 384-9233

Missing Children Hotline (24 hours daily):
(800) 222-3463

Patient's Rights Bureau (24 hours daily):
(800) 440-2391

San Bernardino County Department of Behavioral Health
24 HOUR ACCESS UNIT
(888) 743-1478

Hospitals that provide Emergency Psychiatric Assessments (24 hours daily):

Victor Valley Global Medical Center (760) 245-8691
St. Mary's Medical Center (760) 242-2311
Desert Valley Hospital (760) 241-8000
Barstow Community Hospital (760) 256-1761

Member Safety Plan:

By signing below, I acknowledge that I have received a copy of this document, in addition to the Local Mental Health Plan's Complaint & Grievance Brochure and form, and the Department of Behavioral Health Benefits Guide and handbook.

Client Signature:

Acceptance of HIPAA Notice of Privacy Practices

Our full privacy policy is available for your review in the waiting area
You may also request a copy from the front desk to take home with you. It contains important information about how your confidential health information will be handled by our offices.

I certify that I have been provided access to a copy of the HIPAA Notice of Privacy Practices.

_____ _____

Patient Signature Date

_____

Patient Printed Name

MEDI-CAL REQUIRED INFORMING MATERIALS

Consistent with regulatory requirements stated in the Code of Federal Regulations §438.10 and the California Code of Regulations §1810.360(e) "The MHP of the beneficiary shall provide its beneficiaries with a booklet and provider list upon request and when a beneficiary first receives a specialty mental health service from the MHP or its contract providers."

Guide to Medi-Cal Mental Health Services Booklet	☐ Provided ☐ Offered, but Declined
Provider List	☐ Provided ☐ Offered, but Declined
EPSDT Pamphlet	☐ Provided
Your Rights to Make Decisions about Medical Treatment	☐ Provided
Notice of Privacy Practices	☐ Provided
Educated on Grievance Process	☐ Provided

Signature of Client _____ Date _____

Signature of Parent/Guardian _____ Date _____

Signature of Staff _____ Date _____

MATERIALES DE INFORMACIÓN MEDI-CAL

De conformidad con los requisitos reglamentarios establecidos en el Código de Regulaciones Federales n.o 438.10 y el Código de Regulaciones de California n.o 1810.360(e) "El MHP del beneficiario proporcionará a sus beneficiarios un folleto y una lista de proveedores a petición y cuando un beneficiario primero recibe un servicio especializado de salud mental del MHP o sus roveedores contractuales."

Guia Para Servicios De Salud Mental de Medi-Cal	☐ Recibido ☐ Ofrecido, pero Declinó
Lista de Proveedores	☐ Recibido ☐ Ofrecido, pero Declinó
Pamplet de EPSDT	☐ Recibido
Sus Derechos a Tomar Decisiones Sobre el Tratamiento Médico	☐ Recibido
Aviso de Prácticas de Privacidad	☐ Recibido
Educado en el Proceso de Queja	☐ Recibido

Firma del Cliente _____ Fecha _____

Firma del padre o tutor _____ Fecha _____

Firma del personal _____ Fecha _____

Yucca Family Medical Care, Inc.
57675 29 Palms Hwy, Suite 111 Yucca Valley, CA 92284
(760) 365-8500 *telephone* (760) 365-5014 *fax*

Welcome,

The state of California request that each client be provided the following notice:

NOTICE TO CLIENTS
The Board of Behavioral Sciences receives and responds to complaints regarding services provided within the scope of practice of (marriage and family therapists, licensed educational psychologists, clinical social workers, or professional clinical counselors). You may contact the board online at www.bbs.ca.gov or by calling 916-574-7830.

I have read the above notice.

Sign_____

Date_____

Acknowledgement of Receipt of *Information* – Advanced Directives

I, _____, hereby acknowledge that I received information about Advanced Health and Mental Health Care Directives as described in the brochures titled "Your Right to Make Decisions about Medical Treatment" and "What Patients Should Know About Mental Health Advance Directives."

I do / do not have an Advanced *Health Care* Directive at this time.
I do / do not have an Advanced *Mental Health* Directive at this time.

_____ _____
Signature of Consumer/Legal Representative Date

Acknowledgement of Receipt of Advanced Directive(s)

I, _____, hereby acknowledge that I have completed a:

- ☐ Advanced Health Care Directive
- ☐ Advanced Mental Health Care Directive

I provided a copy as indicated above to Center Staff.

_____ _____
Signature of Consumer/Legal Representative Date

_____ _____
Signature of Staff Receiving copy of Directive(s) Date

EMERGENCY SERVICES GUIDE

Police/Fire/Ambulance: (24 hours daily) For Medical Emergencies or Hostile Situations: Call 911

San Bernardino County – Sheriff's Department – Morongo Basin Region (760) 366-3781
Morongo Basin Fire Dept. (760) 365-3335

Hospital

High Desert Medical Center
6601 White Feather Road, Joshua Tree, CA 92252
760-366-3711

Crisis Walk-In Center (24 Hour)

Valley Star Crisis Walk In Center
7293 Dumosa, Suite 2, Yucca Valley, 92284
760-365-2233

Hotlines

Suicide Prevention Hotline (24 hours daily):
(800) 273-8255

ACCESS Unit phone number 888-743-1478

Poison Control (24 hours daily):
(800) 876-4766

Child Protective Services (24 hours daily):
(909) 384-9233

Missing Children Hotline (24 hours daily):
(800) 222-3463

Patient's Rights Bureau (24 hours daily):
(800) 440-2391

San Bernardino County Department of Behavioral Health
24 HOUR ACCESS UNIT
(888) 743-1478

Hospitals that provide Emergency Psychiatric Assessments (24 hours daily):

Victor Valley Global Medical Center (760) 245-8691
St. Mary's Medical Center (760) 242-2311

Desert Valley Hospital (760) 241-8000
Barstow Community Hospital (760) 256-1761

Member Safety Plan:

_____

_____

By signing below, I acknowledge that I have received a copy of this document, in addition to the Local Mental Health Plan's Complaint & Grievance Brochure and form, and the Department of Behavioral Health Benefits Guide and handbook.

Client Signature: _____ Date: _____

Telehealth Services Consent

Use of Telehealth

Telehealth involves Program staff using technology (internet-connected devices and applications) to video-call you on your internet-connected device (e.g., cell phone, tablet, computer, laptop). Telehealth may be used to provide your assessment and treatment services.

What is Telehealth and how do Telehealth Services work?

Telehealth services are used when the Program staff cannot be physically present with you to provide assessment and treatment services. Telehealth allows you and the Program staff to talk with and see one another using internet-connected devices and video chat applications.

You will be encouraged to participate in the Telehealth session in a private area with minimal disruptions. You may also request to have a friend or family member present just like during an in-person session. The Program staff will be in a private room at another location with a device that has audio and video ability. Program staff will check to make sure the equipment is working properly and that you and the staff can see and hear one another.

Telehealth and Confidentiality

We are dedicated to protecting your confidentiality and the security of your medical information (see Client Notice of Privacy Practices). All existing confidentiality protections apply. All existing laws regarding client access to mental health information and copies of mental health records apply.

There is no permanent video or voice recording kept of the Telehealth session. Client identifiable images or information from the Telehealth interaction shall not occur without the consent of the client or as otherwise permitted by law.

We have identified applications that allow us to meet with you through Telehealth which protect your visual and audio communications with us during that process. We will ask you to use these applications which may require you to download an application onto your device. It will ask you to allow it to connect to your device's speakers and camera just while the Telehealth session is active.

In emergency situations (natural disaster, pandemic, crisis) you might request we use another application that we haven't approved. We will do our best to work with you but won't be able to assure the confidentiality of that Telehealth session if a non-approved app is used. We will ask you to acknowledge these risks and we will document in your record that you understood those risks and consent to the use of non-approved Telehealth applications.

Client Choice

You have the option to withhold consent at this time or to withdraw this consent at any time, including any time during a session, without affecting the right to future care, treatment or risking the loss or withdrawal of any program benefits to which you would otherwise be entitled.

If you choose not to consent to Telehealth services, the program may be unable to provide you with the convenient and readily available services and services will be rescheduled for a later date and/or a diff[illegible]

Benefits & Risks of Telehealth

I understand that I can expect benefits from Telehealth but that no results can be guaranteed or assured. Telehealth provides me access to medical care that otherwise might not have been available in person. Despite reasonable and appropriate efforts, there is the possibility that:

- The transmission of medical information could be disrupted or distorted by technical failures in transmission;
- The transmission of medical information could be interrupted by unauthorized persons (Note: this risk may be increased if I use a Telehealth application that hasn't been vetted and approved by Stars Behavioral Health Group;
- The electronic storage of medical information generated by telehealth service in one or more databases could be accessed by unauthorized persons;
- Telehealth care, treatment and services may not be as complete as in person care;
- Telehealth does not negate or minimize the risks that may be inherent in a medical/mental illness or condition.

I understand that it is impossible to list every possible risk, that my condition many not be cured or improved, and in rare cases, may get worse.

Treatment Services

I agree to take part in Telehealth services offered by Valley Star Adult FSP/GMH to receive my assessment and treatment services. Program staff explained and talked to me about the following:

- Telehealth potential risks and benefits
- Confidentiality of Telehealth services
- How the Telehealth service works
- What we'll do if our Telehealth session gets interrupted and our back up plan
- How we'll handle different situations that could come up during the Telehealth session

I have read and agree to all conditions for treatment and Telehealth set forth herein. I acknowledge that I have received a copy of this agreement.

Client: _____ _____

Print Name Signature

Parent/Guardian (if applicable): _____

Staff / Witness _____

For *verbal consent*, note: _____(date)_____(time).

Staff shall continue to make efforts to obtain written consent

Safety Plan

Warning Signs (thoughts, images, mood, situation, behavior) that a crisis may be developing:

1. _____

2. _____

3. _____

Internal Coping strategies- Things I can do to take my mind off my problems without contacting another person (relaxation techniques, physical activity):

1. _____

2. _____

3. _____

People and social settings that provide distraction:

1. Name _____ Phone _____

2. Name _____ Phone _____

3. Place _____ 4. Place _____

People whom I can ask for help:

1. Name _____ Phone _____

2. Name _____ Phone _____

3. Name _____ Phone _____

Professionals or agencies I can contact during crisis:

1. Clinician _____ Phone _____

2. Psychiatrist _____ Phone _____

3. Physician _____ Phone _____

4. Social Worker _____ Phone _____

Suicide Hotlines: 1-800-SUICIDE, 1-800-273-TALK

Making the environment safe:

1. _____

2. _____

The one thing that is most important to me and worth living for is:

_____

_____ _____