WVU Medicine
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 (HIPAA), 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 your life. Although psychotherapy can be beneficial, it may not be helpful for everyone. Notably, the process of therapy can be emotionally 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, guilt, 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.

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 14 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 and is life threatening, call 911 or go to the emergency room.

## Agreement

I certify that I have read, understand, and agree to abide by the information outlines above regarding my utilization of WVU MEDICINE Behavioral Medicine and Psychiatry services and about my patient rights. I acknowledge that I have received and reviewed the HIPAA 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 WVU MEDICINE 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.

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Signature of Patient (14 and older) Printed Name of Patient Date

_____

Signature of Parent/Guardian Relationship to Patient: □ Self □ Custodial Parent □ Guardian

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

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Signature of Provider Date

□ Copy requested by patient □ Copy kept by office

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 WVU MEDICINE 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 □ Unemployed □ Full Time Student □ Part Time Student

Employer/School Name: _____

Mailing Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Department: _____

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## Child and Adolescent Psychological Assessment and Intake History

*Please fill out the following completely and to the best of your ability. If you have copies of previous evaluations or school records (e.g., IEP, 504-Plan, etc) please feel free to bring them.*

**CONFIDENTIAL**

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Today's Date: _____

Patient's Name: _____ Date of Birth: _____ Age: _____

Sex: _____ Race: _____ Ethnicity: □ Hispanic □ Non-Hispanic

Primary Address: _____

**Main reason for your visit:** _____

I would like for my child to receive the following (circle all that apply):

**INDIVIDUAL THERAPY** **PSYCHOLOGICAL TESTING** **FAMILY THERAPY** **GROUP THERAPY** **NOT SURE**

Primary Caregiver's Name: _____

Biological Mother's Name: _____ Mother's Age: _____

Mother's Occupation: _____ Length of Employment: _____

Mother's Address: _____

Telephone: (Day) _____ Permission to leave a message? □ Yes □ No

(Evenings) _____ Permission to leave a message? □ Yes □ No

Biological Father's Name: _____ Father's Age: _____

Father's Occupation: _____ Length of Employment: _____

Father's Address: _____

Telephone: (Day) _____ Permission to leave a message? □ Yes □ No

(Evenings) _____ Permission to leave a message? □ Yes □ No

Current Status of Biological Parents: □ Married (Date of Marriage _____)

□ Separated (Date of Separation _____)

□ Divorce (Date of Divorce _____)

□ Never Married (Legal Custodian: _____)

**Legal custody of children*: _____ Physical custody of children: _____**

***If there is a custody agreement, please attach documentation verifying legal custody.**

Please list information about your child's siblings (including step-siblings):

Name Age Relationship

_____

_____

_____

Please list other individuals currently living in the home:

Name Age Relationship

_____

_____

_____

Within your household/ family, with who does your child get along best? _____

Are there other relatives or adults that are important caretakers to your child (i.e. stepparent, significant other, and grandparent)? Please list:

Name Age Relationship

_____

_____

_____

Are their firearms within the home? □ Yes □ No

If yes, how are they stored? _____

Does your family feel safe in the neighborhood where you live? □ Yes □ No

If no, please explain: _____

**Current Symptoms Checklist:**

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

Other_____

**School**

Current School: _____ Date began: _____

Grade: _____ Teacher(s): _____

Does your child receive special education services? □ No □ Yes

If yes, please explain: _____

_____

Has your child ever repeated a grade? □ No □ Yes - If yes, which grade(s): _____

Has your child ever skipped a grade? □ No □ Yes - If yes, which grade(s): _____

Has your child ever failed a class? □ No □ Yes - If yes, which class (es): _____

Has your child ever been evaluated for learning problems before? □ No □ Yes

If yes, please explain: _____

Was a diagnosis made? □ No □ Yes - If yes, what diagnosis? _____

Has your child ever received accommodations, special services, or been placed in a special resource room? □ No □ Yes - If yes, what grades? _____

Please described resources: _____

Has your child ever received individual tutoring? □ No □ Yes - If yes, what grades? _____

What subjects: _____

Please describe your child's academic performance (grades) in the following subjects:

Elementary School: Math _____ Science _____ English_____

Middle School: Math _____ Science _____ English_____

High School: Math _____ Science _____ English_____

Does your child get in trouble at school because of behavior? □ No □ Yes –

If yes, describe: _____

Do you/ your child get in trouble on the bus or in after-school programs because of behavior?

□ No □ yes – If yes, describe: _____

Which adults, if any, are involved in helping with homework? _____

**Medical/Developmental History**

General Physical Health: □ Excellent □ Good □ Fair □ Poor

Hand Preference: □ Left □ Right □ Ambidextrous

Does your child wear corrective lenses (e.g. glasses or contacts)? □ No □ Yes

Does your child require a hearing aid or have any hearing impairment? □ No □ Yes

Has your child received regular check-ups, eye exams, and hearing exams? □ No □ Yes

Does your child currently take any prescription medications? □ No □ Yes

If yes, please list medication and dosage: _____

_____

Is your child currently receiving any counseling services? □ No □ Yes

If yes, where? _____

Has your child received counseling services in the past? □ No □ Yes

Is yes, when and where? _____

Describe any prenatal complications or complications in your child's birth or infancy? _____

_____

Were there any delays in your child obtaining developmental milestones (e.g., crawling, walking, talking, etc.)?

□ No □ Yes - If yes, please explain: _____

_____

**Leisure & Social History**

Is your child involved in any extracurricular and/ or community activities? □ No □ Yes

If yes, please describe: _____

Does your child have any hobbies or special interests? ? □ No □ Yes

If yes, please describe: _____

How do you/ How does your child spend free time, relax, and/ or have fun? _____

_____

What is your child good at? _____

How many close friends do you/ does your child have? □ None □ 1-2 □ 3-5 □ More than 6

Age of closest friends: □ Mostly younger □ mostly same age □ Mostly older □ Mix of ages

Where does your child spend time with friends? □ School □ Neighborhood □ Other: _____

Outside your household/ family (children and adults), with whom does your child get along best?

_____

**Family Health History**

Have any family members been diagnosed with the following:

| | |
|---|---|
| Learning Disability | □ No □ Yes - Name(s): _____ |
| ADD/ADHD | □ No □ Yes - Name(s): _____ |
| Mental Retardation | □ No □ Yes - Name(s): _____ |
| Depression | □ No □ Yes - Name(s): _____ |
| Anxiety | □ No □ Yes - Name(s): _____ |
| Psychiatric Illness | □ No □ Yes - Name(s): _____ |

Are there any medical conditions that run in your family? □ No □ Yes

If yes, please explain: _____

Is there anyone in your family who you are particularly worried about now? □ No □ Yes

If yes, please explain: _____

Have you or anyone else in your family been treatment and/or have problems with alcohol or substance abuse?

□ No □ Yes – Name(s): _____ When: _____

Diagnosis: _____

Have there been past or present concerns regarding domestic violence, physical, or sexual abuse in your family? □ No □ Yes

If yes, please explain: _____

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Has someone close to your family/ your child been victimized by violence? □ No □ Yes

If yes, please explain: _____

**Suicide Risk Assessment:**

Has your child ever had feelings or thoughts that he or she did not want to live? ( ) Yes ( ) No

**If NO, please skip to next page. If YES, Please answer the following questions with your child:**

- **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? _____
- What (if 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?_____
- What decreases the desire and helps you feel better?_____
- Have you ever thought about how you would kill yourself? If YES, what is the method? _____
- Is the method you would use readily available? _____
- Have you planned a time for killing yourself? If YES, when?_____
- What would stop you from killing yourself? _____
- Do you feel hopeless and/or worthless? _____
- Have you ever had thoughts of harming yourself even if you did not want to actually end your life? _____
- **Have you ever tried to kill or harm yourself in the past? If YES, when was the most recent time?**_____
    - **Please describe what happened**: _____

      _____

** If your child is in a crisis (suicidal) please take him/her to the Emergency Department at the nearest hospital or dial 9-1-1*

**Substance Use:**

Has your child 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? _____

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

Has your child used street drugs in the past 3 months? ( ) Yes ( ) No

If yes, which ones and for how long? _____

Has your child abused prescription medications? ( ) Yes ( ) No

If yes, which ones and for how long? _____

**Check if your child has ever tried any of the following:**

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

**Tobacco History:**

Has your child ever smoked cigarettes? ( ) Yes ( ) No

Has your child ever used smokeless tobacco (chewing tobacco)? ( ) Yes ( ) No

## 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. _____