SM MEDICAL CENTER

INITIAL CLIENT INFORMATION FORM

PATIENT DEMOGRAPHICS			
LAST NAME:	FIRST NAME:		MIDDLE NAME:
GENDER: ☐ MALE ☐ FEMALE ☐ OTHER	DOB:	AGE:	SSN:
ADDRESS LINE:			
CITY:	STATE:		ZIP CODE:
HOME PHONE #:	CELL PHONE #:		E-MAIL:
MARITIAL STATUS (check one) ☐ SINGLE ☐ MARRIED ☐ DIVORCED ☐ WIDOW ☐ PARTNERSHIP			
ETHNICITY (check one) ☐ HISPANIC OR LATINO ☐ NON-HISPANIC OR LATINO			
RACE (check one) ☐ ASIAN ☐ NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER ☐ BLACK OR AFRICAN AMERICAN ☐ WHITE ☐ AMERICAN INDIAN OR ALASKA NATIVE ☐ OTHER RACE ☐ REFUSE TO REPORT			
PREFERRED LANGUAGE (check one) ☐ ENGLISH ☐ SPANISH ☐OTHER_____			
CONTACT PREFERENCE (check one) ☐ CELL PHONE ☐ HOME PHONE ☐ E-MAIL			
REFERRED BY:			
EMPLOYMENT INFORMATION			
EMPLOYER NAME:	PHONE #:		OCCUPATION:
ADDRESS LINE:			
CITY:	STATE:		ZIP CODE:
MEDICAL INSURANCE			
MEDICARE #:	MEDICAID #:		
HMO #:	OTHER (NAME AND POLICY #):		
PHARMACY INFORMATION			
NAME:	PHONE #:		
ADDRESS LINE:			
CITY:	STATE:		ZIP CODE:
EMERGENCY CONTACT INFORMATION			
LAST NAME:	FIRST NAME:		MIDDLE NAME:
PHONE #:	RELATIONSHIP:		
ADDRESS LINE:			
CITY:	STATE:		ZIP CODE:
GUARDIAN (IF APPLICABLE) INFORMATION			
LAST NAME:	FIRST NAME:		MIDDLE NAME:
PHONE #:	RELATIONSHIP:		
ADDRESS LINE:			
CITY:	STATE:		ZIP CODE:

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II- CONCERNS

(Please answer the following questions to the best of your abilities.)

II a) What are the primary concerns that have resulted in the client to seek care (Check off all that apply)

__ Anxiety
__ Panic Attacks
__ Fear of Places
__ Sadness
__ Depression
__ Traumatic Incident
__ Concentration Problem
__ Eating Concerns
__ Impulsivity
__ Memory Problem
__ Hallucinations
__ Anger Concerns
__ Relationship Concerns
__ Change in Life/Adjustment
__ Hyperactivity
__ Sleep Concerns
__ Physical Aggression
__ Sexual Dysfunction
__ Thoughts of Hurting Others
__ Substance Abuse (Please Specify):
__ Medical Concerns (Please Specify):
__ Other:

II b) Does the client's family have a history of mental illness? Yes___ No ___
* If "Yes", please specify (the family member's relationship to client and diagnosis):

_____

II c) Does the client have any allergies? Yes ___ No ___
*If "Yes", please specify:

_____

II d). Please list any medication that the client is currently taking

Medication Name	Dose (Strength)	Taken for	Prescribed by

SM MEDICAL CENTER

INITIAL CLIENT INFORMATION FORM

III- CONSENT FOR MEDICAL TREATMENT (page 1 of 2)

DIRECTIONS: Please "Initial" the lower right-hand corner of each page, acknowledging that you have read and understood every page of the *Informed Consent for Services.*

CONFIDENTIALITY

Confidentiality means that the mental health professionals and their supervisors have a responsibility to clients in regard to safeguarding information obtained during treatment. Clients of SM MEDICAL CENTER should respect each other's confidentiality as well, and not discuss who they see or what they may overhear at the SM MEDICAL CENTER.

It is important that you understand that all identifying information about your assessment and treatment is kept confidential. Even within the organization, information about your case is only shared with those who will confer with your clinician to enhance the services you receive. These include other professionals-in-training, supervisors at SM MEDICAL CENTER, the Clinical Director of SM MEDICAL CENTER, and Licensed Mental Health Professional-Interns Board Approved Supervisors.

In order to protect your confidentiality, any written, telephone, or personal inquiries about clients will not be acknowledged. You must sign a release of information before any information about you is given outside of SM MEDICAL CENTER. In order for us to coordinate our treatment with other mental health or medical professionals, SM MEDICAL CENTER will ask you to sign a release of information to allow us to discuss or correspond with other professionals who may have been involved.

LIMITS OF CONFIDENTIALITY

It is important that you understand that the laws in the State of Nevada allow exceptions to confidentiality. In certain situations, mental health professionals are required by law to reveal information obtained during your sessions to person(s) or agencies without your permission. Also, in these situations we are not required to inform you of your actions. Examples of such limits of confidentiality for mental health professionals are when clients state that they want to hurt themselves (suicidality) and/or hurt another identifiable person(s) (homicidally).

Within the State of Nevada, all mental health professionals are also deemed to be "Mandated Reporters". A "Mandated Reporter" is required by law to inform the State of Nevada of any known or suspected forms of abuse/neglect in regards to the following individuals: Abuse/Neglect of a Child, Statutory Sexual Seduction (A person 18 years of age or older with a person under the age of 16; NRS 200.364[3]), Abuse/Neglect of an Elderly Individual. and Abuse/Neglect of a Mentally/Physically Handicapped Individual.

If at any time you have questions in regard to the limits of your confidential mental health services, please contact our office or your licensed mental health professional with who you receive mental health services from.

TRAINING AND RESEARCH

SM MEDICAL CENTER supports an environment of continual professional growth with all of our professional staff members and professionals-in-training. Therefore, we require permission to record and directly observe the therapeutic services that we provide for our clients. The recordings and direct observation are used for instruction and supervisory input and are necessary to ensure our clients receive the highest quality of services possible. The recordings are on a dedicated server and may only be reviewed by professionals- in-training, the Clinical Director of SM MEDICAL CENTER, and Clinical Supervisors of SM MEDICAL CENTER. If a professional-in- training is required to have further professional input provided by their academic supervisors in regards to their progress in skill development with various forms of therapeutic services here at SM MEDICAL CENTER, the professional-in-training will require the client's expressed written consent to utilize such recorded therapeutic services. You may inquire at any time as to who is participating in your treatment. The recordings will not be used for any other purpose without your permission and will be deleted when they are no longer useful for educational or supervision purposes.

INITIALS: _____

SM MEDICAL CENTER

INITIAL CLIENT INFORMATION FORM

III- CONSENT FOR MEDICAL TREATMENT (page 2 of 2)

Another primary function of SM MEDICAL CENTER is to conduct meaningful research on human problems and the treatments that address these problems. This allows us to improve the services you receive and upgrade the services for future clients. Because of this, you may be asked to complete a few questionnaires, assessments, or surveys prior to, during and after the course of treatment. By participating in these questionnaires, assessments, or surveys, you are allowing SM MEDICAL CENTER to use the confidential data you submit for scholarly research/publications.

FEES AND APPOINTMENTS

Payment of fees, including any required co-pays, is expected at the time of each appointment. We request that payment be made before your session begins. If you are using insurance benefits, SM MEDICAL CENTER will file insurance claims for you, and we will honor any contractual agreements with managed health care companies that have specific reimbursement restrictions and claim requirements. If you are not using a Managed Care/PPO/HMO insurance plan and wish to file your own claim, we expect full payment at the time of service, and we will provide you with a statement for services rendered. Monthly payment arrangements are available if needed for clients who have established a payment record for three months.

DISCLOSURE STATEMENT

I hereby acknowledge that I have read, have been completely explained, and understood all aspects of the SM MEDICAL CENTER *Informed: 1 Consent for Services.* By signing this *Informed Consent for Services,* I agree to participate in the following forms *of* services during the course of treatment:

I also acknowledge that I may withdrawal from any or all participation of these therapeutic services at any time during the course of treatment with expressed, written consent to SM MEDICAL CENTER.

Print Name: _____Date: _____

Signature of Patient or Legal Guardian: _____Date: _____

SM MEDICAL CENTER

INITIAL CLIENT INFORMATION FORM

IV- Controlled Medication Patient Agreement (page 1 of 2)

Patient Name: _____DOB: _____

The use of_____ (name of medication) may cause addiction and is only one part of the treatment for:_____(print diagnosis)

The goals of this medication are:

o To improve my ability to function. o To help my as much as possible without causing dangerous side effects.

I have been told that:

1. If I drink alcohol or use street/recreational drugs, I may not be able to think clear and I could become sleepy and risk personal injury.
2. I may get addicted to this medicine.
3. If I or anyone in my family has a history of drug or alcohol problems, there is a higher chance of addiction.
4. If I need to stop this medicine, I must do so slowly, or I may get very sick.

I agree to the following

1. I am responsible for my medications. I will not share, sell, or trade my medicine. I will not take anyone else's medication.
2. I will not increase my medication until I speak with my provider or the clinic nurse.
3. My medication may not be replaced if it is lost, stolen or used up sooner than prescribed.
4. I will keep all appointments set up by my provider (such as: primary care, pain management, mental health, physical therapy, or substance abuse treatments)
5. I will bring the pill bottles with any remaining pills of this medicine to each clinic visit.
6. I agree to give blood or urine sample if asked to test for drug abuse.

Refills:

Refill will only be made in person follow up appointments during regular office hours at the provider's discretion. No refills will be authorized after business hours or on holidays. I must make an appointment to see our providers for any refills of controlled medication. No exceptions will be made.

I must keep track of my controlled medication. No early or emergency refill may be made.

SM MEDICAL CENTER

INITIAL CLIENT INFORMATION FORM

IV- Controlled Medication Patient Agreement (page 2 of 2)

Pharmacy:

I will only use one pharmacy to fill/obtain my medication(s). My doctor may talk with the pharmacist about my medication(s). If necessary, please inform your provider's office of any changes to your pharmacy.

PREFERRED PHARMACY INFORMATION		
NAME:	PHONE #:	
ADDRESS LINE:		
CITY:	STATE:	ZIP CODE:

Prescriptions from other doctors:

If I see another doctor who gives me controlled medication(s) (for example: dentist, a provider from and emergency room or another hospital, etc.) I must bring this medicine to our office in the original bottle, even if there is no pills/capsules left.

Privacy

While I am taking this medication(s), my provider may need to contact other providers to get information about my care and/or use of this medication(s). I will be asked to sign a release at that time.

Termination of agreement

If I break any of these rules, or my provider decided that this medication(s) is hurting me more than helping me, this medication(s) may be stopped by me provider(s) in a safe way.

I have talked about this agreement with my provider or medical staff and I understand the above rules.

Provider Responsibilities

As your provider, I agree to perform regular checks to see how well the medication(s) is working. I agree to provide primary care (if applicable) even if you are no longer obtaining controlled medication(s) from Therapeutic Integrated Medical Care Inc.

Print patient name/ Legal Guardian: _____/_____Date: _____

Signature of patient/Legal Guardian: _____/_____Date: _____

Name and Signature of provider: _____/_____Date: _____

Name and Signature of staff witness: _____/_____Date: _____

SM MEDICAL CENTER

INITIAL CLIENT INFORMATION FORM

V- CONSENT TO USE AND DISCLOSE YOUR PROTECTED HEALTH INFORMATION

This form is an agreement between you, (the client) _____,

and us, (the center) SM MEDICAL CENTER.

When the SM MEDICAL CENTER examines, tests, diagnoses, treats, or refers you, the client, to another organization, the SM MEDICAL CENTER will be collecting what the law calls "Protected Health Information" (PHI) about you. The SM MEDICAL CENTER needs to use this information in our office(s) to decide on what treatment is best for you, the client, and to also provide treatment. The SM MEDICAL CENTER may also share this information with others to arrange payment for your treatment, to help carry out certain business or government functions, or to help provide other treatment to you, the client. By signing this form, you are also agreeing to let the SM MEDICAL CENTER use your PHI and to send it to others for the purposes described above. Your signature below acknowledges that you have read or heard our Notice of Privacy Practices, which explains in more detail what your rights are with your PHI and how the SM MEDICAL CENTER LLC can use and share your information.

If you do not sign this form agreeing to our Privacy Practices, the SM MEDICAL CENTER cannot treat you. In the future, the SM MEDICAL CENTER may change how our organization uses and shares your information, and therefore, the SM MEDICAL CENTER may change our Notice of Privacy Practices. If the SM MEDICAL CENTER does change our Notice of Privacy Practices, you can obtain a copy of the Notice of Privacy Practices by calling our office. If you are concerned about your PHI, you have the right to ask our organization not to use or share some of it for treatment, payment, or administrative purposes. The SM MEDICAL CENTER LLC will then stop using or sharing your PHI, but the organization may already have used or shared some of it. Therefore, the SM MEDICAL CENTER LLC cannot change that previously submitted information.

I hereby acknowledged that I have read and understood this CONSENT TO USE AND DISCLOSE YOUR HEALTH INFORMATION.

Print patient name/ Legal Guardian: _____Date: _____

Signature of Patient/Legal Guardian: _____Date: _____

Name and Signature of Staff Witness: _____Date: _____

SM MEDICAL CENTER

INITIAL CLIENT INFORMATION FORM

VI- HIPAA RELEASE OF INFORMATION

Patient Name: _____ DOB: _____ SSN: _____

I hereby authorize the following information to be disclosed to and/or obtained from the following name/organization:
Information Release To: SM MEDICAL CENTER
Address: 2621 WEST CHARLESTON BLVD STE D, LAS VEGAS NV 89102
Phone #: (725) 301-1182
Fax #: (702) 441-2134

☐ Description of Information ☐ Assessment ☐ Testing Information

☐ Educational Information ☐ Diagnosis ☐ Psychosocial Evaluation

☐ Continuing Care Plan ☐ Current Treatment Update

☐ Presence/Participation in Treatment Psychological Evaluation

☐ Treatment Plan or Summary Progress in Treatment

☐ Other:

Purpose: The purpose of this disclosure of information is to improve assessment and treatment planning, share information relevant to treatment and when appropriate, coordinate treatment services. If other purpose, please specify:

Revocation: I understand that I have a right to revoke this authorization, at any time by sending written notification to the name/organization's address listed above. I further understand that a revocation of the authorization is not effective to the extent that action has been taken in reliance on the authorization. Expiration: Unless sooner revoked, this authorization expires on *a year from the date or signature,* or as otherwise indicated:

Conditions: I further understand that SM MEDICAL CENTER will not condition my treatment on whether I give authorization for the requested disclosure.

Form of Disclosure: Unless you have specifically requested in writing that the disclosure be made in a certain format, we reserve the right to disclose information as permitted by this authorization in any manner that we deem to be appropriate and consistent with applicable law, including, but not limited to, verbally, in paper format, or electronically.

Re-disclosure: Federal law prohibits the person or organization to whom disclosure is made from making any further disclosure of substance abuse treatment information unless further disclosure is expressly permitted by the written authorization of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2.

Print patient name/ Legal Guardian: _____Date: _____

Signature of Patient/Legal Guardian: _____Date: _____

Name and Signature of Staff Witness: _____Date: _____

SM MEDICAL CENTER

INITIAL CLIENT INFORMATION FORM

VII- NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY SED/SMI CONSENT

All pages of this form must be completed and submitted to the DHCFP or its designee within five working days after the SED or SMI determination, to ensure timely notification, if is not completed it will be sent back to the sender to complete and this delay the process Fax to the DHCFP Managed Care & Quality Assurance, (775) 684-3774. For complete policy regarding SED/ SMI disenrollment from managed care, refer to MSM Chapter 3600, which is available on the DHCFP website at www.dhcp.nv.gov. This form serves as consent to the evaluator working with the family to communicate determinations with the DHCFP/Medicaid and/or its designee (e.g., contracted Managed Care Organizations (MCOs) or fiscal agent), and, only if applicable, to Nevada Division of Mental Health and Developmental Services (MHDS) and/or the Nevada Division of Child and Family Services (DCFS).

SED consent: (for children under the age of 18):

I hereby authorize, _____SM MEDICAL CENTER LLC_____(*name of agency)* to:

1) Conduct an assessment for the sole purpose of determining whether my child has a severe emotional disturbance (SED) and;
2) Share the results of this assessment and determination only with the above-named entities, and me. This Agency has explained fully, and to my satisfaction, the reasons as to why they believe my child requires an assessment at this time. All parties shall keep such assessment information strictly confident

Print client name or Responsible: _____ Signature: _____

Medicaid ID Number: _____ Date: _____

Address: _____ Phone #: _____

SMI consent: (for adults 18 years of age and older):

I hereby authorize, _____SM MEDICAL CENTER LLC_____ *(name of agency)* to:

1) Conduct an assessment for the sole purpose of determining whether I have a Serious Mental Illness (SMI) and;

2) Share the results of this assessment and determination only with the above-named entities, and me. This Agency has explained fully, and to my satisfaction, the reasons as to why they believe I require an assessment at this time. All parties shall keep such assessment information strictly confidential.

Print client name or Responsible: _____ Signature: _____

Medicaid ID Number: _____ Date: _____

Address: _____ Phone #:_____

SM MEDICAL CENTER

INITIAL CLIENT INFORMATION FORM

VIII- NEVADA DIVISION OF HEALTH CARE FINANCING AND POLICY MANAGED CARE ENROLLMENT

This form serves as an account of the recipient's wishes in regard to their Medicaid managed care enrollment. If disenrollment is requested and approved prior to monthly cut-off, the Nevada Division of Health Care Financing and Policy (DHCFP) will disenroll the Medicaid managed care recipient from his/her health plan on the first day of the month following submission of this form. Following disenrollment, all covered medically necessary services, including but not limited to services specific to the recipient's SED or SMI diagnosis, will be authorized and reimbursed through Fee-for-Service Medicaid. If no disenrollment is requested, the recipient will continue to receive services through their health plan. *If the recipient is currently exempt from managed care for reasons other than an SED or SMI determination, the recipient will remain Fee-for- Service Medicaid as long as that exemption is in effect.*

If this is your first determination, please indicate your choice below (choose only one):

____I wish to disenroll from managed care and be covered under Fee-for-Service Medicaid.

____I wish to remain in managed care and keep my enrollment with my health plan.

____I am currently covered under Fee-for-Service Medicaid and wish to remain that way.

If this is your annual re-determination or you were previously disenrolled from managed care due to your SED or SMI determination, please indicate your choice below (choose only one):

____ I wish to remain Fee-for-Service Medicaid.

____ I wish to disenroll from managed care and be covered under Fee-for-Service Medicaid.

____ I wish to return to managed care and be enrolled in a health plan.

Print client name or Responsible: _____ Signature: _____

Medicaid ID Number: _____ Date: _____

Address: _____ Phone #: _____

*Or the signature of the person authorized to act on behalf of the individual under the laws of the State where the individual resides. If signed by an authorized individual (as described above), this signature certifies that: I) this person is authorized under State law to complete this disenrollment, and 2) documentation of this authority is available upon request.

Disclaimer:

Pursuant to the State of Nevada Title XKQ State Plan, Nevada Check Up recipients must remain enrolled with the managed care organization that is responsible for on-going patient care.

Nevada Medicaid Newly Eligible, defined as childless adults ages 19-64, and the expanded parent and caretakers ages 19-64, who are made eligible as part of the PPACA expansion population and who are receiving the Alternative Benefit Plan, cannot opt out of managed care, where available, based on a determination of serious Mental Illness (SSI).