Patient Name _____Date of Birth:_____

111 Roberts Road Ste 150, Grindstone, PA 15442
Phone: 724-785-4346| Fax: 724-364-7117

707 Ligonier Street, Latrobe, PA 15650
Phone: 724-537-9515| Fax: 724-537-9516

5301 Grove Road M123, Pittsburgh, PA 15236
Phone: 412-677-9100| Fax: 412-207-2252

Name: _____Social Security Number:_____
Address: _____

Date of Birth:_____ Home Phone: _____ Cell Phone: _____

Emergency Contact: _____Phone: _____

Primary Care Dr.:_____Location:_____

Parent/ Guardian: (If under the age of 18 years old) _____

Primary Insurance Provider: _____Insurance Number: _____

Policy Holder's Name:_____D.O.B_____Employer:_____

Secondary Insurance Provider: _____Insurance Number: _____

****

Main reason for today's visit: _____

Other concerns:_____

In the past month, have you had little interest or pleasure in doing things, or felt down, depressed or hopeless? Yes or No
In the past month, have you had any thoughts of hurting yourself or others? Yes or No
In the past month, have you had any thoughts of killing yourself ? Yes or No
Have you completed a living will or durable power of attorney for health care? Yes or No

SURGICAL HISTORY: Please list all prior operations (with dates), if none, write NONE:

_____

_____

PERSONAL MEDICAL HISTORY: Please indicate whether you have had any of the following medical problems

____Heart disease ____High blood pressure ____High cholesterol ____Diabetes (*specify type)* _____

___Thyroid problem ____Kidney disease ____Asthma/Lung disease ____Cancer ____Other _____

FAMILY HISTORY: Please indicate the current status of your immediate family members:
Please indicate family members (parent, sibling, grandparent, aunt or uncle) with any of the following conditions:

Alcoholism _____High cholesterol_____ Cancer, specify type_____ High blood pressure_____
Heart disease _____Stroke _____Depression/ suicide_____ Bleeding or clotting disorder_____
Genetic disorders_____ Asthma/COPD _____Diabetes_____ Psychiatric, specify type_____

SOCIOECONOMICS Occupation: _____ Employer: _____

Years of education/highest degree: _____ Marital Status: Single Married Divorced Widowed Other

Spouse/ partner's name: _____ Number of Children/ ages: _____

Who lives at home with you? _____

Patient Name _____Date of Birth:_____

SOCIAL HISTORY

Tobacco Use

Do you smoke cigarettes or use any other tobacco products?
If yes, how much_____
Are you interested in quitting? □ No □ Yes

Alcohol Use

Do you drink alcohol? □ No □ Yes # drinks/week _____
Is your alcohol use a concern for you or others? □ No □ Yes

Drug Use

Do you use any recreational drugs? □ No □ Yes
If yes, what kind?_____
Have you ever used needles to inject recreational drugs? □ No □ Yes

Sexual Activity

Sexually active: □ No □ Yes □ Not currently
Current sex partner(s) is/are: □ Male □ Female
Birth Control method: _____ □ None needed
Have you ever had any sexually transmitted diseases (STDs)?
□ No □ Yes
Are you interested in being screened for sexually transmitted diseases? □ No □ Yes

OTHER CONCERNS

Caffeine Intake: □ None □ Coffee/tea/soda_____ cups/day

Weight: Are you satisfied with your weight? □ No □ Yes
Diet: How do you rate your diet? □ Good □ Fair □ Poor

Exercise:

Do you exercise regularly? □ No □ Yes
What kind of exercise? _____
How long (minutes) _____ How often? _____

Safety:

Is violence at home a concern for you ? □ No □ Yes
Have you ever been abused? □ No □ Yes
Do you have a weapon in your home? □ No □ Yes
What type of weapon (s) (ex. gun, knife, etc.)_____

_____

Are you currently taking **Methadone** or **Suboxone**? □ No □ Yes
If Yes, Please notify staff, as certain medications combined with these substances can be life threatening.

WOMEN'S HEALTH HISOTRY or Not Applicable

pregnancies _____ # deliveries _____ # abortions _____ # miscarriages _____

Age at start of periods: _____ Age at end of periods:_____

MEDICATIONS: Prescription and non-prescription medicines, vitamins, home remedies, birth control pills, herbs, etc.
If none, write NONE.

Medication	Dose (e.g., mg/pill)	How many times per day

PAYMENT POLICY:I understand that co-pay is due at time of service. I also understand that I am responsible for any remaining balances, and 50% of my balance must be paid at the time of service or I may not be seen. I also understand that if I am required to be rescheduled, I may not be seen or receive prescriptions until adhere to payment policy.

_____ _____
Signature of Patient or Parent/Representative (if under 14 years old) Date

_____ _____
Witness ***Date***

Patient Name _____Date of Birth:_____

Western PA behavioral Health Resources

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Consent to Treatment
(Initial on each line)

I have been informed about the treatment offered at Western PA Behavioral Health Resources, and I agree to participate in treatment. I understand that an individualized treatment plan will be developed by the Clinicians of Western PA Behavioral Health Resources. The plan will outline treatment goals. I will participate in the development of my treatment plan, and I agree to participate in all aspects of the plan. I am aware that no guarantees have been made with regard to services from Western PA Behavioral Health Resources due to variables that can impact treatment. I give my consent for the release of any information regarding treatment to my insurance company(s). This consent includes treatment plan, psychiatric evaluation, medications, therapy, and any other pertinent information that may be requested in order to approve or authorize the services provided. _____

Mental Health Treatment at this practice requires that patients participate in all scheduled appointments in order to improve the patient's overall health. Patients will be seen by the physician or nurse practitioner for medication management and will be assigned to a licensed therapist who will facilitate therapy sessions. Patients are required to participate in therapy at least one time per month if receiving medications, unless otherwise specified by the doctor. Patients are required to call at least 24 hours in advance to reschedule or cancel any appointments. Three no shows of any scheduled appointment may result in discharge. After discharge, the patient must wait 6 months in order for case to be reviewed for continued treatment. _____

- I agree to conduct myself in a courteous manner in the doctor's office. I will not bring any weapons or illegal items with me to my appointment. I understand that my safety and the safety of other patients and staff is of paramount importance I agree not to conduct any illegal or disruptive activities in the doctor's office. _____
- I understand that three no shows or cancellations under 24 hours within a period of 6 months may result in discharge from treatment or changes to my treatment plan. I understand that I must call at least 24 hours in advance to reschedule or cancel any appointment and non-compliance can result in discharge. _____
- I agree to adhere to the payment policy outlined by this office. All copays must be paid at the time of service. If there is a balance, 50% of balance must be paid at time of service. _____
- I agree that my prescription can only be given to me at my scheduled appointment. A missed appointment may result in me not getting my prescription until my next appointment. I understand that my medication is my responsibility and I agree to keep it in a safe, secure place. I understand that lost or stolen medication cannot be replaced. I agree to take my medication as prescribed. I will keep the physician and therapist informed of any changes in medications or other mental health or drug and alcohol services I am receiving as this could impact treatment and safety. I understand that I may be discharged if I do not comply. I understand that medication alone is not sufficient treatment for my condition, and I agree to participate in individual therapy sessions as recommended by the doctor. _____
- I will inform the physician and therapist if I am taking **Methadone** or **Suboxone**. I understand that I cannot be prescribed any benzodiazapines (Xanax, Klonopin, etc.) while taking **Methadone** or **Suboxone**, as there could be life threatening side effects when combined. I understand that I may be subject to random urine screenings. _____

Follow-Up

I give my consent for the staff at Western PA Behavioral Health Resources to contact me after discharge. The purpose of the contact will be to collect information about treatment and status of aftercare plan. As a participant in mental health treatment at Western PA Behavioral Health Resources, I freely and voluntarily agree to accept this treatment contract. _____

_____ _____
Signature of Patient or Parent/Representative (if under 14 years old) Date

_____ _____
Witness ***Date***

Patient Name _____Date of Birth:_____

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Patient Consent for Use and Disclosure of Protected Health Information

I hereby give my consent for Western PA Behavioral Health Resources to use and disclose protected health information about me to carry out treatment, payment and health care operations. (*The Notice of Privacy Practices, provided by Western PA Behavioral Health Resources, describes such uses and disclosures more completely.*)

I have the right to review the Notice of Privacy Practices prior to signing this consent. Western PA Behavioral Health Resources reserves the right to revise its Notice of Public Practices at any time. A Notice of Privacy Practices may be obtained upon request.

With this consent, Western PA Behavioral Health Resources may call phone numbers provided in my case file regarding appointments or other information pertaining to my clinical care. The best numbers to reach me at are listed below.

Daytime Phone Number_____Alternate Phone_____

With this consent, Western PA Behavioral Health Resources may mail items that assist the practice in carrying out treatment, payment and health care operations, such as appointment reminder cards and patient statements, items that pertain to the termination of treatment, as long as they are marked *Personal and Confidential.* My Mailing addressed is listed below.

Mailing address_____

By signing this form, I am consenting to allow Western PA Behavioral Health Resources, to use and disclose my protected health information to carry out treatment, payment and health care operations, including pharmacy. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign his consent, or later revoke it, Western PA Behavioral Health Resources may decline to provide treatment to me. My preferred pharmacy is listed below.

Pharmacy_____

Along with my consent for use and disclosure of protected health information, I received a copy of *Your Health Information Privacy Rights*.

_____
Patient Signature

_____ _____
Signature of Parent/Representative (if under 14 years old) Date

_____ _____
Witness Date

Patient Name _____ Date of Birth:_____

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I, the undersigned, hereby give our consent for the exchange and discussion of the confidential information concerning:

PATIENT NAME: _____ D.O.B: _____ MA#:_____

I give authorization to the persons/agencies below INITIALED below to release information from my treatment record to Western PA Behavioral Health Resources. Records requested will be used for billing, assessment, treatment plan development, and provision of services. I also authorize Western PA Behavioral Health Resources to release information from my patient record to the below mentioned persons/agencies, for billing, assessment, treatment plan development, and provision of services.

I understand that information will be disclosed for purposes noted above and that the information released will be limited to the following items: Psychiatric Evaluation, Physical Exam, Course of Treatment, Summary of Hospitalization , Discharge Summary, Drug &Alcohol Records , Lab/Urine Reports, Medications, Diagnosis, Developmental History, Treatment Recommendations, Progress, Treatment Plan, Academic Records, Current IEP/Educational Plan, Attendance, Observations, Two way written Communication, Two way verbal Communication and Legal History.

DO NOT RELEASE INFORMATION REQARDING: _____

__PCP: (NAME/PHONE)_____

__BEACON HEALTH OPTIONS, PO Box 1853, Hicksville, NY 118021853

__INSURANCE COMPANY: (NAME/PHONE) _____

__PHARMACY: (NAME/PHONE/CITY) _____

__SCHOOL DISTRICT: (NAME/PHONE) _____

__EMERGENCY CONTACT: (NAME/PHONE) _____

__CHILDREN AND YOUTH SERVICES: (COUNTY/PHONE)_____

__ JUVENILE PROBATION: (COUNTY/PHONE) _____

__DRUG AND ALCOHOL PROVIDER: (COUNTY/PHONE)_____

__ INTERMEDIATE UNIT ONE: PHONE 724-938-3241 FAX 724-935-8722

__OTHER (NAME/PHONE)_____

__OTHER (NAME/PHONE)_____

- I understand that information used or disclosed under the Authorization could potentially be re-disclosed by the person receiving the information and may no longer be subject to privacy protection provided to me by law.
- I understand that WPABHR may not require that I sign this Authorization in order to receive treatment.
- I have read this form and understand its contents after it has been explained to me. This authorization remains effective until. _____

  if no date, expires in 90 days
- I understand that this Authorization is effective for 90 days from the date of signature, unless otherwise specified below. No time frame may exceed one year from the date of signature. I understand that I have the right to revoke this authorization at any time by sending a written request to the entity/ person I authorized above to release the information.

Patient/Representative (if applicable)Name_____Relationship_____

Patient/Representative (if applicable)) Signature_____Date_____

Witness_____Date_____

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CRISIS PLAN

What are warning signs that a crisis may occur? If you were to encounter a crisis situation, what could start the crisis? Do you start to feel a certain way? Do you have urges to act a certain way?_____

_____

_____

_____

*****Describe a Typical Crisis Situation*****

Do you have scary thoughts? Do you become violent? Do others become violent? (If you do not experience crisis situations, describe a typical emergency situation that you may encounter that you may have to manage._____

_____

_____

*****Interventions and coping skills to use*****

What can you or others do to stay calm or calm the situation down? Separate from one another? Contact a support person? How can a support person help you? Go for a walk? Take a nap? What positive activities help to calm the situation down?_____

_____

_____

*****What is the best thing to do after the crisis is over? *****

Does it help to talk to someone after? Do you need time away from people after? What works for you to move past the crisis situation?_____

_____

_____

Remember:
- TAKE YOUR MEDICATION AS PRESCRIBED
- IF YOU EXPERIENCE SIDE EFFECTS-call the office, your PCP, or go directly to your nearest emergency room
- Keep all your scheduled appointments

People to call:
911
1-800-SUICIDE (1-800-273-8255)
Crisis Number:_____
Office Number: 724-785-4346
Neighbor/Friend:_____
Other:_____

Patient/Representative Signature:_____ Date:_____

Witness Signature:_____ Date:_____

Patient Name _____Date of Birth:_____

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Please circle one

Race

American Indian or Alaska Native

Black or African American

Native Hawaiian or other Pacific Islander

Patient Refusal

White

Ethnicity

Hispanic or Latino

Not Hispanic or Latino

Patient Refusal

Preferred Language

English

Other: _____

Organ Donor

Yes

No

Religion:_____