WVU Medicine: University Healthcare Physicians
Behavioral Medicine and Psychiatry
2004 Professional Court
Martinsburg, WV 25401
Phone: (304) 596-5780 Fax: (304) 596-5781

INFORMED CONSENT AND PATIENT SERVICES AGREEMENT

This document (referred to as "the Agreement") contains important information about our professional services and business policies. It also contains summary information about the Health Insurances Portability and Accountability Act (HIPPA), which is a federal law that provides privacy protections and patient rights regarding the use and disclosure of your Protected Health Information (PHI) used for the purpose of treatment, payment, and healthcare procedures. HIPAA requires that I provide you with a Notice of Privacy Practices ("the Notice") for use and disclosure of PHI for treatment, payment and healthcare operations. The Notice, which is a part of this Agreement, explains HIPAA and its application to your PHI in greater detail.

This is a legal document; please read it carefully before signing. If you have any questions about this document and/or would like a copy, please ask your provider or a staff member. You may revoke this Agreement in writing at any time. That revocation will be binding on me unless I have already taken action in reliance on it; if there are obligations imposed on me by your health insurer to process or substantiate claims made under your policy; or if you have not satisfied any financial obligations you have incurred.

West Virginia Patient Rights

You are entitled by law to receive information about methods of assessment and treatment the nature of any clinical techniques used, the duration of planned care (if known), and about your doctor's fee schedule. You may always seek a second opinion and may terminate any elective treatment with any practitioner at any time. Sexual intimacy is never appropriate in a relationship with any health care provider and should be reported to the provider's respective licensing board. Your communications with our providers are confidential; although, you should be aware of the exceptions to this rule under certain circumstances (listed elsewhere in this document).

The practice of mental health services in West Virginia is regulated by the West Virginia Board of Examiners of Psychologists. Any questions, concerns, or complaints regarding the practice of mental health services may be directed to the Board by mail at P.O. Box 3955, Charleston, WV 25339-3955 or by phone at (304) 558-3040.

The Nature of Psychological Consultations/Psychotherapy

There may be both risks and benefits associated with psychotherapy. Psychotherapy may improve your ability to relate to others, provide a better understanding of yourself, assist in diagnosis and treating mental health issues and/or coping with medical issues, and help you cope with stressors in my life. Although psychotherapy can be beneficial, it may not be helpful for everyone. Notably, the process of therapy can be emotional taxing and patients may experience uncomfortable feelings or unpleasant memories. For example, when engaging in psychotherapy, there is risk you will experience varying levels of sadness, guilty, anxiety, anger, frustration, loneliness, helplessness, or other distressing feelings. Further, patients may recall unpleasant memories. These feelings or memories may emerge during or after a therapy session and could bother you while engaging in other activities (e.g. work, school, etc.). Most of these risks are common and to be expected when people are making changes in their lives. While therapy has been proven to be effective for many patients, there is a risk that therapy may not work well for you.

The Nature of Psychological/Neuropsychological Assessment

There may also be both risks and benefits associated with psychological/neuropsychological assessment. The process may help you and your treatment team have a clearer understanding of the psychological, personality, and behavioral factors at work in your emotional, cognitive, and physical functioning at a given moment in time. Depending on the case, assessment may include an interview and various paper-and-pencil tests or computerized tests. The goals may include helping to better inform your care team when considering various surgical procedures, treatment plans/options, and/or psychotherapy or psychiatric treatment.

Such evaluations typically take a number of hours and may be scheduled over more than one session or day. After your provider has had time to analyze the data, there will be a meeting to discuss the results, impressions, and recommendations for treatment and follow-up, as indicated. Your provider will also send a formal report to the physician or other health care provider who referred you for the evaluation. Psychological/neuropsychological assessment requires your cooperation and full effort to obtain accurate results. While the assessment process is designed to be helpful, it may also be emotionally challenging and may, at times, cause distress.

Confidentiality

Our providers maintain confidentiality in accordance with the ethical guidelines and legal requirements of their profession. Effective treatment sometimes requires that staff members share confidential information with other staff members within WVU Medicine. The most common cases, in which my confidentiality is not protected, include:

1. When doing so is necessary to protect patients or someone else from imminent physical and/or life-threatening harm.
2. When a patient is "gravely disabled," meaning that he or she lacks the capacity or refuses to care for him/herself and such lack of self-care presents substantial threat to his/her well-being.
3. When the abuse, neglect, or exploitation of a child, elder adult, or dependent adult is suspected.
4. When a patient pursues ethical, civil, or criminal action against WVU Medicine or its staff.
5. When a patient is involved in a legal proceeding and there is a court order for the release of records or when a release is otherwise required by law.

More About Confidentiality

There are two primary situations in which part of your case may be discussed with another medical provider. First, when your provider is unavailable or away from the office for a few days, another psychologist may be available in times of emergencies. Therefore, he or she needs to know about you. Generally, this provider will only what he or she would need to know for an emergency. Of course, this provider is bound by the same laws and rules to protect your confidentiality. Second, your behavioral health notes are available for view to our medical team and other professionals within the WVU Medicine, University Healthcare Physicians, and Epic/Integrated Providers systems. This provides the opportunity for high-quality treatment and comprehensive care. These people are also required to keep patient information private. If you wish for something to not be in your behavioral health note, please let your provider know.

Minors and Parents

Patients under 18 years of age (who are not emancipated) and their parents/guardians should be aware that the law may allow parents/guardians to examine the child's treatment records, unless the psychologist decides that such access is likely to injure the child. Because privacy in psychotherapy is often crucial to successful progress, it is sometimes a provider's policy to request an agreement from parents that they consent to let their child have his/her own confidentiality, because this is best for treatment progress. Of course, the parents would be notified immediately in the case of any danger presented to the child or others.

Emergency

If you are experiencing a psychological emergency that is life threatening, call 911 or go to my nearest emergency room.

Agreement

I certify that I have read, understand, and agree to abide by the information outlines above regarding my utilization of UHP Behavioral Medicine and Psychiatry services and about my patient rights. I acknowledge that I have received and reviewed the HIPPA agreement. I have had the opportunity to discuss any questions regarding the above information and have had my questions, if any, completely answered. I hereby give my consent to authorize UHP Behavioral Medicine and Psychiatry to evaluate, treat, and/or refer me to others, as needed. I agree to act according to the points covered in the agreement. I, the patient (or his or her parent or guardian), understand I have the right not to sign this form and can withdraw consent at any time. I understand I can choose to discuss my concerns with you, the provider, before I start (or the patient starts) treatment. I hereby agree to enter into treatment with this provider (or to have the patient enter treatment), and to cooperate fully and to the best of my ability, as shown by my signature here.

_____ _____

Signature of Patient (or person acting for patient) Date

_____

Printed Name of Patient

Relationship to Patient: □ Self □ Custodial Parent □ Guardian

□ Other person authorized to act on behalf of the patient: _____

_____ _____

Signature of Provider Date

□ Copy requested by patient □ Copy kept by office

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OFFICE POLICIES

1. Required for All Appointments - At each visit you must bring your current insurance card, photo identification, and a method of payment. We accept cash, check, credit/debit cards. Failure to provide your insurance card with co-pay or payment in full (if no insurance) may result in your appointment being rescheduled. Additionally, please notify our staff of any address or insurance changes before your appointment.
2. Payment for Services - Payment for services rendered is required at the time of the visit.
3. Insurance - We have made prior arrangements with many insurers and health plans. We will bill those plans with which we have an agreement and will collect any required co-payment at the time of service. **In the event your health plan determines a service to be "NOT COVERED," you will be responsible for the complete charge**. In that event, we will bill you and payment is due upon receipt of that statement.
    a. Medicare - We will bill Medicare for you. We do accept Medicare assignment; however, the patient is responsible for the yearly DEDUCTIBLE plus the 20% Medicare doesn't pay if you do not have a secondary insurance.
4. Emergencies - **Our office does not provide "emergency services."** If the patient during the course of his/her treatment has an urgent concern, an appointment will be scheduled as soon as possible. If the patient has a critical emergency, we recommend that patients present to their nearest emergency department or call 911.
    a. After Hour Calls - The office has an answering service that you may leave a message with after office hours. They will page the provider, if indicated. The provider will then provide recommendations through the answering service.
5. Cancellation Policy - Please notify our office **24 hours in advance** if an appointment will be missed to avoid being charged for the time that was reserved for you. **Failure to show up for two appointments without notification or repeated late cancellations are grounds for termination of services and referral.**
6. Prescription refill - Please contact your pharmacist to request maintenance medication refills. If you do not have additional refills authorized, the pharmacy will need to fax a refill request to our office for approval. **Call your pharmacist at least five (5) business days ahead** of the need for a refill. Before we approve a refill request we will need to look at your chart, verify the proper dosage, check for the appropriate response to the drug, and see if any lab test is needed prior to filling your medication. If you have a prescription that has to be hand written, please call the office and make the request. There will be no refills approved on weekends or holidays.
    a. Controlled medications - **Physicians will not re-write any controlled medications before it is time for them to be filled again.** It is your responsibility to maintain safeguard of your prescriptions once you leave the office. We will not make any exceptions.
7. Documents/Forms to be filled out - Please allow at least **ten (10) days** for any documents/forms, etc. to be completed by the provider. If an address or fax number is provided to us as to where it needs sent, we will mail or fax the forms for you. Otherwise, we will call you when they are finished and ready to be picked up.

Patient Agreement

I have read the office policies and agree to abide by them. I, the undersigned, hereby authorize examination and any other medical services deemed necessary by the healthcare providers of WVU Medicine: University Healthcare Physicians Department of Behavioral Medicine and Psychiatry. I authorize my healthcare providers to release to my insurance company information concerning healthcare, advice, treatment, or supplies provided to me. I, the undersigned, authorize payment of medical benefits for services rendered to me. I understand that I am financially responsible for any amount not covered by my insurance contract. I authorize release of information acquired in the course of my examination and treatment to any other healthcare provider(s) involved in my care.

Medicare Authorization

I, the undersigned, authorize the healthcare provider to release to the Social Security Administration and Health Care Financing Administration or its intermediaries or carrier any information needed to determine benefits payable for related services. I authorize the same information to be sent to my secondary insurance carrier. I authorize the payment of Medicare benefits to UHP Behavioral Medicine and Psychiatry for any services furnished to me.

Signature of patient or legal guardian: _____**Date:** _____

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PATIENT INFORMATION

Patient Name: _____
Last First Middle

Prior Last Names: _____

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____

Sex: □ M □ F □ T Marital Status: □ Single □ Married □ Divorced □ Widow/er □ Separated □ Other: _____
Sexual Orientation: □ Heterosexual □ Homosexual □ Bisexual □ Asexual □ Questioning □ Other: _____
Race: □ African American □ Asian □ Caucasian □ Hispanic □ Native American □ Other: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email Address: _____ (Permission to Leave Message: □ Yes □ No)

Phone: Home: _____ (Permission to Leave Message: □ Yes □ No)
Cell: _____ (Permission to Leave Message: □ Yes □ No)
Other: _____ (Permission to Leave Message: □ Yes □ No)

Preferred Method of Contact/Number: _____ (Permission to Leave Message: □ Yes □ No)

Guarantor Information: (Person responsible for the payment. Parent /Guardian if under age 18)

Guarantor Name: _____
Last First Middle
Guarantor relationship to patient: _____

Social Security Number: _____-_____-_____ Date of Birth: _____/_____/_____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell / Other: _____

Insurance Information:

Name of Primary Insurance: _____ Policy ID Number: _____

Subscriber Name: _____ Subscriber Social Security #_____-_____-_____

Subscriber relationship to patient: _____ Subscriber Date of Birth: _____/_____/_____

Insurance Address: _____

Group Number: _____ Subscriber Employer / Group Name: _____

Insurance Effective Date: _____/_____/_____ Subscriber work status: □ Full Time □ Part Time □ Retired

Secondary Insurance Information: (Please fill out secondary insurance if applicable)

Name of Secondary Insurance: _____ Policy ID Number: _____

Subscriber Name: _____ Subscriber Social Security #_____-_____-_____

Subscriber relationship to patient: _____ Subscriber Date of Birth: _____/_____/_____

Insurance Address: _____

Group Number: _____ Subscriber Employer / Group Name: _____

Insurance Effective Date: _____/_____/_____ Subscriber work status: □ Full Time □ Part Time □ Retired

Emergency Contact Information:

Person to notify / Next of kin: _____

Last First Middle

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Cell / Other: _____

Relationship to Patient: _____

Protected Health Information Permission: (Optional)

I, _____, give WVU Medicine: University Healthcare Physicians: Behavioral Medicine and Psychiatry permission to disclose future appointments and protected health information with the person(s) listed below:

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Name: _____ Phone Number: _____

Patient Signature: _____ Date: _____

Patient Employer Information:

Work Status: □ Full Time □ Part Time □ Retired □ Unemployed □ Full Time Student □ Part Time Student

Employer Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Department: _____

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PATIENT HISTORY FORM

Patient's Name: _____ Todays Date: _____

Date of Birth: _____

Main reason for today's visit: _____

_____

Current Symptoms Checklist:

( ) Depressed Mood	( ) Racing thoughts	( ) Excessive worry	( ) Anxiety Attacks
( ) Unable to enjoy activities	( ) Impulsivity	( ) Sleep pattern disturbance	( ) Avoidance
( ) Increase in risky behavior	( ) Hallucinations	( ) Loss of Interest	( ) Increased libido
( ) Concentration/forgetfulness	( ) Decreased need for sleep	( ) Suspiciousness	( ) Change in appetite
( ) Excessive guilt	( ) Excessive Energy	( ) Fatigue	( ) Increased irritability
( ) Decreased libido	( ) Crying spells	( ) Other_____	

Past Mental Health History:

Outpatient treatment ( ) Yes ( ) No If yes, please describe when, by whom and nature of treatment.

Reason Dates Where

_____

_____

_____

Psychiatric Hospitalization: ( ) Yes ( ) No If yes, please describe for what reason, when and where.

Reason Date Where

_____

_____

_____

Developmental History:

Where there any complications with your mother's pregnancy or with your birth, or were you born prematurely?
( ) Yes ( ) No ( ) Unsure

Did you experience any difficulty learning to walk, talk, read, write or reach any other developmental milestone(s)?
( ) Yes ( ) No ( ) Unsure

Was there any type of child abuse in your family?
( ) Yes ( ) No ( ) Unsure

How many siblings do you have? _____

How would you describe your childhood?

_____

_____

Educational History

Were you ever formally tested for and/or diagnosed with a learning disability? ( ) Yes ( ) No ( ) Unsure
If "yes", please explain: _____

How many years of education have you completed? _____

Social History

Have you ever experienced a traumatic event like being robbed, assaulted, raped or having been in combat? ( ) Yes ( ) No ( ) Unsure

If "yes", please explain: _____

Are you involved in any lawsuit or legal matter with whom you want the doctor's help by sending reports, evaluations, etc. to an attorney or to the court? ( ) Yes ( ) No

If "yes", please explain: _____

Have you ever had legal problems, arrests, been in jail or prison? ( ) Yes ( ) No

If "yes", please explain: _____

Please list anything else you think is important for your provider to know about your psychological or social history:

_____

_____

Medical History

Which of the following conditions are you currently being treated or have been treated for in the past? (Please Check)

General Medical:

( ) Heart disease	( ) Shortness of breath	( ) Eye disorder/Glaucoma	( ) Diabetes
( ) Atrial Fibrillation	( ) COPD/emphysema	( ) Osteoarthritis	( ) Colitis
( ) Heart Attack	( ) Thyroid Problems	( ) Ear Problems	( ) Ulcer
( ) High cholesterol	( ) Liver problems/ Hepatitis	( ) Swollen Ankles	( ) Asthma
( ) Kidney/bladder problems	( ) High blood pressure	( ) Lung problems/cough	( ) Stroke
( ) Low blood pressure	( ) Sinus problems	( ) Headaches/Migraines	( ) Seizures
( ) Heartburn (reflux)	( ) Seasonal Allergies	( ) Arthritis	
( ) Anemia or blood problems	( ) Tonsillitis	( ) Ulcers/colitis	

( ) Other_____

Neurological:

( ) Memory Problem	( ) Alzheimer's Disease	( ) Lewy Body Disease
( ) Parkinson's Disease	( ) Vascular Dementia	( ) Fronto-temporal Dementia
( ) Multiple Systems Atrophy	( ) Huntington's Disease	( ) Progressive Supranuclear Palsy
( ) ALS (Lou Gherig's Disease)	( ) Essential Tremor	( ) Dystonia
( ) Multiple Sclerosis	( ) Head or Brain Injury	( ) Epilepsy or other seizure disorder
( ) Stroke		

Cancer:

( ) Breast Cancer	( ) Prostate Cancer	( ) Lung Cancer
( ) Ovarian Cancer	( ) Brain Cancer	( ) Radiation
( ) Cervical Cancer	( ) Other (type:)	( ) Chemotherapy

Sleep:

( ) Restless Leg Syndrome	( ) Insomnia	( ) Nightmares
( ) REM Sleep Behavior Disorder	( ) Sleep Apnea	( ) Narcolepsy
( ) Periodic Limb movements		

Mind-Body, Auto-Immune and Immune-Deficiency:

( ) Lupus	( ) Irritable Bowel Syndrome	( ) Psychogenic seizure (non-epleptic seizures)
( ) Psychogenic movement disorder	( ) Other conversion disorder	( ) Chronic Fatigue Syndrome/SEID
( ) Fibromyalgia	( ) Endometriosis	( ) Rheumatoid Arthritis
( ) HIV	( ) AIDS	

Other-Gynecological:

( ) Infertility	( ) Abnormal PAP	( ) Menopause
( ) Sexually transmitted Disease	( ) Miscarriage	( ) Loss of Infant

Have you ever had a concussion, head injury, brain injury, seizures or loss of consciousness?

( ) Yes ( ) No ( ) Unsure

If "yes", please explain: _____

Have you ever undergone an evaluation of your memory, thinking or other cognitive/mental abilities before?

( ) Yes ( ) No ( ) Unsure

If "yes", where, when and with whom? _____

What was the diagnosis as you remember it? _____

Has a doctor ever told you that you should not drive? _____

Please list your surgical history:

_____

_____

_____

Please list your doctors' names and specialties:

_____

_____

_____

Family Psychiatric History: Has anyone in your family been diagnosed with or treated for:

( ) Post Traumatic Stress	( ) Alcohol abuse	( ) Depression	( ) Anger
( ) Substance Abuse	( ) Schizophrenia	( ) Bipolar disorder	( ) Violence
( ) Anxiety	( ) Suicide	( ) ADHD	( ) Other

Suicide Risk Assessment:

Have you ever had feelings or thoughts that you didn't want to live? ( ) Yes ( ) No

If NO, please skip to next page. If YES, Please answer the following:

- Do you currently feel that you do not want to live? ( ) Yes ( ) No
- How often do you have these thoughts? _____
- When was the last time you had thoughts of dying? _____
- Has anything happened recently to make you feel this way? _____
- On a scale of 1 – 10 (ten being the strongest) how strong is the desire to kill yourself currently? _____
- Would anything make it better?_____
- Have you ever thought about how you would kill yourself? _____
- Is the method you would use readily available? _____
- Have you planned a time for this? _____
- Is there anything that would stop you from killing yourself?_____
- Do you feel hopeless and/or worthless? _____
- Have you ever tried to kill or harm yourself before? _____

Substance Use:

Have you ever been treated for alcohol or drug use or abuse? ( ) Yes ( ) No

If yes, for which substance? _____

If yes, where were you treated and when? _____

How many days per week do you drink any alcohol?_____

What is the least number of drinks you will drink in a day? _____

What is the most number of drinks you will drink in a day? _____

In the past 3 months, what is the largest amount of alcoholic drinks you have consumed in one day? _____

Have you ever felt you should cut down on your drinking or drug use? ( ) Yes ( ) No

Have you ever felt bad or guilty about your drinking or drug use? ( ) Yes ( ) No

Have you ever had a drink or used drugs first thing in the morning to steady your nerves or to get rid of a hangover? ( ) Yes ( ) No

Do you think you may have a problem with alcohol or drug use? ( ) Yes ( ) No

Have you used street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones and for how long? _____

Have you abused prescription medications? ( ) Yes ( ) No

If yes, which ones and for how long? _____

Check if you have ever tried any of the following:

( ) Methamphetamine ( ) Cocaine ( ) Stimulants ( ) Heroin ( ) Hallucinogens / LSD
( ) Marijuana ( ) Ecstasy ( ) Methadone ( ) Alcohol ( ) Pain killers (not prescribed)
( ) Tranquilizer/sleeping pills ( ) Other _____

_____

_____

Tobacco History:

Have you ever smoked cigarettes? ( ) Yes ( ) No

Do you currently smoke? ( ) Yes ( ) No

If yes, how many packs per day on average? _____

How many years have you smoked? _____

In the past? ( ) Yes ( ) No

How many years did you smoke? _____

When did you quit? _____

Have you ever used smokeless tobacco (chewing tobacco)? ( ) Yes ( ) No

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ALLERGY AND MEDICATION LIST

Patient Name: _____ Date of Birth: _____

Allergies

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Current Medications: (Including Supplements, Vitamins, and Herbal Medications)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____
11. _____
12. _____
13. _____
14. _____
15. _____