Comprehensive HEALTHCARE

Consent to Treatment

I, hereby give my consent for

_____,

(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	**Proposed Interventions**
Potential Benefits	**Risks & Side Effects of Proposed Interventions, Medications**
Treatments/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.

Comprehensive HEALTHCARE

Client Information

(Please fill out all information listed below)

Client Information: (Please Print)

Date _____

Client Name:

_____ _____ _____

(Last name) (First Name) (Middle)

Gender: ☐ **Male** ☐ **Female** ☐ **Transgender**
☐ **Intersex (person born with characteristics of both)**
☐ **Unknown**

Client Address:

_____ _____ _____ _____

Mailing Address **City** **State** **Zip**

Home Phone Number _____

Social Security # _____

Date of Birth: _____

Employer: _____

Work Phone # _____

Emergency/Next of Kin Information: (Please Print)

Emergency Contact Name: _____

Phone Number: _____

Emergency Contact Relationship: _____

Next of Kin Name: _____

Phone Number: _____

Next of Kin Relationship: _____

Address: _____

_____ _____ _____ _____

Mailing Address **City** **State** **Zip**

☐ **Self**	☐ **Community MH Agency**
☐ **Community CD Provider**	☐ **Individual Professional Staff**
☐ **Hospital ER**	☐ **Employer or Co-worker**
☐ **Family or Friend**	☐ **Residential Facility**
☐ **Social Service Agency**	☐ **Secure Detox Facility**
☐ **School**	☐ **Court**
☐ **Law Enforcement**	☐ **Crisis Triage**
☐ **Other**	☐ **Sobering Center or Detox**

☐ **Community Hospital Psychiatric Unit**
☐ **Community Hospital Medical Unit**
☐ **MH Evaluation & Treatment Facility**
☐ **Probation**
☐ **Corrections**
☐ **Tribe**
☐ **State Hospital**

The following is for agency use only:

Comprehensive Healthcare	Client Name:
	Client ID Number:
CMH-759B (5/7/2020)	Date of Birth:

Client Questionnaire

Physical Health

Medical care provider name: _____

Name of office or clinic: _____

When was the last visit? _____

Have you had a physical exam within the past year?

☐ Yes ☐ No

If yes, did your provider weigh you? ☐ Yes ☐ No

For children and adolescents, are immunizations up to date?

☐ Yes ☐ No

Please check ✓ or list any current medical symptoms or condition(s):

Heart/Blood Vessel Problems

Heart disease ..…… ☐

High blood pressure ….. ☐

Other: _____ ☐

Lung / Airway problems ☐

Immune Disorders ☐

Bone / Joint / Muscle Problems ☐

Nerve / Brain Problems

Head injury……. ☐

Seizures ……. ☐

Stroke ……. ☐

Headaches …… ☐

Sleep disorders ……... ☐

Other: _____ ☐

Please check ✓ or list any current medical symptoms or condition(s):

Substance Abuse / Addiction ☐

Tobacco / Nicotine use ☐

Mouth / Dental Problems ☐

Kidney / Urinary Tract Problems ☐

Liver or Gall Bladder Diseases ☐

Hepatitis ..... ☐

Other: _____ ☐

Mental Health Problems ☐

Hormonal Disorders ☐

Diabetes ..... ☐

Thyroid..... ☐

Other: _____ ☐

Please check ✓ or list any current medical symptoms or condition(s):

Cancer ☐

Type: _____

Pregnancy ☐

Digestive Problems

Vomiting or Diarrhea…… ☐

Other: _____ ☐

Infectious Diseases

Tuberculosis …… ☐

Sexually transmitted disease …... ☐

HIV …… ☐

Other: _____ ☐

Please check ✓ or list any current medical symptoms or condition(s):

Blood Disorders

Anemia …… ☐

Other: _____ ☐

Moderate or High Nutritional / Eating Concerns ☐

Moderate or High Pain ☐

Location: _____ ☐

Please list any other current symptoms or conditions:

_____

Are you currently receiving medical treatment for any of the above symptom(s) or conditions? ☐ Yes ☐ No

Are you NOT being treated for any of the above symptom(s) or condition(s)? ☐ Yes ☐ No

Behavioral Health

Do you see a counselor, therapist or psychiatrist? ☐ Yes ☐ No

Have you ever received inpatient psychiatric or chemical dependency treatment services? ☐ Yes ☐ No

Have you ever received treatment for problem gambling? ☐ Yes ☐ No

If yes, when and where?

_____

_____

_____

_____

_____

Current or Prior Military Service

Which branch: _____

When: _____

If discharged, type and date: _____

Educational Status

Are you currently enrolled in an education program, have a high school diploma or GED? ☐ Yes ☐ No

If no, are you interested in entering an educational program? ☐ Yes ☐ No

For children and adolescents, name of current school:

_____

Grade: _____

Vocational Status

Are you currently employed or have an occupation? ☐ **Yes** ☐ **No**

If no, are you interested in a referral for vocational/ occupational assessment? ☐ **Yes** ☐ **No**

Legal Status

Currently on an LRA (court order for mental health treatment)? ☐ **Yes** ☐ **No**

Is there currently a power of attorney or guardianship on this client? ☐ **Yes** ☐ **No**

Please list any current or pending legal involvement:

Legal Status (continued from page 9)

Currently under a civil or criminal court order for mental health or addiction treatment? ☐ Yes ☐ No

Currently on probation for 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: _____

Cultural Identification

With which culture / ethnicity do you identify?:

_____

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 <u>significant</u> when you have them for <u>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</u>. 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 Internalizing 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**

(Continued on next page.)

(Continued from previous page.)

During the past 12 months, did …

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.

  A GAIN SS Screening must be located in every client file.

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**

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

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

(Continued on next page.)

(Continued from previous page.)

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

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.)

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**

EDUCATION 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: (Leave blank if under age 13)

- ☐ 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 / Alaskan Native
- ☐ Laotian
- ☐ Native Hawaiian
- ☐ Middle Eastern
- ☐ Other Pacific Islander
- ☐ Korean
- ☐ Cambodian
- ☐ Other Asian
- ☐ Black / African American
- ☐ Asian Indian
- ☐ Filipino
- ☐ Chinese
- ☐ Guamanian / Chamorro
- ☐ White
- ☐ Japanese
- ☐ Other

SPANISH/HISPANIC ORIGIN:

- ☐ **Yes, Mexican**
- ☐ **Yes, Puerto Rican**
- ☐ **No, Not of Hispanic Origin**
- ☐ **Yes, Cuban**
- ☐ **Yes, Origin Unknown**
- ☐ **Unknown**
- ☐ **Yes, Other Specific Hispanic**

RESIDENTIAL ARRANGEMENTS:

- ☐ **Independent Living (Adult)**
- ☐ **Private Residence (Adult)**
- ☐ **Dependent Living (Adult)**
- ☐ **Private Residence (Child)**
- ☐ **Residential Care**
- ☐ **Foster Home/Foster Care**
- ☐ **Homeless**
- ☐ **Jail / Correctional Facility**
- ☐ **Crisis Residence**
- ☐ **Other Residential Status**
- ☐ **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:** _____

I further understand that de-identified information during the treatment process may be collected and provided to state and federal entities 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 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.

Outpatient Services No-Show and Cancellation Policy

Please check off each box:

We want you to be successful in your treatment including your personal responsibility for self-care. To that end, we find that clients who fail to keep their scheduled appointments on a consistent basis are less likely to benefit from our services. Also when clients fail to keep appointments, or fail to cancel them on a timely basis by providing at least 24 hours advance notice, we are unable to schedule other clients into those unused appointment times. For those reasons, we have implemented the following policy with respect to clients who fail to keep appointments.

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:

☐ **If not Medicaid eligible, I may be billed for failure to show without notification where a reasonable explanation is not provided.**

☐ **I may be discharged from services if I fail to keep two (2) scheduled appointments in a row (this includes individual therapy, group and psychiatric appointments).**

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.**

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 requires compliance with the following rules and regulations. Violation of any of these rules may result in your being dismissed from the program.
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 fulfill their agreed upon financial obligations with Comprehensive Healthcare.
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**