CENTER FOR FOCUSED CARE, LLC

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Initial Evaluation Form

Today's Date:	**DOB:**
Name:	**Home Phone:**
Address:	**Cell Phone:**
	Email:
Emergency Contact Name:	**Emergency Contact phone:**

Mental Health/Behavioral Health Insurance: (If you have more than one insurance company, please include the same information below for the secondary insurance on the back of this page)

Insurance Name:	**POLICY HOLDER INFORMATION**	**ADDRESS (If different from above)**
Policy #:	Name:	
Group #:	Date of birth:	
Member #:	Social Sec#:	
Copay:	Relationship to you:	
Employer:	Self / spouse / parent / child	
Medical Assist:		Policy holder Phone:

Pharmacy Insurance Benefit: _____

What brings you to us today?:

_____

_____

_____

Primary Care Physician: _____ Phone #: _____

Pharmacy: _____ Phone#: _____

Therapist: _____ Phone#: _____

Other providers: _____

_____

Occupation/Employment: _____

Past Mental Health History: Who have you seen in the past for mental health, including hospitalizations?

Provider / Hospital	Dates	Reason/Diagnosis

Any suicide attempts in the past: _____

Medication History (Please list all current and past medications):

Drug Allergies: _____

CURRENT MEDICATIONS AND DOSE DATE	PAST MEDICATIONS AND DOSE DATE

Family Mental Health History (parents, siblings, grandparents, cousins): ☐ - denies history

☐ Depression	Whom:
☐ Anxiety	Whom:
☐ ADHD	Whom:
☐ Bipolar I	Whom:
☐ Bipolar II	Whom:
☐ Schizophrenia	Whom:
☐ Suicide	Whom:
☐ Suicide attempt	Whom:

Medical History (Please check all that apply and answer the follow-up questions) ☐ - denies history

☐ Anemia (low blood)	☐ Fibromyalgia	☐ Headaches/Migraines
☐ Arthritis	☐ Heart Attack/Disease	☐ Reflux (GERD)/Colitis/Ulcer
☐ Asthma/COPD/Emphysema	☐ High Blood Pressure	☐ Stroke
☐ Cancer	☐ High Cholesterol	☐ Thyroid Condition
☐ Chronic Pain:	☐ Kidney Disease	☐ Seizures
☐ Diabetes I ☐ Diabetes II	☐ Liver Disease	☐ Other

Family Medical History (Please check all that apply and answer the follow-up questions) ☐ **- unknown**

☐ Anemia (low blood)	☐ Fibromyalgia	☐ Headaches/Migraines
☐ Arthritis	☐ Heart Attack/Disease	☐ Reflux (GERD)/Colitis/Ulcer
☐ Asthma/COPD/Emphysema	☐ High Blood Pressure	☐ Stroke
☐ Cancer	☐ High Cholesterol	☐ Thyroid Condition
☐ Chronic Pain:	☐ Kidney Disease	☐ Seizures
☐ Diabetes I ☐ Diabetes II	☐ Liver Disease	☐ Other

Surgical history:

_____

_____

Do you still have regular periods? Yes/No N/A Date of last menstrual period: _____

Tabacco use: Yes/No Packs/day: _____ Number of years: _____

Alcohol use: Yes/No Alcohol type: _____ Drinks/week :_____ Drink intensity: _____

Illicit/Illegal drugs: Yes/No Type of drugs: _____

Legal problems: _____

Abuse History (Have you ever been treated in a way you would consider abusive?)

Type of abuse	Age at the time	Relationship to Abuser/Circumstances
Neglect		
Emotional/Verbal		
Physical		
Sexual		

Regular Exercise: Yes/No _____

Hobbies/ interests: _____

Family Structure/Living Situations: ***How would you describe the family you grew up in?:***

Close and supportive / Cold and Distant / Neglectful / Chaotic and Unpredictable / Abusive

City you were born in: _____ **Birth Order:** _____

Family Members that live with you (please include your siblings, parents, children etc.)

_____

_____

All of the above information is true and accurate to the best of my knowledge

Sign: _____ Date: _____

CENTER FOR FOCUSED CARE, LLC

PATIENT RIGHTS AND RESPONSIBILITIES

As a patient of Center for Focused Care, you have the right to:

- Be treated with dignity and respect
- Open and private communication
- Communicate concerns and complaints and have them addressed in a reasonable length of time.
- Decline participation in treatment activities that may conflict with your religious and/or cultural beliefs.
- Participate in treatment plan development.
- Request and receive information about clinical staff's professional capabilities including education, training, experience, and licensure.
- Receive information concerning fees, methods of payment, insurance reimbursement, anticipated length of treatment, and clinic policies.
- Disclose information to your discretion
- Know the limits of confidentiality and the circumstances in which clinic staff are legally required to disclose information to others.
- Request a summary of your record to include diagnosis, type of treatment, and progress in treatment.
- Have your records kept in a secure and locked area, and your electronic record protected and secured.

You have the **responsibility** to:

- Keep scheduled appointments.
- Actively participate in treatment.
- Pay any amounts as determined by your insurance company and any amounts not covered by insurance at time of service.

EMERGENCY CONSENT FORM

In case of emergency, I _____, hereby give my consent to Center for Focused Care, LLC to speak with or release information to:

1. **_____ Phone #: _____**
2. **Verbally disclose information from my client record to emergency and/or law enforcement personnel in the case of an emergency where written permission cannot be obtained.**
3. **Extend permission for emergency medical treatment to be administered should I be unable to give verbal consent at the time of such injury or illness.**

I understand that I have no obligation whatsoever to disclose any information from my client record and I understand that I may revoke this consent at any time by notifying Center for Focused Care, LLC in writing.

Patient Name:_____

Signature: _____ Date: _____

Witness: _____ Date: _____

FINANCIAL RESPONSIBILITY AGREEMENT

The providers and staff of Center for Focused Care, LLC want to provide you with the best possible care. Part of this care includes a professional agreement that you will pay for services we provide to you, as our patient. This includes copays, coinsurance and deductibles. If you are unable to pay due to a hardship or unforeseen financial circumstances, it is your responsibility to speak with the office manager to set up a payment plan or to discuss a plan of action.

Center for Focused Care, LLC is currently paneled with the following insurances:

Highmark Blue Shield	**Aetna**
UPMC	**Medicare**

You can contact any of the above listed insurance companies to find out if Center for Focused Care, LLC is under contract with your particular plan and what behavioral health services are covered under your plan. We will bill your insurance company with the information that is provided to us by you. If that insurance is not accurate or no longer valid, **you will be billed for that visit.**

We do have a self-pay rate depending on the time spent with your provider and payment is due at the time of service.
Therapy, with the licensed therapists, self-pay rate is $100 per visit, and $125 for new therapy patients.

ALL COPAYS, BALANCES AND SELF PAY RATES ARE DUE AT THE TIME OF SERVICE UNLESS YOU HAVE PREVIOUSLY CONTACTED THE OFFICE MANAGER FOR AN EXCEPTION.

PLEASE NOTE: WE ARE NOT PARTICIPATING WITH MEDICAL ASSISTANCE OR ANY MEDICAL ASSISTANCE PRODUCT. IF YOU HAVE A MEDICAL ASSISTANCE PRODUCT, IT CANNOT BE BILLED THROUGH THIS OFFICE. YOU, THE PATIENT, WILL BE RESPONSIBLE FOR ANY CHARGES, COPAYS, COINSURANCE OR DEDUCTIBLES.

***Not all self pays are accepted. This is up to the discretion of the provider.

I have read this financial responsibility agreement and agree to its contents:

_____

Patient signature Date

_____

Printed Name Relationship to person receiving services

_____

Witness Date

06102022

Financial Agreements/Contracts

I understand if I have an unpaid balance to Center for Focused Care, LLC and do not make satisfactory payment arrangements, my account may be placed with an external collection agency. I will be responsible for reimbursement of the fee of any collection agency, which may be based on a percentage at a maximum of 35% of the debt, and all costs and expenses, including reasonable collection and attorney's fees incurred during collection efforts.
In order for Center for Focused Care, LLC or their designated external collection agency to service my account, and where not prohibited by applicable law, I agree that Center for Focused Care, LLC and the designated external collection agency are authorized to (1) contact me by telephone at the telephone number (s) I am providing, including wireless telephone numbers, which could result in charges to me, (2) contact me by sending text messages (message and data rates may apply) or emails, using any email address I provide and (3) methods of contact may include using pre-recorded/artificial voice message and/or use of an automatic dialing device, as applicable. Furthermore, I consent the designated external collection agency to share personal contact and account related information with third party vendors to communicate account related information via telephone, text, e-mail, and mail notification.

_____

Patient signature Date

_____

Printed Name Relationship to person receiving services

_____

Witness Date

NO SHOW/LATE CANCELLATION POLICY

In our efforts to continue to deliver high-quality and efficient mental health care, Center for Focused Care, LLC has instituted a 'No Show/Late Cancel Policy'. This is not meant to be punitive, but to allow this office, with a limited amount of time and resources, to work with individuals who are highly committed to their treatment. We ask that our patients notify our office at least 24 hours in advance of their appointment time if unable to attend.

IF YOU FAIL TO SHOW FOR A SCHEDULED APPOINTMENT, OR IF YOU FAIL TO NOTIFY US AT LEAST 24 HOURS IN ADVANCE OF YOUR APPOINTMENT, THE FOLLOWING INTERVENTIONS WILL BE TAKEN:

1ST MISSED APPT:	**$0**	**Therapists:**	**1st MISSED APPT:**	**$0**
2ND MISSED APPT:	**$75**		**2ND MISSED APPT:**	**$30**
3RD MISSED APPT:	**$125**		**3RD MISSED APPT:**	**$60**

After the 3rd missed appointment, a referral to another provider/practice and closure of your chart may result. Exceptions to the fees are not automatic and will only be granted in cases of medical emergencies, hospitalizations or other family emergencies. Documentation of medical issues may be required.

_____

Patient signature Date

_____

Printed Name Relationship to person receiving services

_____

Witness Date

HIPAA Compliance Patient Consent Form

Our Notice of Privacy Practices provides information about how we may use or disclose protected health information.

The notice contains a patient's rights section describing your rights under the law. You ascertain that by your signature that you have reviewed our notice before signing this consent.

The terms of the notice may change, if so, you will be notified at your next visit to update your signature/date.

You have the right to restrict how your protected health information is used and disclosed for treatment, payment or healthcare operations. We are not required to agree with this restriction, but if we do, we shall honor this agreement.

The HIPAA (Health Insurance Portability and Accountability Act of 1996) law allows for the use of the information for treatment, payment, or healthcare operations.
By signing this form, you consent to our use and disclosure of your protected healthcare information and potentially anonymous usage in a publication. You have the right to revoke this consent in writing, signed by you. However, such a revocation will not be retroactive.

By signing this form, I understand that:

· Protected health information may be disclosed or used for treatment, payment, or healthcare operations.
· The practice reserves the right to change the privacy policy as allowed by law.
· The practice has the right to restrict the use of the information but the practice does not have to agree to those restrictions.
· The patient has the right to revoke this consent in writing at any time and all full disclosures will then cease.
· The practice may condition receipt of treatment upon execution of this consent.

May we phone, email, or send a text to you to confirm appointments? YES NO

May we leave a message on your answering machine at home or on your cell phone? YES NO

May we discuss your medical condition with any member of your family? YES NO

If YES, please name the members allowed:

_____

_____

This consent was signed by: _____
(PRINT NAME PLEASE)

Signature: _____ Date: _____

Witness: _____ Date: _____

Informed Consent to Treat

It is by my own choice that I seek treatment at Center for Focused Care, LLC. I authorize the physicians and providers of Center for Focused Care, LLC to provide treatment that they judge beneficial to me. I understand that this may include tests, examinations, medical treatment and consultations with the appropriate caregivers. No guarantees have been made to me regarding the outcome of this care.

I agree to the release of information from my files for reimbursement for health care services including SSA, Medicare, Medicaid, Insurance companies, welfare agencies, identified family, referring physicians and referred medical facilities.

I understand and give my consent that certain information pursuant to the 1990 Act 148 Commonwealth of Pennsylvania HIV/AIDS policy may not be confidential under the provision of the act.

I understand that all information is strictly confidential and will not be released unless and/or except:

- It is authorized in writing or abuse or neglect is suspected
- Center for Focused Care, LLC or its members are ordered by the court to do so
- The threat of physical danger to anyone (including the patient) is suspected
- State Correctional Institutions and county prisons request information for continuity of care
- It is necessary for third party payers
- Reviewers and inspecters such as, The Office of Mental Health and Substance Abuse request it for the purpose of licensure and certification

Telehealth

The potential benefit of Telehealth services is that I will be able to talk with mental health staff from a local setting for an evaluation of my needs. I will be able to participate in mental health services, and if appropriate, be prescribe medications.

The potential risk of Telehealth services is that there could be a partial or complete failure of the equipment being used which could result in mental health staff's inability to complete the evaluation, mental health services, and/or prescription process. These services rely on technology, which allows for greater convenience in service delivery. There are risks in transmitting information over technology that include, but are not limited to, breaches of confidentiality, theft of personal information, and disruption of service due to technical difficulties.

There is no permanent video or voice recording kept of the telehealth service session.

All existing confidentiality protections apply.

All existing laws regarding client access to mental health information and copies of mental health records apply.

I understand the limits of confidentiality and the above information regarding Consent to Treatment and Telehealth. It is without any pressure or coercion that I sign this consent.

Signature of patient if 14 or older/otherwise parent Date

Printed Name Relationship to person receiving services

Witness Date