Comprehensive HEALTHCARE

Consent to Participate in Telehealth Services

I, _____, have been asked to receive behavioral health services through the telehealth system. I understand the use of the video conferencing equipment is a method of health care delivery in which services are delivered to an individual by a provider at a site other than where the individual is located. I understand that, there are no known risks involved with receiving my care in this way.

I understand there are no additional charges or fees for clinical services I will receive through the use of the telehealth system. I understand that the equipment will be shown to me and I will see how it works before I receive any services. I understand that my participation in telehealth is voluntary and I may refuse to participate or decide to stop participation at any time.

I understand that my privacy and confidentiality will be protected. I also understand communication through the telehealth system occurs over secure telecommunications lines dedicated for this purpose. I understand that the likelihood of a videoconference being intercepted by an outsider is similar to the potential interception of a phone call. I understand no video or audio recording of the service(s) will be made.

I have read this document and I hereby consent to participate in receiving behavioral health services through the telehealth system under the terms described above. I understand this document will become a part of my medical record.

_____ _____
Client Signature Date

_____ _____
Witness Signature Date

If the client is age 12 and below, or has been determined to be incompetent to give medical consent please complete below:

_____ _____
Parent, Legal Guardian, or Authorized by the Court Date

_____
Relationship to Client

_____ _____
Witness Signature Date

Client ID # _____

Comprehensive HEALTHCARE

Financial Agreement

Gross Monthly Income: Click here Number of Dependents: Click here % of unit Fee: Click here

☐ **Private Pay** ☐ **Insurance**

	Primary Insurance	Secondary Insurance
Insurance Company Name:	Click here to enter text.	Click here to enter text.
Insurance Company Address:	Click here to enter text.	Click here to enter text.
	Click here to enter text.	Click here to enter text.
	Click here to enter text.	Click here to enter text.
Insurance Company Phone Number:	Click here to enter text.	Click here to enter text.
Insured's Name/Relationship:	Click here to enter text.	Click here to enter text.
Insured's Date of Birth:	Click here to enter text.	Click here to enter text.
Insured's Social Security #:	Click here to enter text.	Click here to enter text.
Group Name / #:	Click here to enter text.	Click here to enter text.
Employer:	Click here to enter text.	Click here to enter text.

I (We) understand that COMPREHENSIVE HEALTHCARE will bill my (our) insurance company at full fee rate. I (We) will be responsible for any amount not paid by the insurance up to co-payment amounts or percentage of the unit fee.

MEDICAID – SERVICE CARD MUST BE PRESENTED EACH MONTH OF SERVICE

☐ I will be responsible to pay a full fee for each service provided with no coupon.

PROVIDER ONE ID#: Click here to enter text. PROGRAM: Click here to enter text.

☐ **MEDICARE**

HIC: Click here to enter text.

Medicare Lifetime Authorization

Authorization Period From Click Here to Click here *

*** or until rescinded. I permit a copy of this authorization to be used in place of the "original"**

PAYMENT IS EXPECTED AT THE TIME OF SERVICE FOR PRIVATE PAY AND/OR INSURANCE CLIENTS

This document does not obligate me to receive services. If I do receive services, I understand that my signature upon this document shall be treated as a contract. If the terms of this contract are not met, services may be suspended or terminated and my account may be referred to a collection agency. I also acknowledge receipt of a current list of services with associated fees and understand that these fees may change during the course of treatment. There will be advance notice of a fee change. My signature below indicates that I have received a copy of the COMPREHENSIVE HEALTHCARE Financial Policy.

AUTHORIZATION FOR RELEASE OF INFORMATION AND ASSIGNMENT OF BENEFITS

I hereby authorize payment of benefits to be made directly to COMPREHENSIVE HEALTHCARE for services provided. I authorize COMPREHENSIVE HEALTHCARE to release information on my behalf to facilitate third-party payment for service I have incurred. I understand that I am financially responsible for any charges not covered by this assignment.

Click here to enter text. — Comprehensive Healthcare Representative Signature

X Click here to enter text. — Responsible Party/Guarantor Signature

Click here — Date

Name: Click here to enter text.

*Please print Responsible Party Name & Address

Clinic Routing

Original: Accounts Receivable

Yellow: Client

Address: Click here to enter text.

City: Click here to enter text. State: Click here Zip: Click here

Comprehensive Healthcare

☐ Mental Health ☐ Chemical Dependency

☐ Evaluation & Treatment

CMH-500 (5/18/20)

Client Name: Click here to enter text.

Client ID Number: Click here to enter text.

Date of Birth: Click here to enter text.

Comprehensive HEALTHCARE

Consent for Treatment

I, hereby give my consent _____,

(Please print name of client)

to receive services at Comprehensive Healthcare. I understand that informed consent is an ongoing process.

I have been advised of the risks, benefits and possible side effects of the assessment to evaluate the need for services. I understand that the assessment does not obligate either Comprehensive Healthcare or me to continue services.

During the course of treatment, I will be provided with information about:

- My Condition
- Potential Benefits
- Treatments/Medications
- Proposed Interventions
- Risks & Side Effects of Proposed Interventions, and Medications
- Problems Related to Recovery and Likelihood of Success

I voluntarily agree to an assessment and/or treatment and to follow recommendations for treatment at Comprehensive Healthcare. If involved in Substance Use Disorder Treatment by Comprehensive Healthcare, I voluntarily agree to urinalysis once upon admission to the program and at any time during the duration of treatment. I understand that I am not bound to participate in or consent to any activity that goes against my religious or ethnic belief system.

I further understand that de-identified information during the treatment process may be collected and provided to state and federal entities to comply with grant requirements and for statistical purposes. This information is protected and will be held confidential in accordance to the provisions of federal confidentiality law and regulations, Washington State law provisions, and HIPAA. I understand that I may receive services even if I chose to not participate in or complete data collection components.

I have been informed that in the case of suspected child abuse/neglect, as well as other forms of abuse, it is required that Comprehensive Healthcare report this to the Department of Children, Youth, and Families.

I further understand that I may refuse any services proposed or withdraw from any aspect of assessment or treatment at any time, to the extent permitted by law.

Client Rights Acknowledgement

☐ I have been given a copy of Comprehensive Healthcare's client rights form.

Acknowledgement of Receipt of Privacy Notice

☐ I have been given a copy of Comprehensive Healthcare's notice of privacy practices that describes how my health information is used and shared.

Comprehensive Healthcare ☐ Yakima ☐ Ellensburg ☐ Sunnyside ☐ Goldendale ☐ White Salmon ☐ Pasco ☐ Walla Walla	Client Name:
	Client ID Number:
CMH-538 Consent for Treatment (2/19/2020)	Date of Birth:

Mental Health Advance Directive Verification

(Pertains to Adults only - 18 years and older)

By signing below, I am verifying that:
I have received an explanation about the Washington State Advance Directive Program.

I understand the information that was provided to me and that I have had adequate opportunity to ask questions about the Advance Directive Program.

I have elected to:

☐ I have obtained and completed the legal documentation regarding the Advance Directive Program (it is my responsibility to complete and submit this information).

☐ I have not yet obtained nor completed the legal documentation at this time, although I may do so at any time in the future.

Documentation

☐ I am requested to provide a copy of the following documents (if they exist), Medical Advance Directive, Durable Power of Attorney for Healthcare, Guardianship letters, Parenting Plan, Court Order for Custody or Least Restrictive Alternative order. I am also requested to sign releases for any prior treatment.

Program Rules

- Participation at Comprehensive Healthcare includes the following rules and regulations.
- All patients shall respect the privacy and confidentiality of any person who participates in Comprehensive Healthcare activities.
- No patient shall commit an act of violence, nor threaten to commit an act of violence against the staff or other patients and/or their property.
- All patients shall refrain from the possession, use and trafficking of all psychoactive chemicals or substances.
- All patients shall hold Comprehensive Healthcare free from harm or claim arising out of loss of their personal property or damage thereto.
- All patients understand that violation of any program rule may result in their dismissal from the program.

By signing this document, I verify that I have read and received Program Rules; that I consent to treatment and I have received the Client Rights and the Notice of Privacy Practices.

_____ _____
Client (if 13 years of age or above) Date

_____ _____
Legal Guardian/ Power of Attorney *(please print)* Date

Comprehensive HEALTHCARE

Client Information

(Please PRINT and complete all requested information to the best of your ability.)

Client Information Date: _____

Name: _____ _____ _____
Last First Middle

Preferred name to be called if different from above: _____

Gender: ☐ Female ☐ Male ☐ Transgender
☐ Self-Identify _____

Address: _____ _____ ____ _____
Mailing address City State Zip

Home Phone Number: _____

Social Security #: _____ **Date of Birth:** _____

Employer: _____ **Work Phone #:** _____

Emergency/Next of Kin Information:

Emergency Contact Name: _____ **Phone Number:** _____

Emergency Contact Relationship: _____

Address: _____ _____ _____ _____
Mailing address City State Zip

Next of Kin Name: _____ **Phone Number:** _____

Next of Kin Relationship: _____

Address: _____ _____ _____ _____
Mailing address City State Zip

Primary Referral Source (check one):

☐ Self or Family

☐ Referred by:

Organization/Agency: _____

Referent name: _____

Address: _____

Phone: _____

Client Questionnaire

I. PHYSICAL HEALTH

Medical care provider's name: _____

Name of office or clinic: _____ When was your last visit? _____

Have you had a physical exam within the past 12 months? ☐ Yes ☐ No

For children and adolescents: Are immunizations up to date? ☐ Yes ☐ No

Do you have, or have you had, any of the following (check all that apply)?

☐ AIDS/HIV
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Bone/Joint/Muscle Problems
☐ Breathing Problems
☐ Cancer
Type: _____
☐ Chest Pains
☐ Currently Pregnant
☐ Diabetes
☐ Digestive Problems
☐ Frequent Diarrhea
☐ Frequent Headaches
☐ Frequent Vomiting
☐ Head Injury
☐ Heart Attack
☐ Heart Disease
☐ Hemophilia
☐ Hepatitis A
☐ Hepatitis B or C
☐ High Blood Pressure
☐ High Cholesterol
☐ Hormonal Disorders
☐ Immune Disorders
☐ Kidney/Urinary Tract Problems
☐ Liver or Gall Bladder Diseases
☐ Low blood Pressure
☐ Seizures
☐ Sexually Transmitted Infections
☐ Sleep Disorders
☐ Stroke
☐ Thyroid Disease
☐ Tobacco / Nicotine Use
☐ Tuberculosis
☐ Ulcers

Have you ever had any serious illnesses not listed above?

☐ No ☐ Yes If ***Yes***, please list: _____

Are you currently receiving medical treatment for any of the items checked above? ☐ Yes ☐ No

If you are NOT receiving treatment for any of the above checked items, would you like to be referred for care?

☐ Yes ☐ No

Pain Screening Questions:

How would you rate your **pain** level today? (check one)

☐ 0 ☐1 ☐2 ☐3 ☐4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10

No Pain *Moderate Pain* *Severe Pain*

Are you currently receiving medical care for your pain? ☐ Yes ☐ No

If you rated your pain 4 or higher, and it is not being treated, would you like to be referred for care? ☐ Yes ☐ No

Nutrition Screening Questions:

Have you experienced weight gain or loss of 10 pounds or more in the last three months? ☐ Yes ☐ No

Do you have any concerns about your nutrition, diet, or the foods you are eating? ☐ Yes ☐ No

In the past 12 months, have you found yourself:

☐ Tightly controlling what you eat? ☐ Over-eating or binge-eating? ☐ Causing yourself to throw up after eating?

Are you currently experiencing any dental problems, or problems with your mouth or gums? ☐ Yes ☐ No

If ***Yes***, would you like to be referred for care? ☐ Yes ☐ No

II. BEHAVIORAL HEALTH	
Are you currently seeing a counselor, therapist or other treatment provider for mental health or substance use disorder treatment?	☐ Yes ☐ No If ***Yes***, where: _____
Have you ever seen a counselor, therapist or other treatment provider for mental health or substance use disorder treatment?	☐ Yes ☐ No If ***Yes***, where: _____
Have you ever received inpatient mental health or substance use disorder treatment services? ☐ Yes ☐ No If ***Yes***, where and when: _____ _____	
Have you ever received treatment for problem gambling? ☐ Yes ☐ No If ***Yes*** where and when _____ _____	

III. CURRENT OR PRIOR MILITARY SERVICE
Which branch: _____ When: _____
If discharged, type and date? _____

IV. EDUCATIONAL STATUS		
What is the highest degree of level of school you have completed? ☐ Less than high school diploma ☐ High school diploma or GED ☐ Some college, but no degree ☐ Associates or Technical Degree ☐ Bachelor's Degree ☐ Master's Degree or higher		
Are you currently enrolled in an education program?	☐ Yes	☐ No
If ***No***, are you interested in entering an educational program?	☐ Yes	☐ No
For children and adolescents: Name of current school: _____ Grade: _____ ☐ Not currently attending		

V. VOCATIONAL STATUS		
Are you currently employed?	☐ Yes	☐ No
Are you interested in a referral for vocational, occupational, or career and job search assessment or support?	☐ Yes	☐ No

VI. LEGAL		
Are you currently on an LRA (court order for mental health treatment)?	☐ Yes	☐ No
Does someone have a power of attorney or guardianship designated for you?	☐ Yes	☐ No
Please list any current or pending legal involvement: _____ _____		
Are you currently under a civil or criminal court order for mental health or substance use disorder treatment?	☐ Yes	☐ No
Are you currently on probation or community supervision?	☐ Yes	☐ No
If you are on community supervision with Washington State Department of Corrections, what is the name and phone number of your Community Corrections Officer (CCO)? Name: _____ Phone: _____		

VII. CULTURAL & SPIRITUAL IDENTIFICATION
How would you best describe your cultural or ethnic identity? _____
With which religious or spiritual backgrounds or traditions do you most identify? _____
How might your cultural identity, spiritual beliefs, or traditional practices best be incorporated into your treatment services? _____

VIII. SIGNATURES

Client or Legal Representative: _____ **Date:** _____

Intake specialist: _____ **Date:** _____

Global Appraisal of Individual Needs-Short Screener (GAIN-SS)

The following questions are about common psychological, behavioral or personal problems. These problems are considered ***significant*** when you have them for two or more weeks, when they keep coming back, when they keep you from meeting your responsibilities, or when they make you feel like you can't go on. Please answer the questions ***Yes*** or ***No***.

Mental Health Internalizing Behaviors (IDScr 1)		
During the past 12 months, have you had significant problems. . .		
a. with feeling very trapped, lonely, sad, blue, depressed, or hopeless about the future?	☐ Yes	☐ No
b. with sleep trouble, such as bad dreams, sleeping restlessly or falling asleep during the day?	☐ Yes	☐ No
c. with feeling very anxious, nervous, tense, scared, panicked or like something bad was going to happen?	☐ Yes	☐ No
d. when something reminded you of the past, you became very distressed and upset?	☐ Yes	☐ No
e. with thinking about ending your life or committing suicide?	☐ Yes	☐ No
IBS Sub-scale Score (0 to 5)		_____

Mental Health Externalizing Behaviors (EDScr 2)		
During the past 12 months, did you do the following things two or more times?		
a. Lie or con to get things you wanted or to avoid having to do something?	☐ Yes	☐ No
b. Have a hard time paying attention at school, work or home?	☐ Yes	☐ No
c. Have a hard time listening to instructions at school, work or home?	☐ Yes	☐ No
d. Been a bully or threatened other people?	☐ Yes	☐ No
e. Start fights with other people?	☐ Yes	☐ No
EBS Sub-scale Score (0 to 5)		_____

Substance Abuse Screen (SDScr 3)		
During the past 12 months did. . .		
a. you use alcohol or drugs weekly?	☐ Yes	☐ No
b. you spend a lot of time either getting alcohol or drugs, using alcohol or drugs, or feeling the effects of alcohol or drugs (high, sick)?	☐ Yes	☐ No
c. you keep using alcohol or drugs even though it was causing social problems, leading to fights, or getting you into trouble with other people?	☐ Yes	☐ No
d. your use of alcohol or drugs cause you to give up, reduce or have problems at important activities at work, school, home or social events?	☐ Yes	☐ No
e. you have withdrawal problems from alcohol or drugs like shaking hands, throwing up, having trouble sitting still or sleeping, or use any alcohol or drugs to stop being sick or avoid withdrawal problems?	☐ Yes	☐ No
SDS Sub-scale Score (0 to 5)		_____

This screening tool is intended for self-administration; however, it may be administered by agency staff if deemed to be valuable by the agencies policies and procedures. If the client is received with an accompanying GAIN SS screen completed by a referring agency, the receiving agency reserves the right to administer a new GAIN-SS to assure the screening was administered in an acceptable manner.

FOR AGENCY USE ONLY:

GAIN-SS QUADRANT PLACEMENT

☐ No quadrant placement
☐ Quadrant I: **Low/Low**: Less severe mental disorder, low substance disorder
☐ Quadrant II: **High/Low**: More severe mental disorder and less severe substance disorder
☐ Quadrant III: **Low/High**: Less severe mental disorder and more severe substance disorder
☐ Quadrant IV: **High/High**: Both a more severe mental disorder and severe substance disorder

Comprehensive HEALTHCARE

Trauma Screen

Below is a list of traumatic events or situations. Please mark YES if you have experienced or witnessed the following events, or mark NO if you have not had that experience.

1. Serious accident, fire or explosion …….. ☐ Yes ☐ No
2. Natural disaster (tornado, flood, hurricane, major earthquake) …… ☐ Yes ☐ No
3. Non-sexual assault by someone you know (physically attacked/injured) …… ☐ Yes ☐ No
4. Non-sexual assault by a stranger …… ☐ Yes ☐ No
5. Sexual assault by a family member or someone you know …….. ☐ Yes ☐ No
6. Sexual assault by a stranger …….. ☐ Yes ☐ No
7. Military combat or a war zone ……... ☐ Yes ☐ No
8. Sexual contact before you were age 18 with someone who was 5 or more years older than you ☐ Yes ☐ No
9. Imprisonment …….. ☐ Yes ☐ No
10. Torture …….. ☐ Yes ☐ No
11. Life-threatening illness ……... ☐ Yes ☐ No
12. Other traumatic event: …… ☐ Yes ☐ No
13. Of the questions to which you answered YES, which was the worst: (Please list the question #) …… _____
14. Which of the above incidences is the reason for which your are currently seeking treatment? (Please list the question #) …… _____

Please check YES or NO regarding the event listed in question 14:

Were you physically injured? ☐ Yes ☐ No

Was someone else physically injured? ☐ Yes ☐ No

Did you think your life was in danger? ☐ Yes ☐ No

Did you think someone else's life was in danger? ☐ Yes ☐ No

Did you feel helpless? ☐ Yes ☐ No

Did you feel terrified? ☐ Yes ☐ No

(If client answers Yes to any of the questions, please have them complete form CMH-759A PCL-5.)

Comprehensive Healthcare	Client Name:
	Client ID Number:
CMH-759B (4/21/2020)	Date of Birth:

Personal Information

Please select one option from each underlined section (unless noted differently)

Primary Language:

☐ English ☐ Spanish ☐ American Sign Language ☐ Other (Specify): _____

Smoking Status:

☐Current Smoker ☐ Former Smoker ☐Never Smoked

Military Service:

☐ Yes ☐ No

Educational Level:

☐Unknown ☐ No Formal Schooling ☐Preschool ☐ Kindergarten

Grade: ☐1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐9 ☐ 10 ☐ 11 ☐ 12

☐ High School Diploma or GED ☐ Vocational School

College / University

☐ Freshman, Year 1 ☐ Sophomore, Year 2 or AA Degree ☐ Junior, Year 3 ☐ Senior, Year 4

☐ Bachelor's Degree ☐ Graduate / Professional School

School Attendance: (Last 3 Months)

☐ Yes ☐ No

Employment:

☐ Full Time (More than 35 hrs/week) ☐ Unemployed (Actively Looking) ☐ Retired ☐ Other Classification (e.g. Volunteers)

☐ Part Time (less than 35 hrs/week) ☐ Homemaker ☐ Disabled ☐ Sheltered/Non-Competitive Employment

☐ Employed (PT/FT Unknown) ☐ Student ☐ Unknown ☐ Not Applicable

Sexual Orientation

☐ Heterosexual ☐ Gay or Lesbian ☐ Bisexual ☐ Choose Not To Disclose ☐ Questioning

Marital Status:

☐Single / Never Married ☐ Divorced ☐ Married / Committed Relationship

☐ Separated ☐ Widowed ☐ Unknown

Race(s): (Choose up to three options)

☐ American Indian / Alaska Native ☐ Chinese ☐ Laotian ☐ Other Pacific Islander ☐ Other

☐ Asian Indian ☐ Filipino ☐ Middle Eastern ☐ Native Hawaiian

☐ Black / African American ☐ Guamanian / Chamorro ☐ Korean ☐ White

☐ Cambodian ☐ Japanese ☐ Other Asian

Spanish/Hispanic Origin:

☐ Yes, Mexican ☐ Yes, Puerto Rican ☐ Yes, Origin Unknown ☐ Yes, Other Specific Hispanic

☐ No, Not of Hispanic Origin ☐ Yes, Cuban ☐ Unknown

Residential Arrangements:

☐ Independent Living (Adult) ☐ Private Residence (Adult) ☐ Homeless ☐ Jail / Correctional Facility

☐Dependent Living (Adult) ☐Private Residence (Child) ☐ Crisis Residence ☐ Other Residential Status

☐ Residential Care ☐ Foster Home/Foster Care ☐ Institutional Setting ☐ Unknown

Independent Living (Adult): This category describes adult clients living independently in a private residence and capable of self-care. It includes clients who live independently with case management support or with supported housing supports. This category also includes clients who are largely independent and choose to live with others for reasons not related to mental illness. They may live with friends, spouse, or other family members. The reasons for shared housing could include personal choice related to culture and/or financial considerations. Dependent Living (Adult): This category describes adult clients living in a house, apartment, or other similar dwellings and is heavily dependent on others for daily living assistance. Residential Care: Individual resides in a residential care facility. This level of care may include a group home, therapeutic group home, board and care, residential treatment, rehabilitation center, or agency-operated residential care facilities. Private Residence (Adult): This category reflects the living arrangement of adult clients where "independent"/"dependent" status is unknown. Otherwise, use "independent living"/"dependent living" as appropriate. Private Residence (Child): Use this code for all children living in a private residence regardless of living. Foster Home / Foster Care: Individual resides in a foster home. A foster home is a home that is licensed by a county or State department to provide foster care to children, adolescents, and/or adults. This includes therapeutic foster care facilities. Therapeutic foster care is a service that provides treatment for troubled children within private homes of trained families. Homeless: No fixed address; includes homeless shelters. Crisis Residence: A time-limited residential (24 hours/day) stabilization program that delivers services for acute symptom reduction and restores clients to a pre-crisis level of functioning. Institutional Setting: Individual resides in an institutional care facility with care provided on a 24 hour, 7 days a week basis. This level of care may include skilled nursing/ intermediate care facility, nursing homes, institute of mental disease (IMD), inpatient psychiatric hospital, psychiatric health facility, veterans' affairs hospital, or state hospital. Jail / Correctional Facility: Individual resides in a jail and/or correctional facility with care provided on a 24 hour, 7 days a week basis. This includes a jail, correctional facility, detention centers, and prison.

For Agency Use Only

Team & Staff Assignment: _____ **Pain Follow-Up:** ☐ Yes ☐ No

Discharge: ☐Tx Completed ☐ Dropout/Left Against Advice ☐ Terminated ☐ Transferred ☐ Incarcerated

☐ Death ☐ Suicide ☐ Lost Contact ☐ Other ☐ Unknown

Clinician Name: _____ **Patient ID:** _____

Date: _____ **Patient Name:** _____