enterhealth outpatient
CENTER OF EXCELLENCE

A BETTER WAY to recover.

Dr. Harold C. Urschel, III, MD, MMA
Dr. Irina Gromov, MD, PhD
Dr. Susana E. Mendez, DOM, MSOM, ABMPP, LCDC, CAS
Dr. Joshua Masino, PsyD
Dr. Judith L. Campbell, PhD, BSN, RN, CARN
Debra Lewis, MS, LPC

Welcome! We understand that addiction is a chronic medical illness — no different from other chronic illnesses such as diabetes or asthma. Our medical practice specializes in addiction psychiatry and therapy. Therefore, we can offer support and help to you in understanding and fighting this disease through treatment, without disruption to your everyday life. We offer several different personalized treatment plans based upon your needs and requirements.

An appointment has been scheduled for you at our office on:

Date:_____Time:_____Provider:_____

At the outset of our relationship, we will need to perform a thorough psychiatric history and evaluation with you in order to best assess our ability to help you in your current situation. Consequently, we ask that you complete our patient registration packet ***prior to your appointment***. This will allow us to spend less time "taking your history" and more time strategizing with you about how best to treat your current needs(s). If you are not able to complete all components of this packet prior to your arrival, we may not be able to complete your assessment in the first visit. Consequently, we will require a second visit in order to complete the evaluation and treatment plan best suited to your needs.

We take our responsibility to help you seriously. Your first visit with us will be a consultation. At that time, we will determine if a mutual, on-going relationship would be acceptable.

We sincerely look forward to the privilege of helping you.

Best regards,

Sarah Saunders
Practice Administrator

General Practice Information and Policies

Our Location: 8222 Douglas Avenue, Suite 375, Dallas, Texas (One Preston Centre Building). Parking is available on each side of the building or in the parking garage located behind the building. Reserved parking is available for you on the 3rd floor, numbers 113, 114, 115, 116, and 118.

New Patient: Your first appointment will consist of a full psychiatric assessment; the consultation fee is $500.

Medical Information: Please complete the attached patient assessment completely. If you have medical records or laboratory results, please bring them with you. Laboratory results older than six months are not viable. We will order laboratory testing to ensure we have the most up to date information available.

Current Medication(s): Please bring the medications you are currently taking with you.

Medical Insurance: We are an out of network provider. You are responsible for payment of services from Enterhealth Outpatient Services. You can request copies of your superbills that you can submit to your insurance carrier for reimbursement. However their reimbursement may not cover all services. Regardless of insurance, payment remains your responsibility.

Appointment Cancellations: Our office sees patients by appointment only. If you are unable to keep your appointment, please notify us at 214.905.5090 as soon as possible, so we are able to offer your appointment time to another patient.

Late Appointment: Please be on time for your appointment. **If you arrive more than ten (10) minutes late to an appointment we will not be able to see you.** The appointment will have to be rescheduled and you will be charged a late cancellation fee of $150.

Office Management: You can reach Sarah Saunders, our Practice Director, at 214.905.5090.

Appointments:

- Our office opens at 8:00 am, Monday through Friday, except for holidays, which will be posted in advance.
- Our office closes from 12:00 noon to 1:00 PM for lunch.
- Our office closes at 5:00 pm unless other appointment arrangements have been made between our providers and patients.
- Patient appointments are scheduled by calling the office during regular office hours.

Appointment Reminders: The day prior to your appointment, we will notify you via telephone (unless you indicate you prefer e-mail contact) of the date, time and co-pay amount of your next visit. However, if we cannot reach you, it is your responsibility to keep your appointment.

Patient Information: It is **your responsibility** to advise our office of any change(s) to your address, telephone number(s), or other pertinent patient information.

Notice of Privacy Practices: Upon registration at Enterhealth Outpatient Services, you will be asked to sign and you will receive a copy of our Notice of Privacy Practices. This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. We

take the privacy of your information very seriously. This notice of Privacy Practices is effective beginning April 14, 2003. If you have any questions, please contact our office at 214.905.5090.

Prescriptions and Prescription Refills:

- Prescriptions provided by our providers will be given to you on the date of service. Any requests for prescription refills must be faxed to our office (214.905.1998) by your drugstore. Prescription refills will be handled within one business day of receipt.
- **Requests for prescription refills will not be authorized during the weekend** – only Monday through Friday during normal business hours.

Emergency (Critical) Situations:

- If a situation poses immediate risk to health and life, call 911 and/or go to the nearest Emergency Room immediately.
- After normal business hours, you may call our general number at 214.905.5090 or our answering service at 972.943.4426.
- You may call the Practice Director Sarah Saunders, at all times at 214.905.5090.

Financial Policy:

- Payment is due at time of service by cash, check, Visa, MasterCard or Discover.
- A copy of your credit card will be made and kept in your file.
- NSF checks returned by your bank will be collected in cash only, and a fee of $35 will be charged to you.

Patient Cancellations and Failure to Arrive for a Scheduled Appointment: A late cancellation fee of $150 will be charged for any appointment **not cancelled or rescheduled 24 hours in advance**. A fee of $190 will be charged for an appointment that has been made and **not kept (no-show)**. Please call 214.905.5090 to avoid being charged for a late cancellation or a no-show appointment.

Additional Services:

- *Medical records* provided to the patient or entities other than medical providers, when approved by the patient. In this case, there is a fee of $35 for the first five pages and $1.00 per page thereafter, per record provision. Additional fees may be assessed for extensive records.
- A fee of $25 will be charged to the patient for preparation *of special letters or short documents* provided to entities other than medical providers.
- *Consultations provided by the physician or nurse practitioner to third parties* as requested or agreed to by the patient. A fee of $250 will be charged based on the time involved in the consultation.
- *Medical report provision or completion of forms for entities other than medical providers.* All medical reports and/or forms are completed at a cost of $35. Additional fees may apply, depending on the complexity of the documentation. Any additional costs will be discussed with the patient prior to completion of these records.
- *Payment for legal services* provided on behalf of the clinician due to actions of the patient or the patient's family, which requires legal intervention to protect the patient's records will be charged to the patient at a rate of $250 per hour.

PATIENT REGISTRATION INFORMATION

DATE: _____ NAME: _____ AGE: _____ SEX: _____

BIRTHDATE: _____ ADDRESS: _____

CITY: _____ STATE: _____ ZIP CODE: _____

E-MAIL ADDRESS: _____

HOME PHONE: _____ WORK PHONE: _____

CELL PHONE: _____ SOCIAL SECURITY # _____ DRIVER'S LIC. # _____

SINGLE: ____ MARRIED: ____ DIVORCED: ____ WIDOWED: ____ OCCUPATION: _____

REFERRAL SOURCE: _____

****

NAME OF SPOUSE OR NEXT OF KIN: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP CODE: _____
(If different from patient)

HOME PHONE: _____ WORK PHONE: _____ CELL PHONE: _____

EMPLOYED: YES or NO EMPLOYER: _____

ADDRESS: _____ CITY: _____ STATE: ____ ZIP CODE: _____

****

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

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CONSENT FOR TREATMENT

I, _____, agree to admit and participate in the program at Enterhealth Outpatient Services , Center of Excellence. I have been oriented by the staff as well as informed regarding the purpose of the program. The following areas have been discussed with me and I acknowledge full understanding and acceptance:

(1) the specific condition to be treated;
(2) the recommended course of treatment;
(3) the expected benefits of treatment;
(4) the probable health and mental health consequences of not consenting;
(5) the side effects and risks associated with the treatment;
(6) any generally accepted alternatives and whether an alternative might be appropriate;
(7) the qualifications of the staff that will provide the treatment;
(8) the name of the primary counselor;
(9) the client grievance procedure;
(10) the Client Bill of Rights as specified in §148.701 of this title;
(11) the program rules, including rules about drug screen, and gifts, as applicable;
(12) violations that can lead to disciplinary action or discharge;
(13) any consequences used to enforce program rules;
(14) the estimated daily charges, including an explanation of any services that may be billed separately to a third party or to the client, based on an evaluation of the client's financial resources;
(15) the facility's services and treatment process; and
(16) opportunities for family to be involved in treatment.

Note: This information shall be explained to the client and consenter in simple, non-technical terms. Documentation of the explanation shall be dated and signed by the client, the consenter, and the staff person providing the explanation.

Estimated Daily Charges:
The estimated daily rate for each client is based on the individualized plan of care.

Additional services outside of the estimated daily charges may include: detoxification, urgent medical evaluations/assessments, laboratory fees, nutritional any other off-site testing or therapeutic services that may be recommended by the treatment team.

Other adjunct costs may include, additional yoga/massage sessions or acupuncture sessions (group or individual).

Program services and treatment process:
Enterhealth Outpatient Services Center of Excellence program provides an evaluation of all aspects of a client's health status within the scope of the facility practice and provides treatment designed by a multidisciplinary treatment team. Problems or needs identified may be deferred temporarily or until treatment has been completed as indicated. Goals and objectives will be

identified for each problem and progress towards those goals reviewed periodically. The client will be involved in this process. Continuing Life Care planning will be initiated upon admission and assessed continuously and provided upon discharge. Outside providers will be involved in the treatment process if recommended by the treatment team and with the client's consent. Individual therapy, group therapy, experiential therapy, medication therapy and management, and other modalities of treatment will be employed in the treatment process as indicated.

Family Involvement:
Family involvement is encouraged and offered to all clients' family members with the consent of the client. Individual family therapy and multi family therapy will be offered to all families during the clients' Treatment. Family members are encouraged to attend support group as appropriate

I have been given an explanation of the information in a manner that I understand clearly. I have been given copies of the Grievance Procedure, Bill of Rights, and Program Rules. I give my consent for treatment at Enterhealth Outpatient Center of Excellence..

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

If necessary to provide further explanation of consent to treatment due to physical or mental condition, please note date and time completed below.

_____ _____
Client Signature Date

_____ _____
Staff Signature Date

This Consent is subject to revocation at any time by the client, except to the extent that disclosure has already been made prior to the revocation.

This consent will expire upon the discharge of the client from Enterhealth Outpatient Services, Center of Excellence.

_____ _____
Client signature Date

_____ _____
Consenter Date

_____ _____
Staff Date

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CONSENT TO URINE DRUG TEST/BREATHALYZER

I, _____, give my consent for Enterhealth Outpatient Services to randomly test me for drugs and/or alcohol at my initial consultation and during the course of my treatment. This consent is in effect as long as I am a patient at Enterhealth Outpatient Services.

Patient Signature Date

Witness Date

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CONSENT AND AUTHORIZATION TO RELEASE INFORMATION

MEDICAL RECORDS, INSURANCE, PATIENT INFORMATION, PRIMARY CARE PHYSICIAN
EMERGENCY CONTACT PERSON

I, _____, (D.O.B.) _____, SSC #: _____ - _____ - _____
hereby request and authorize the use and disclosure of health information as described below. I authorize (please check and initial all appropriate items):

Enterhealth Outpatient Services | 8222 Douglas Avenue, Suite 375 | Dallas, TX 75225

CHECK & INITIAL: ☐___ **To Release Information To** | ☐___**To Obtain Information From** | ☐___**To Exchange Information With**

_____
Name of Person or Organization — Relation to Client (Referral, Attorney, Spouse, Etc.)

_____
Street Address — City/State/Zip Code

_____
Home # Cell # Work # Fax # Email

CHECK & INITIAL: **I request that the information be released in the following method(s)**

☐___written/photocopy | ☐___verbal | ☐___ mailed | ☐___ faxed | ☐___ e-mailed | ☐___telephone/1:1 consultation

Dates of Hospitalization/Treatment: _____

CHECK & INITIAL: **Extent of information to be included**

☐___ Psychiatric Evaluation
☐___ Psychosocial History
☐___ Psychological Evaluation Reports
☐___ Notification of Discharge/Discharge Plan
☐___ Master Treatment Plan & Updates
☐___ Discharge Summary
☐___ Continuing Care Plan
☐___ HIV/AIDS/STD/Hepatitis Testing Results
☐___ Other (Specify): _____

This disclosure authorization is specifically intended to include any references to diagnosis, testing, and/or treatment for communicable diseases, including sexually transmitted diseases (e.g. – HIV/AIDS-related illness), mental health services, and drug and/or alcohol services governed by 42 CFR Part 2.

CHECK & INITIAL: **Reason for release of information**

☐___ Continuity of Care | ☐___ Legal | ☐___ Other (Specify): _____

This is a voluntary authorization and, under most circumstances, medical care is not conditional on signing of the authorization. Records will not be released unless this authorization form is signed and dated. I understand that I may revoke this consent at any time by giving written notice to the Medical Records Department of the Facility listed above. If revoked, the revocation will not apply to information previously disclosed under the consent. Information used or disclosed can no longer be protected by the privacy practices of this facility, and may be subject to re-disclosure. I further understand that the above consent will automatically expire **one year** from discharge. I agree to waive all claims against the facility for the release of the information defined above.

Attention recipient: This information has been disclosed to you from the records of a person whose confidentiality is protected by Federal Law. Federal Regulation (42 CFR Part 2) prohibits you from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by such regulations. A general authorization for the release of the medical or other information is not sufficient for this purpose.

_____
Client — Date

_____
Client Representative — Date

_____
Enterhealth Staff / Witness — Date

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Debra Lewis, MS, LPC

NOTICE OF PRIVACY PRACTICES

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. This notice of privacy practices is effective on April 14, 2003. Please review it carefully.

This notice describes how your protected health information may be used and disclosed, your rights with regard to your protected health information, and our duties to protect such information.

I. USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

How we may use and disclose your protected health information.

Without Your Authorization:

Treatment, payment, and operations information. We may disclose protected health information to covered entities and business associates regarding treatment, payments, and our operations. We may provide health services to you in an emergency, and where there are substantial barriers to communicating with you when we believe you intended for us to treat you. Here are some examples of how we might have to use or disclose your protected health information:

1. We may have to disclose your protected health information to another health care provider, or a hospital, etc., if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health condition.
2. We may have to disclose your examination and treatment records and your billing records to another party (i.e. your insurance company), if they are potentially responsible for the payment of your services.
3. We may need to use any protected health information in your file for quality control purposes or any other administrative purposes to run our practice.
4. We may need to use your name, address, phone number, and your clinical records to contact you to provide appointment reminders, protected health information about treatment alternatives, or other health related information that may be of interest to you (i.e. test results). If you are not at home to receive an appointment reminder, a message may be left on your answering machine and/or mailed.

Individuals Involved in Your Care or Payment or Notification. We may disclose your protected health information to your family members or friends who are involved in your care or who assist you in paying for your care. If we need to notify family and/or friends of your medical condition and/or location, we may also disclose your protected health information. This notification may be via a disaster relief effort, such as the American Red Cross.

You. We may, under most circumstances, provide protected health information on your request for copying and inspection and accounting purposes. Personal Representative. We may disclose protected health information to your personal representative should you have one. If under applicable law a person has authority to act on behalf of an individual who is an adult or an emancipated minor in making decisions related to health care, we must treat such person as a personal representative. If under state law a parent, guardian, or other person acting in loco parentis has authority to act on behalf of an individual who is an un-emancipated minor in making decisions related to health care, we must treat such person as a personal representative.

Appointment Reminders. We may use and disclose your protected health information when we contact you of an upcoming appointment.

Prescriptions. We will write, fill, and send prescriptions to covered entities or business associates.

Secretary of the U.S. Department of Health and Human Services. We will provide protected health information to the Secretary in order for the Secretary to investigate issues and determine our compliance with federal privacy requirements.

Individual Referrals. We will disclose protected health information when we make individual referrals for follow up treatment.

Required by Law. We will disclose protected health information when we are required to do so by federal, state, or local law.

Public Health Activities. We may disclose protected health information for public health activities. For example, we may disclose protected health information to a public health agency to assist in an investigation of food poisoning. As another example, we may disclose protected health information to enable a public health agency to study diseases (e.g., cancer registries) or deaths of public health importance.

Health Oversight Activities. We may disclose protected health information for health oversight activities. For example, a health oversight activity may include the disclosure of protected health information in the course of an investigation of a provider's conduct to a state licensing board official.

Cadaveric Organ, Eye or Tissue Donation. We may disclose protected health information if the individual is an organ, eye or tissue donor so that we can assist entities with donations and transplants.

To Avert a Serious Threat to Health or Safety. We may use and disclose protected health information if it is necessary to avert a serious threat to the health or safety of the individual or others or to assist law enforcement authorities in identifying or apprehending an individual.

Coroners, Medical Examiners, and Funeral Directors. We may disclose protected health information to coroners, medical examiners, and funeral directors to assist them in identifying deceased persons, determining the cause of death, or other duties required for them by law.

Research. We may disclose protected health information for medical or health-related research. However, this type of disclosure, similar to some others in this category, will require that the recipient (i.e., researcher) ensure that protected health information will be protected and other requirements are met.

Abuse, Neglect, or Domestic Violence. We may report protected health information to government authorities if we have a reasonable belief that a situation involves abuse, neglect or domestic violence. We will abide by state law in making any disclosures involving abuse, neglect, or domestic violence.

Judicial and Administrative Proceedings. We may release protected health information for judicial and administrative proceedings. Such proceedings would include responses to court orders or subpoenas.

Workers' Compensation. We may disclose protected health information for the purpose of processing and adjudicating workers' compensation claims.

For Specialized Government Functions. We may disclose protected health information if the individual is a member of the military as required by military authorities. This would also include releases for foreign military personnel. Additionally, we may disclose protected health information to federal officials for national security reasons as authorized by law.

Law Enforcement Purposes. We may disclose protected health information for law enforcement purposes if requested by a law enforcement official. For example, we may disclose protected health information if it would assist the law enforcement agent in locating a material witness to a crime.

Planning of Health Care Services. We may disclose protected health information to assist local health partnerships established by law to plan and ensure health care services. For example, we may provide protected health information to assist the partnerships in identifying common diseases in a certain community and providing treatment to improve the health of the community.

Quality and Cost of Services. We may provide protected health information to a nonprofit organization established by law for the purpose of ensuring quality services at reasonable prices. Such a disclosure may be to assist that nonprofit organization in determining the relative quality of services provided by one physician as compared to his peers.

Training of students. We may provide protected health information in training programs in which staff, students, or trainees learn under supervision to practice or improve their skills as health care providers.

Correctional Institutions. When the use and/or disclosure relates to correctional institutions and in other law enforcement custodial situations. For example, in certain circumstances, we may disclose protected health information to a correctional institution having lawful custody of the individual.

Additional Uses in Operations. We may use and disclose protected health information in conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs. In addition to the above, Section 181 of Texas SB 11 also allows use and disclosure relative to Financial institutions for the processing of payments, Non-profit organizations that pays for health care services or prescription drugs for an indigent person only if the agency's primary business is not the provision of health care or reimbursement for health care services. Employee Benefit Plans, Red Cross, and Offenders with mental impairments.

II. **ALL OTHER USES AND DISCLOSURES REQUIRE AUTHORIZATION**

We will ask for your written authorization for any use or disclosure that is not listed above. Once you sign an authorization allowing us to disclose PHI about you in a specific situation, you have the right to later revoke that authorization in writing to prevent future use and disclosure of your protected health information except for disclosures that were being processed before we received your revocation.

III. **YOUR RIGHTS**

Restriction on Release. You may request that we not use or disclose your protected health information (1) for your treatment, payment, or the administration/management of our practice, (2) in notifying family members and friends of your condition or location, and (3) to family and friends involved in your care. We will consider your request but are not legally required to accept it. If we do accept your request, we will not use or disclose your protected health information except as agreed, unless it is required in emergency situations.

Confidential Communications. You may request that we communicate with you at a different location (e.g., at work rather than home) or in an alternative manner (e.g., using a sealed envelope rather than a post card). We will try to accommodate your request provided that you specify the alternative contact or method and pay any additional costs related to such requests.

Access and Amendment. In most cases, you have the right to inspect or receive a copy of your protected health information that we use to make decisions about you. Additionally, if you believe that your protected health information in your record is incorrect or if important protected health information is missing, you have the right to request that this protected health information be corrected or amended.

Accounting. You may request a limited list of instances where we have disclosed your protected health information. The list of disclosures includes only those disclosures occurring after April 14, 2003. Further, the list will not include disclosures: (1) for treatment, payment or related administrative/management purposes; (2) to you; (3) to friends/family involved in your care or payment for your care, or for notifying your family/friends in situations where you indicate that you agree to the disclosure; (4) under certain circumstances for national security or intelligence purposes; and (5) to correctional institutions or law enforcement officials having lawful custody of an inmate or protected health information about an inmate or individual, under certain conditions. Disclosures to health oversight agencies or law enforcement officials may be temporarily suspended if such disclosures delay the activities of the agency or official.

IV. OUR DUTIES

We are required by law to maintain the privacy of your protected health information and to provide you with notice of our legal duties and privacy practices with respect to your protected health information. We must abide by the terms of the notice currently in effect.

We may apply a change in a privacy practice that is described in the notice to protected health information at any time. We reserve the right to change the terms of this notice and to make the new notice provisions effective for protected health information that we maintain. We will provide you with a revised notice upon request. Prior to making a material change in our privacy policies, uses and disclosures, or our legal duties, we will change our notice and post the new notice The Privacy Notice will be posted in the waiting area. The Privacy Notice text will also be provided on our web site in a prominent location. You can also request a copy of our notice at any time by contacting us.

V. COMPLAINTS

If you feel that your privacy rights have been violated, you may inform us by contacting us. You may send a written complaint to the Secretary of the Department of Health and Human Services. We will not punish or retaliate against you for filing any complaint.

VI. CONTACT US

If you have any questions, please call our Practice Director at 214-905-5090.

I have read and have received a copy of the Notice of Privacy Practice from the Enterhealth Outpatient Center of Excellence.

PATIENT SIGNATURE: _____ DATE: _____

WITNESS SIGNATURE: _____ DATE: _____

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Patient Bill of Rights

1. You have all the rights of a citizen of the State of Texas and the United States of America, including the right of "habeas corpus (this means you have the right to ask the court if it is legal, based on the procedures of your court commitment, for you to be kept in the hospital), property rights, guardianship rights, family rights, religious freedom, the right to register and vote, the right to sue and be sued, the right to sign contracts, and all the rights relating to licenses, permits, privileges, and benefits under the law.
2. You have the right to be presumed mentally competent unless a court ruled otherwise.
3. You have the right to be treated without discrimination due to your race, religions, sex, ethnicity, nationality, age, sexual orientation, or disability. If you believe you have been discriminated against for any of the reasons listed about, you may contact the Texas Health and Human Services Civil Rights office at 1-888-388-6332.
4. You have the right to be treated in a clean and humane environment in which you are protected from harm, have privacy with regard to personal needs, and treated with respect and dignity.
5. You have the right to appropriate treatment in the least restrictive, appropriate setting available that provides protection for you and the community.
6. You have the right to be free from mistreatment, abuse, neglect, and exploitation. If you believe you have been abused, neglected, or exploited, you should contact DFPS at 1-800-647-7418.
7. You have the right to protection of your personal property from theft or loss.
8. You have the right to be told in advance of all estimated charges being made, the cost of services provided, sources of the program's reimbursement, and any limitations of length of services. You should be given a detailed bill of services upon request, the name of an individual to contact for any billing questions, and information about billing arrangements and available information about billing arrangements and available options if the insurance benefits are exhausted or denied. You may not be denied services due to an inability to pay for them.
9. You have the right to fair compensation performed in accordance to the Fair Labor Standards Act.
10. When you are admitted to an inpatient or outpatient program, you have the right to be informed of all rules and regulations related to those programs.
11. You have the right to review the information contained in your medical record. If your health care provider says you shouldn't see parts of your record, you have the right to have the decision reviewed. The right to review your records extends to your parent or conservator if you are a minor (unless you have3 admitted yourself to services) and to your legal guardian.
12. You have the right to have your records kept private. You also have the right to be told about the conditions under which information about you can be shared without your permission. You should also be aware that your status as a person receiving mental health services may be shared with jail personnel if you are incarcerated

13. You have the right to be informed of the use of any media devices such as one-way vision mirrors, tape recorders, television, movies, or photographs.
14. Except in an emergency, medical and/or surgical procedures require your permission or the permission of your guardian or legal representative. You have the right to know the advantages and disadvantages of medical and surgical procedures.
15. You have the right to consent or withhold consent to take medication unless a court has ordered you to take them, your guardian has consented to their administration or there is an emergency situation in which you or some else might be harmed due to your behavior.
16. You have the right to consent or withhold consent to participate in research.
17. You have the right to withdraw your permission at any time in all matters for which you have previously consented. If you do not grant consent or if you withdraw your consent for any particular treatment, it will have no effect upon your eligibility for any other care and treatment.
18. You have the right to an individualized treatment plan. You have the right to take part in developing that plan, as well as the treatment plan for your care aft4er you leave the hospital or community program. Your parent/conservator (if you are a minor), or your legal guardian, has the right to participate in the development of the treatment plan. You have the right to request that any other person that you choose take part in the development of the treatment plan. You have the right to request that any person that you choose take part in the development of the treatment plan. Your request should be reasonably considered and you will be informed of the reasons for any denial Staff must document in your medical record that the parent, guardian, conservator or other person of your choice was contacted and invited to participate.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

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CREDIT CARD AUTHORIZATION

I, the undersigned, authorize this card to be used for:

X Enterhealth Outpatient Service of Excellence Payment(s)

X Other:_____

Description of Payment: _____
Card will be charged as invoiced by Enterhealth Outpatient Service of Excellence

Client Name: _____

Card Type: ❑ American Express ❑ Discover ❑ Master Card ❑ Visa

Card Number: _____

Expiration Date: _____ **Card Security Code**: _____

Card Billing Information

First Name: _____

Last Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Cardholder Phone Number: _____

Cardholder Email: _____

This credit card authorization authorizes Enterhealth Outpatient Service of Excellence charges for physician, therapist, no show fee and/or late cancellation fee and any unpaid balances owed to Enterhealth Outpatient Service of Excellence for services rendered. The undersigned hereby agrees not to contest any such amounts paid to Enterhealth Outpatient Service of Excellence.

_____ _____
Cardholder Signature Date

_____ _____
Enterhealth Staff Date

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FINANCIAL AGREEMENT

Client Name: _____ Client Account#: _____

Guarantor Name: _____ Date: _____

A. Treatment Services:

We are committed to supporting you in accomplishing your goals in treatment. You have elected to begin treatment on _____
You have a comprehensive treatment plan that makes it necessary for you to keep all of your appointments. These dates and times have been set aside specifically for you. Once you have been assigned a specific schedule, we cannot change appointments for ANY reason except to reschedule due to illness or personal emergency. Guarantor is financially responsible for any appointments that are considered late, cancel or no show.

The fee for your treatment is _____ and is due payable in full prior to the onset of treatment. Costs associated with your program are based on your individual program; **this is not a week-by-week program.** Our fees and expenses are nonrefundable.

B. Insurance:

You are solely responsible for obtaining any applicable reimbursement from your insurance provider. We will provide you a billing statement for submission to your insurance carrier. Unless other arrangements have been made, we require the account to be paid in full prior to us submitting claim support to the carrier.

C. Payment Terms

Payment is due in full upon admission.

Guarantor hereby authorizes us to utilize a credit card provided, per the executed Credit Card Authorization Form, as a form of payment related to any unpaid balances owed under this Agreement.

D. Payment Guarantee and Financial Responsibility:

I understand that payment to Enterhealth Center of Excellence is my responsibility.

I agree to keep all financial terms and agreements made between Enterhealth Center of Excellence and myself completely private and confidential. This includes payment terms and charge adjustments.

I agree, whether I have signed as guarantor or client, that in consideration of the services to be rendered to the client, I individually obligate myself to pay the expenses for all services.

Should the account be referred to an attorney for collection, I shall pay reasonable attorney's fee and collections expenses. All delinquent account bear interest at the legal rate of (18%) percent per annum.

I certify that I have read the foregoing and as the Client or his/her authorized agent or Guarantor execute the above and accept its terms.

Guarantor Signature _____ Date: _____

Guarantor Name (print) _____ Relation to Patient: _____

Guarantor Home Phone# _____ Cell# _____ Other# _____

Guarantor Address _____

Guarantor City/State/Zip _____

Email address _____

_____ _____

Enterhealth Outpatient Staff Signature Date

enterhealth outpatient CENTER OF EXCELLENCE | A BETTER WAY to recover.

Comprehensive Patient Questionnaire

Name:_____ **Date:**_____ **Date of Birth:**_____

Relationship Status: Single Married Divorced Partner Widowed

Ethnicity: Caucasian African American Hispanic Asian **Other:**_____ _____

Referred By:_____

Briefly describe what brings you to see us today:_____

_____

_____

_____

_____

How long have you had this problem?_____ Has it happened before? Yes/No

Please check the statement below that best describes the course of the problem(s) since they began:

___ The problems have stayed about the same since they started.
___ The problems have steadily worsened since they started.
___ The problems seem to come and go. At time I feel almost back to my usual self then the problems come back.
___ The problems have ups and downs but haven't gone away completely since they started.

Please check the areas below that have affected you're the problem that brought you to see us today:

_____I have legal problems

_____I have/had problems with friends

_____I have problems with family

_____I have problems with my activities

_____I have problems at work

_____I am less social

_____I have financial problems

Clinician Use Only:_____

_____

_____

_____

_____

_____

_____

_____

Please circle the phrases below that describe your problem(s):

Depressed or sad mood
Don't enjoy my activities
Difficulty falling asleep
Wake up throughout the night.
Wake up and don't go back to sleep.
I sleep _____hours per night.
Sleep more than I should.
I have been eating more.
I have been eating less.
I have no energy.
I have less energy.
I don't do things I usually do.
I can't concentrate or focus.
I feel guilty or worthless.
I have thoughts of suicide
I have less interest in sex.
I feel really happy.
People tell me I act "high."
I can get angry quickly.
I can go several days without sleep.
I am sleeping less than I usually do.
I have more energy than normal.
My thoughts go fast in my head.
People tell me I talk too fast.
People tell me I talk too much.
I am the "life of the party."
Others talk about me a lot.
I have a lot of demands on my life,
I am sensitive to what others say.
I feel guilty after sex.
My sexual activities have destroyed good relationships
Sexual fantasies are more enjoyable than sexual activity.
I go on spending sprees.
I make decisions too quickly.
I am more interested in sex.
I am tired all the time.
People tell me I worry too much.
I worry more than others worry.
I have chest pains.
I can't catch my breath.
I have panic or anxiety attacks.
I sweat when I am nervous.
My mouth gets dry quickly.
I get dizzy when I'm nervous.
I feel tingly when I'm nervous.
I have been in situations that I could have been killed /injured
I have been abused physically/ sexually.
I think about others hurting me.
I have nightmares of being in danger.
I think about being in danger for no reason.
I get worried about doing the right thing.
I worry about what others think.
I have problems relating to others.
I think about sex too much.
I am embarrassed by sex.
I use sex to avoid other activities.
I have sexual activities that are strange to others.
I worry about germs a lot.
I wash my hands a lot.
Things have to be balanced.
I worry about being perfect.
I have strange eating habits.
I eat in secret.
I eat until I throw up.
I worry about staying thin.
I always feel fat.
I use medicine to loose weight.
I was a class clown.
I failed to turn in homework.
I can't sit still.
I have unfinished projects.
I daydream a lot.
I often put things off.
I interrupt others.
I have trouble staying focused.
I am accident prone.
I hear voices others can't.
Others say I am paranoid.
I see things others don't see.
I have cut on myself.
I am fearful.
Others put ideas in my heads.
I get messages others don't.
I don't understand others emotional pain.
Sex interferes with my day.
I daydream about sex and fail to do activities.
I spend too much time on porn.
I have trouble controlling my thoughts about sex.

Clinician Use Only:_____

Current Alcohol/Drug Use:

Are you **currently** drinking or using drugs? ____Yes ____No (if no, then skip this section and move on to Social History)

Alcohol

When was the last time you drank anything containing alcohol?

_____

How many days per month do you drink? _____ How many drinks do you have in an average week? _____
What type of alcohol do you usually have? (i.e. beer, wine, liquor,)? _____

Drugs

Are you currently using any of the following?

Yes	No		If yes, when was the last time and how much at a time?
___	___	Marijuana	_____
___	___	Cocaine	_____
___	___	Crack	_____
___	___	Heroin	_____
___	___	Amphetamine	_____
___	___	LSD	_____
___	___	PCP	_____

What is your typical pattern of drug use?____ Everyday____ Most days____ Weekends____ Payday binges

Where, and with whom, do you usually use drugs?

_____

How much do you typically spend on drugs each month? $_____ Are you using drugs IV? Yes/No

Have you recently had any of the following physical withdrawal symptoms when you abruptly stopped using drugs?

_____Fever _____Craving _____Excess Sweating _____Cramping
_____Insomnia _____Restlessness _____Other (specify) _____

Have you recently had any of the following medical problems related to your drug use?

_____Chest Pain or Discomfort _____Problems with Breathing _____Weight Loss _____Seizures

Do you smoke cigarettes, or use any tobacco products? _____YES cigarettes or smokeless tobacco (Circle) _____ NO
How long have you been using tobacco products? _____How much are you using on a daily basis?_____
Are you intending to quit soon? _____YES _____ NO

Clinician Use Only:_____

Substance Abuse History

Substance Abuse Hospitalizations:

When?	Where?	Reason?	Inpatient or Outpatient?

Past Substance Abuse Medications:

Medication	Date Started	Date Stopped	Highest Dose Taken

Have you ever had any blackouts? _____? If yes, when was the last time? _____
Have you ever abused any of prescription medications? _____
What is the longest period (specify days, months or years) that you have ever had without using drugs? _____

Have you ever had any of the following physical withdrawal symptoms when you abruptly stopped using drugs?

_____Fever _____Craving _____Excess Sweating _____Cramping _____Insomnia _____Restlessness
_____Other (specify) _____

Have you ever had any of the following medical problems related to your drug use?

_____Chest Pain or Discomfort _____Problems with Breathing _____Weight Loss _____Seizures

Legal Information

Have you ever been stopped by the police for driving under the influence of alcohol or drugs? ___Yes____No

If yes, how many times have you been stopped? _____

Have you ever been charged with or convicted of a DUI/DWI, public intoxication or other substance related crime? ___Yes____No

If yes, list each time:_____

Have you ever received convictions for any crime? ___Yes____No

Have you ever spent time in jail and/or prison? ___Yes____No If yes, for how long? _____

Are you currently on probation or parole? ___Yes____No

If yes, for what convictions?_____Condition(s) of Probation_____

Please check any of the following relating to your alcohol or drug use:

_____Yes _____No I've felt alcohol or drugs were causing a problem for me
_____Yes _____No I have felt guilty about my use
_____Yes _____No Others have annoyed me by talking about or criticizing my use
_____Yes _____No I have had a desire (or made unsuccessful efforts) to cut down or control my use
_____Yes _____No I've tried unsuccessfully to control my use
_____Yes _____No I've used alcohol or drugs more often or in larger amounts than I intended
_____Yes _____No I've had to increase my use of alcohol or drugs to get the desired effect
_____Yes _____No I've had problems with withdrawal (shakes, nervousness, insomnia, etc.) when I've cut down/stopped using alcohol and/or drugs
_____Yes _____No I've been to a meeting of Alcoholics Anonymous or Narcotics Anonymous
_____Yes _____No Have you ever attended meetings on a regular basis of at least 1/week for 3 months?
_____Yes _____No Are you still attending meetings regularly?
How many meetings per week do you usually attend? _____
What was the date of your last meeting? _____
Why did you stop attending regularly? _____

Past Psychiatric Issues

Have you had a past period in which you had similar problems? ____Yes ____ No If so, when?_____

Have you ever attempted Suicide? ____Yes ____ No If yes, number of times_____ Please explain how you attempted suicide:

_____
_____
_____
_____

Past Mental Health History –Please list any previous psychiatrist, psychologist or therapist you have seen:

Name of Person Seen	Dates Seen? Month and year	Reason?	Inpatient or Outpatient?

Psychiatric Hospitalizations:

When?	Where?	Reason?	Inpatient or Outpatient?

Previous Psychiatric Medications:

Medication	Date Started	Date Stopped	Highest Dose Taken

Episodes of Aggressive Behavior

Have there been incidences when you were involved in physical/ verbal fights/threatened violence against others? ____Yes ____ No

If yes, please explain: _____

_____

Did the episode(s) result in any legal charges? ____Yes ____ No

If yes, what were the

charges?_____

_____

Medical History

Who is your family doctor or "main" doctor? _____When was your last appointment? _____
When was the last time you had lab work done?_____

Are you allergic to any of the following?

Medications:	____Yes ____ No	Which ones?_____
Foods:	____Yes ____ No	Which ones?_____
Pollens/Dust/Animal Dander:	____Yes ____ No	Which ones? _____

Current Medications:

Name of Medicine	How much and how often do you take this medicine?	Reason?	How long have you been taking this medicine?

Do you now or have you had any of the following diseases or problems?

Chicken Pox (varicella)	Yes	No	Epilepsy (fits)/Seizures	Yes	No
Mumps	Yes	No	Parasites (intestinal worms)	Yes	No
Regular Measles (7 day)	Yes	No	Rheumatic Fever	Yes	No
German Measles (3 day)	Yes	No	Diabetes	Yes	No
TB	Yes	No	Cancer	Yes	No
Syphilis	Yes	No	Asthma	Yes	No
Gonorrhea	Yes	No	Ulcer	Yes	No
High Blood Pressure	Yes	No	Glaucoma	Yes	No
Heart Trouble	Yes	No	Cataract	Yes	No
Back Problems	Yes	No	Gallstones	Yes	No
Broken Bones or			Chronic Pain	Yes	No
Accidental Fractures	Yes	No	Lung Problems	Yes	No
Thyroid	Yes	No	Other _____		

Have you had any of the following operations?

Appendix	Yes	No	Heart or Blood Vessels	Yes	No
Gall Bladder	Yes	No	Lungs	Yes	No
Stomach	Yes	No	Hernia	Yes	No
Bowel or Intestine	Yes	No	Bones or Joints	Yes	No
Hemorrhoids	Yes	No	Kidney	Yes	No
Male or Female Organs	Yes	No	Other_____	Yes	No

Women:

Date of last menstrual period _____ Method of contraception _____

Is there any possibility that you are pregnant or are you considering pregnancy? _____

Date of Last Mammogram (if over 35)_____ Date of last pap smear:_____

Family History

Have any of your blood relatives suffered from the following diseases?

High Blood Pressure	Yes	No	If yes, who?_____
Kidney Disease	Yes	No	_____
Heart Disease	Yes	No	_____
Sickle Cell	Yes	No	_____
Diabetes	Yes	No	_____
Cancer	Yes	No	_____
Overweight	Yes	No	_____
Other _____	Yes	No	_____

Family Psychiatric/Substance Abuse History Psychiatric Hospitalizations:

Relation (Father, Aunt, Brother)	Mother's Side / Father's Side	Problem	Ever Hospitalized?	Attempted Suicide?	Medications (if known)

Social History

Family Background and Childhood History:

What is your current age? _____Were you adopted? _____Where were you raised? _____

Please list any siblings and their ages):_____

What was your father's occupation? _____What was your mother's occupation? _____

Parental Background:

Did your parent's divorce? _____If so, how old were you when they divorced? _____If your parents divorced, who raised you? _____ How old were you when your father remarried? _____When your mother remarried? _____
Describe your father and your relationship with him: _____
Describe your mother and your relationship with her:_____
Describe your relationship with your brothers and sisters:_____
What things did you get into trouble for at home?_____
How was discipline handled at home? _____
How old are your parents now? Dad_____ Mom _____ How old were you when you left home? _____
Were you ever physically or sexually abused? _____ If so, at what age(s)?_____

Educational Information:

What things got you in trouble at school? _____
Did you attend college? _____ Where? _____
What was your major? _____What is your highest educational level or degree attained? _____

Occupational History:

Are you currently working? ____Yes ____No How long have you been in your present position? _____
What is your occupation?_____ Where do you work?_____
Where have you worked before and how long (summary only)?_____
Have you ever been in the military? ____Yes ____No (If no, then skip this section and move on to symptom checklist)
Branch_____ Date entered_____ Date discharged_____
Type of discharge_____ Rank at discharge_____
Did you have any psychological problems related to combat experience? ____Yes ____ No
If you have a service-connected disability, for what?_____% Disability_____

Marital History:

If married, what is your spouse/partner's occupation?_____ Where employed?_____
Describe your relationship with your spouse or significant other:_____
_____
Have you had any prior marriages?_____ If so, how many?_____ For how long?_____
Do you have any children? _____ Ages_____
List everyone who currently lives at home:_____
Do you attend church?_____ Where?_____ How often? _____

Do you have any other problems or information that you feel would help us care for you?_____
_____
_____
_____
_____
_____
_____
_____

++++++++++++++++++++++++++++++++++ **For Physician/NP only** ++

Mental Status Exam:

Orientation: (_____)

Appearance: Appropriate Disheveled Poor Hygiene Other:_____

Affect: Flat Labile Restricted Inappropriate Full range

Eye Contact: Good Fair Poor

Mood: Depressed Anxious Guarded Indifferent Aloof Agitated Euphoric

Psychomotor Activity: Retarded Normal Exaggerated

Conversation: Underproductive Over productive
Circumstantial Normal
Loud Pressured
Goal Directed Tangential Ideas of Reference

Thought Content:

Hallucinations: Auditory Visual Tactile Gustatory

Delusions: Paranoid Grandeur Persecution

Insight: Good Fair Poor

Judgment: Good Fair Poor

Intelligence: Below Average Normal Above Average

Calculations: Serial 7's/3's normal

Memory:*Short Term*, Normal or Impaired

Lo*ng Term*, Normal or Impaired

Fund of Knowledge: Normal Impaired

Abstractions: normal/concrete

Suicide Ideation: ____Yes ____No

Plan: ____Yes ____ No

Intent:____Yes ____ No

Safety Plan:_____

Clinician Use Only:_____

Preliminary Problem List:

Psychiatric: _____

Substance Abuse: _____

_____

Medical: _____

_____

Family: _____

_____

Occupational: _____

Legal: _____

Preliminary Diagnosis (Axis I-V):

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V: _____

Initial Treatment Plan:

Medications: _____

_____

Labs: _____

Referred to PCP for HIV/Hepatitis B and C/PPD/Sexually Transmitted Disease Work-up/Other: _____

Individual and/or Group Psychotherapy: _____

Referrals: _____

Return to office: _____ **M.D./N.P.** _____